

Pushing the Profession Forward: The Innovation of the APRT

Mindy Conklin MRT, RRT, RRT-ACCS, AE-C



Disclosures



Monaghan Medical



VAPOTHERM

Objectives



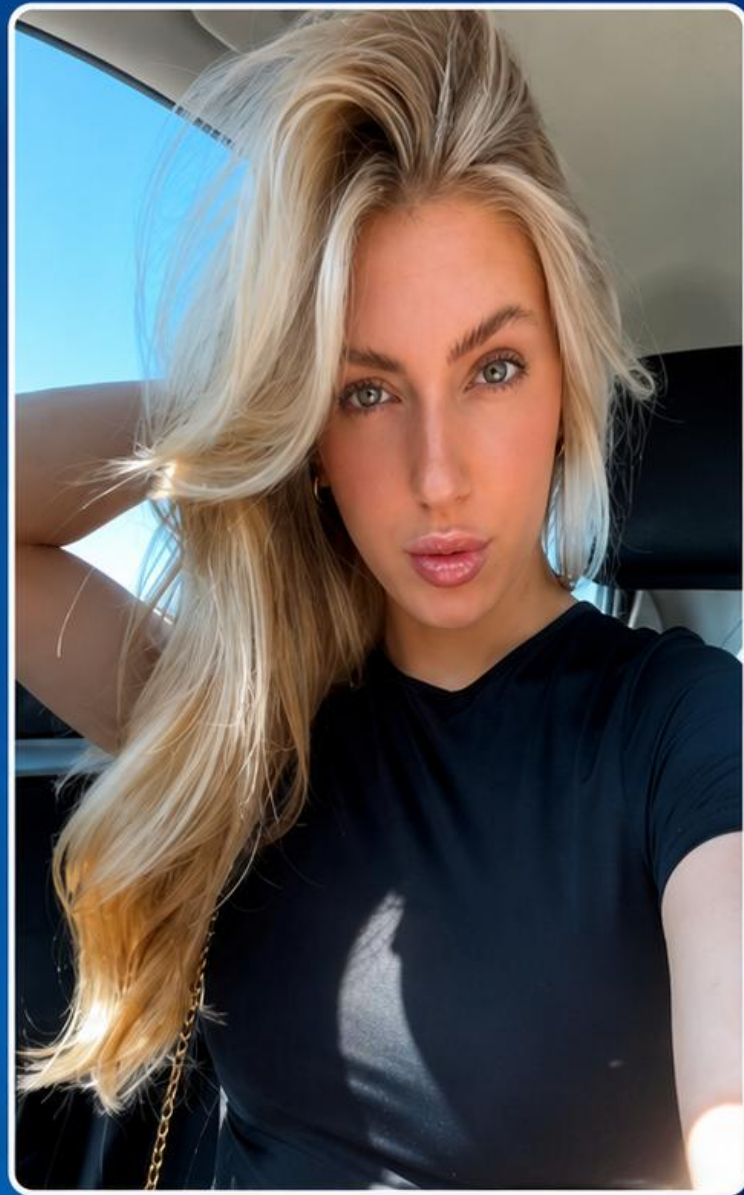
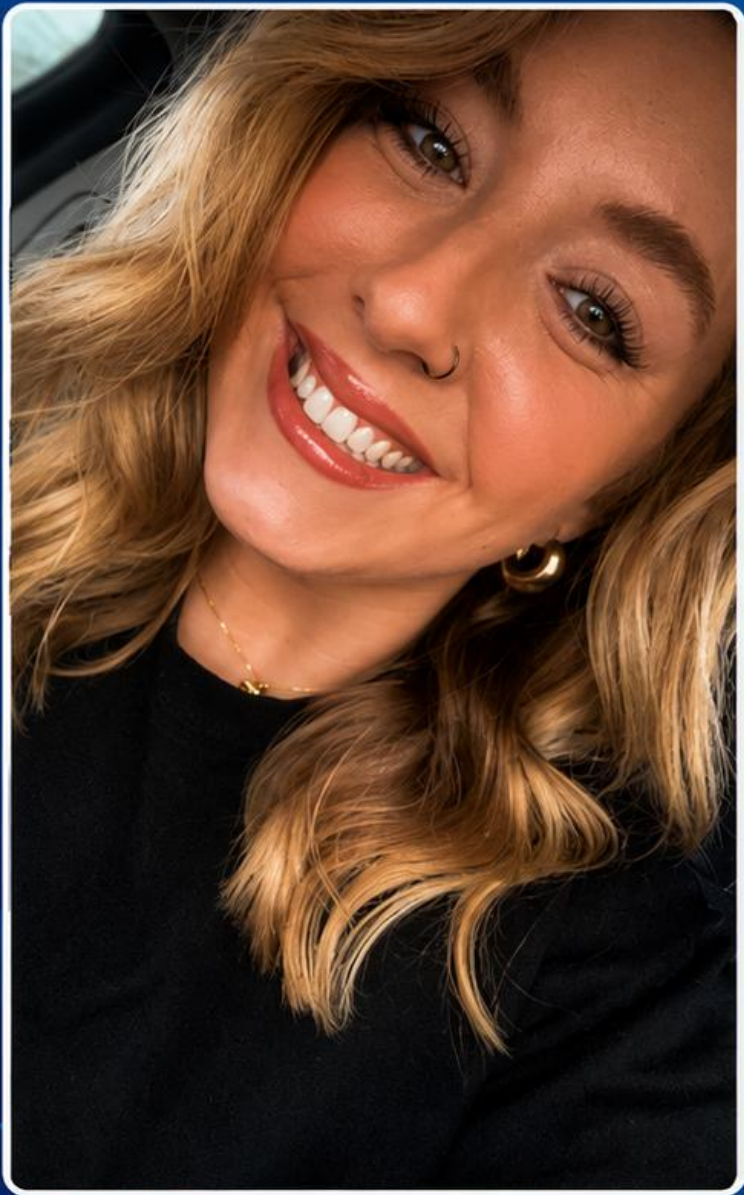
Education Requirements



The Role of the APRT



The Future of the Advanced Practice Respiratory Therapist





— I LOVE ♥ —
RESPIRATORY THERAPY



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.





THE OHIO STATE
UNIVERSITY

Education Requirements

A structured curriculum designed to prepare Advanced Practice Respiratory Therapists for excellence in patient care.

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



[Master of Respiratory Therapy \(osu.edu\)](https://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



THE OHIO STATE UNIVERSITY

Master of Respiratory Therapy (MRT) Program





THE OHIO STATE UNIVERSITY

Master of Respiratory Therapy

APRT APPLICATION REQUIREMENTS

Our Advanced Practice Respiratory Therapist (APRT) program prepares experienced clinicians to lead, advance patient care, and shape the future of respiratory health.



Minimum cumulative GPA of **3.0** on a 4.0 scale



RRT in good standing – **NBRC Verification letter**



BS or MS graduate from a
CoARC-accredited entry-level RT program



One year of experience in their
desired clinical specialty



CV or Resume



Reference Evaluations

The Role of the APRT



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.

THE ROLE OF THE APRT



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.



APRT DAILY PRACTICE



- **Practice within Pulmonary, Sleep, Lung Mass and Thoracic Surgery**

- Outpatient: **Decreased** wait times, **increased** 90 day follow ups, increased PAP compliance, **increase** adherence to smoking cessation remission, **decrease** COPD readmissions



- **Tour: Monday – Friday 8-1630**

No weekends, no Holidays



- **Prescribing & Orders**

Prescribed Habits | Prescribed Agents | Holter monitor | Echos
Sleep Studies – PSG, HSAT's | PAP systems | IVAPS
Hi-FLOW/Supplemental Oxygen | Airway Clearance
Pulmonary Function Test | Imaging | Lung Transplant Work-up
Labs | Mechanical Ventilator | Consult other services



Case 1



- **32-year-old female** with mood disorder (seasonal affective disorder) and **DJD of multiple joints** is being evaluated for management of **excessive daytime sleepiness (EDS)**. Previously on Adderall.



- Excessive daytime sleepiness started when she was in high school. **Got worse while she was in college.** The patient used to experience frequent episodes of excessive sleepiness. She has **fallen asleep in class and while driving.** She slept **10–12 hours a night** and still felt drowsy throughout the day.

Differential Diagnosis and Plan



- Obstructive Sleep Apnea
- Narcolepsy ??



Plan: Polysomnogram (PSG)



Mild OSA or upper airway resistance.



AHI was **3.9**.



RDI was **10.4**.



Supine AHI-3% was **2.4** | Non-Supine AHI-3% was **6.6**.



REM AHI-3% was **19.8** | NREM AHI-3% was **1.1**.



Oxygen Desaturation Index 3% (ODI-3%) was **3.3**.



Mean sleep oxygen saturation was **96%**
with lowest sleep oxygen saturation of **89**.

Follow up/Plan

- **PSG/MSLT**

The PSG revealed no sleep apnea, with an AHI of 3.1/hr and RDI of 3.7/hr. Min SPO2 was 93%. No significant PLMS were seen. MSLT revealed an average sleep latency of 6 minutes and 31 seconds. No SOREMPs.

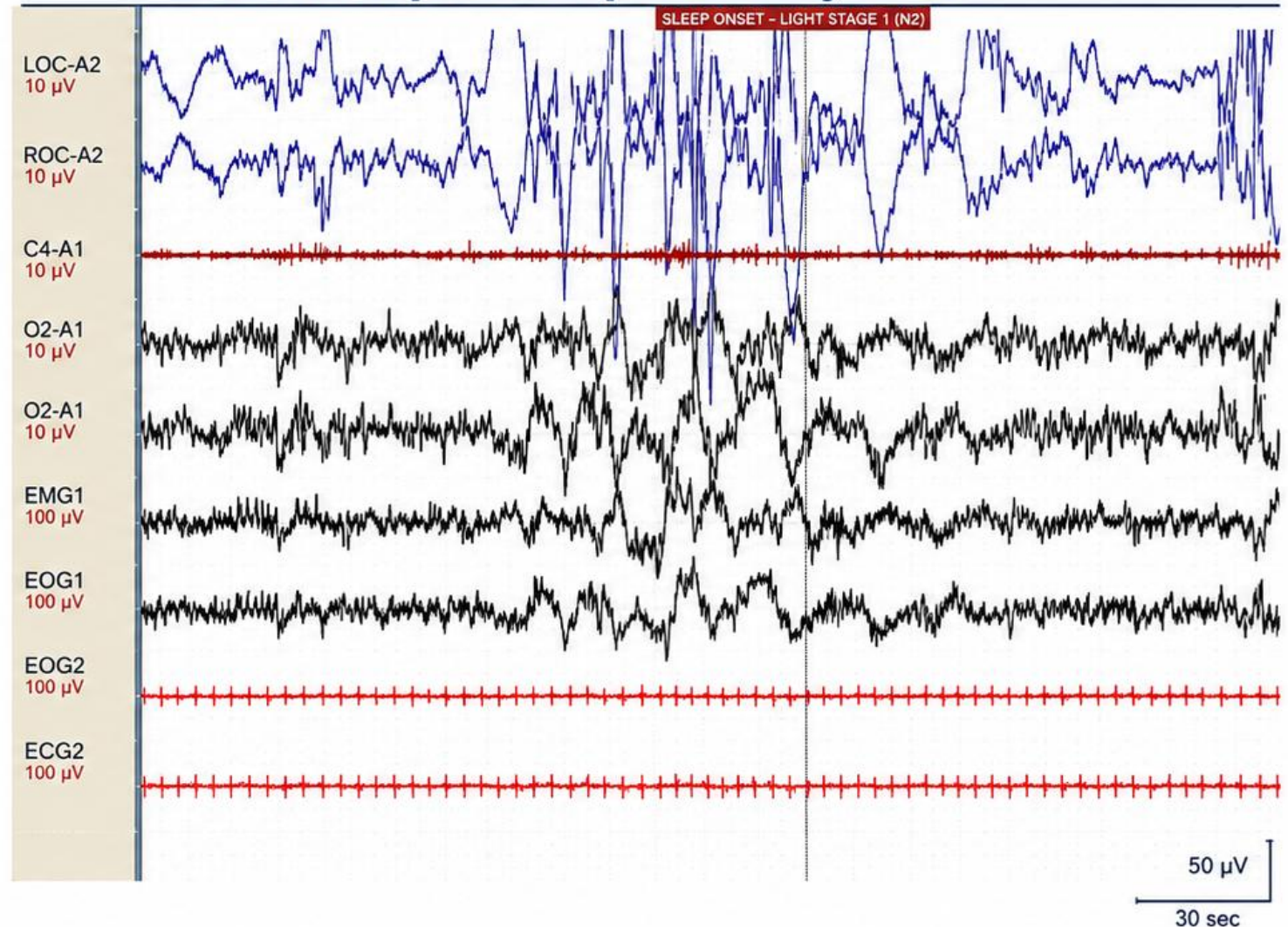


PSG: No Sleep Apnea

MSLT: Average Sleep Latency 6:31

No SOREMPs

Case: Multiple Sleep Latency Test





Case 2



- **77-year-old** patient with history of hyperlipidemia, **GERD**, tobacco dependence, chronic PTSD, depression, anxiety, essential tremors, low back pain, and cervical DJD.



He is a current smoker, **65 pack-years**.
Smokes ½ pack per day.

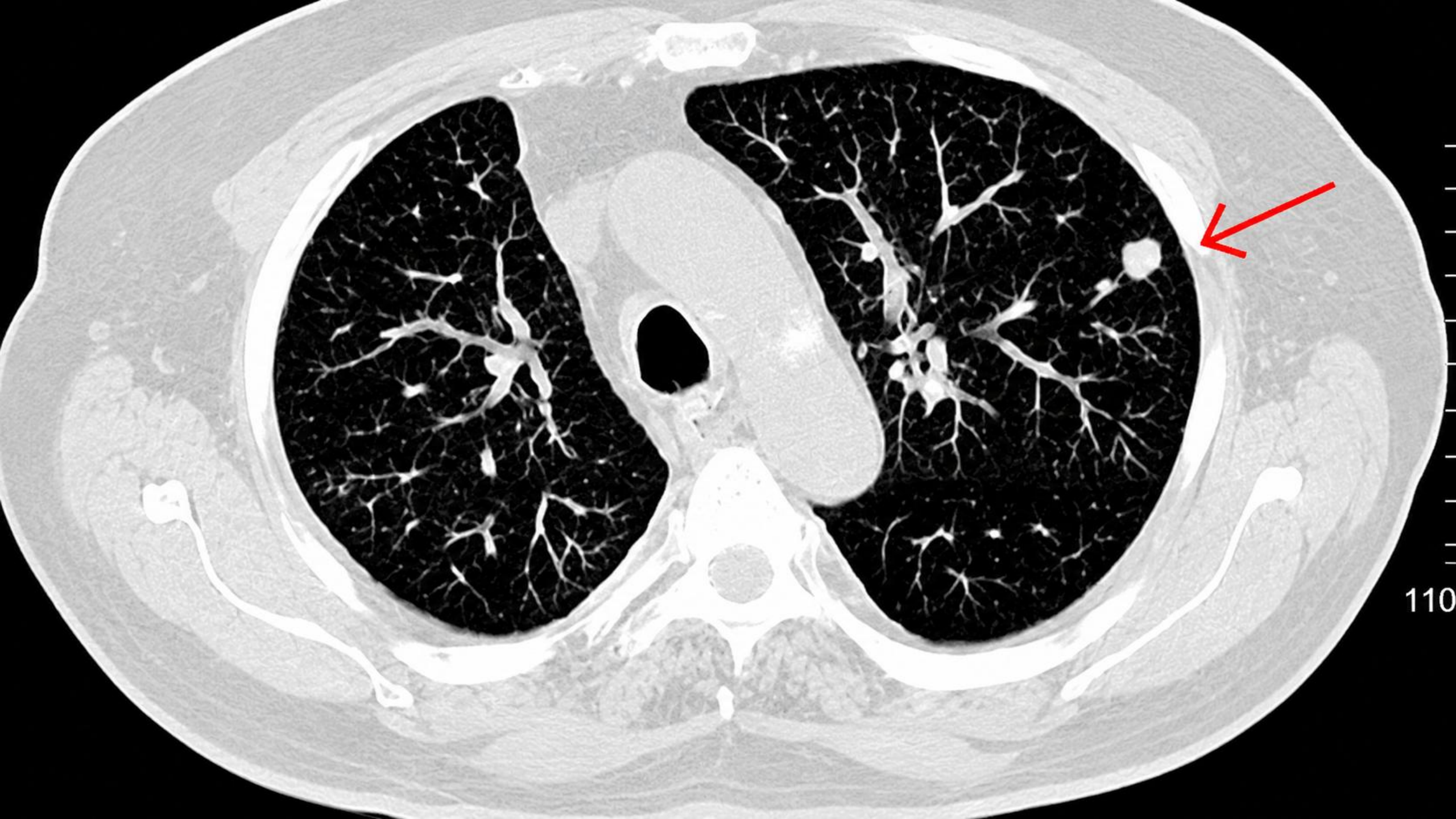


EBUS showed non-small cell lung cancer
Stage 2A t1BN1M.



He presents to clinic to discuss
treatment options.





SPIROMETRY		PRE-BRONCHODILATOR			POST-BRONCHODILATOR			CHANGE	
		Meas	%PRED	LLN	Meas	%PRED	LLN	Meas	CHG
FVC	Liters	2.78	81	2.54	2.95	86	6	0.17	6%
FEV1	Liters	1.87	73	1.86	1.95	76	4	0.08	4%
FEV1/FVC%		67	87	62	66	86	-1	-1	-1%
FEF25-75%	L/Sec	1.09	55	0.80	1.08	54	-1	-0.01	-1%

LUNG VOLUMES		Meas	%REF	LLN
TLC	Liters	5.08	79	5.01
VC	Liters	2.81	74	3.00
RV	Liters	2.27	92	1.39
RV/TLC%		45	115	26
FRC PL	Liters	3.25	92	2.47
ERV	Liters	0.98	92	0.30

DIFFUSION		Meas	%REF	LLN
DLCO	ml/Min/mmHg	11.08	49	16.49
KCO	ml/Min/mmHg/L	2.71	68	2.93
VA	Liters	4.10	72	4.58
IVC		2.73	72	3.00

Plan



1. Cardiology e-consult pre-op evaluation

Cardiology evaluation to assess perioperative cardiac risk and optimize management.



2. Consult placed for Med/Onc for chemo/IO

Referral to Medical Oncology for neoadjuvant/adjuvant chemotherapy and Immunotherapy evaluation.



3. Smoking Cessation

Start Chantix and Nicotine lozenge as needed (f/u) in APRT tobacco clinic for smoking cessation support.



4. Good surgical candidate

Good functional status; walks 2 miles a day.
S/P chemo/IO is appropriate for lobectomy.



Case 3



HISTORY OF PRESENT ILLNESS:



- Has a long history of COVID. Has had the virus 5 times. Was diagnosed with **Long COVID + Myocarditis** and has had worsening symptoms. Was vaccinated.



- **Shortness of breath** has gotten worse over the last 3 months with productive cough – clear sputum. Has a history of allergies, childhood asthma.



- Currently on **Zyrtec** no symptom relief. Has history of **hives** due to seasonal allergies/allergens.



- **Chief Complaint:** Dyspnea



Differential Diagnosis/Plan



Differential Diagnosis

- Seasonal Allergies
- Asthma



Plan

- ✓ Full PFT pre/post bronchodilator
- ✓ CT Chest w/o contrast
- ✓ LAMA/LABA
- ✓ Albuterol PRN
- ✓ Montelukast QD



Differential Diagnosis/Plan



DIFFERENTIAL DIAGNOSIS

- Seasonal Allergies
- Asthma



PLAN

- ✓ Full PFT pre/post bronchodilator
- ✓ CT Chest w/o contrast
- ✓ LAMA/LABA
- ✓ Albuterol PRN
- ✓ Montelukast QD

| Case 4



- A **41-yr female** presents to clinic for worsening **DOE**. Has a pmh migraines, perforated septum, chronic pain, and COVID x 3 in the last three years. In the past had run marathons w/o any SOB or DOE. Reports bout of **COVID in 2024**, since than gets extremely winded when doing any physical activity; previously was running long distances; no know exposures to toxins in the military. **Former Cigarette Smoker 5 pk yr**. Endorses **marijuana** and occasion **cigar use**.



- **Functional status:** Can only walk 2-3 blocks and 2 flights of stairs before DOE.



Spirometry Results



Spirometry 02/06/26



FVC

54



FEV1

22



FEV1/FVC

41



FEF35-75

17





Differential Diagnosis/Plan



Differential Diagnosis

- 1 Bronchiolitis Obliterans Syndrome
- 2 COPD



Plan

- ✓ Full PFT pre/post bronchodilator
- ✓ CT Thorax w/o contrast
- ✓ ICS/LABA
- ✓ SABA prn
- ✓ Encourage use of edibles instead of marijuana
- ✓ Encouraged smoking cessation
- ✓ Return to clinic in 3 months



SUCCESS STORY



- 77 yr old male



- 30 pk yr with moderate COPD



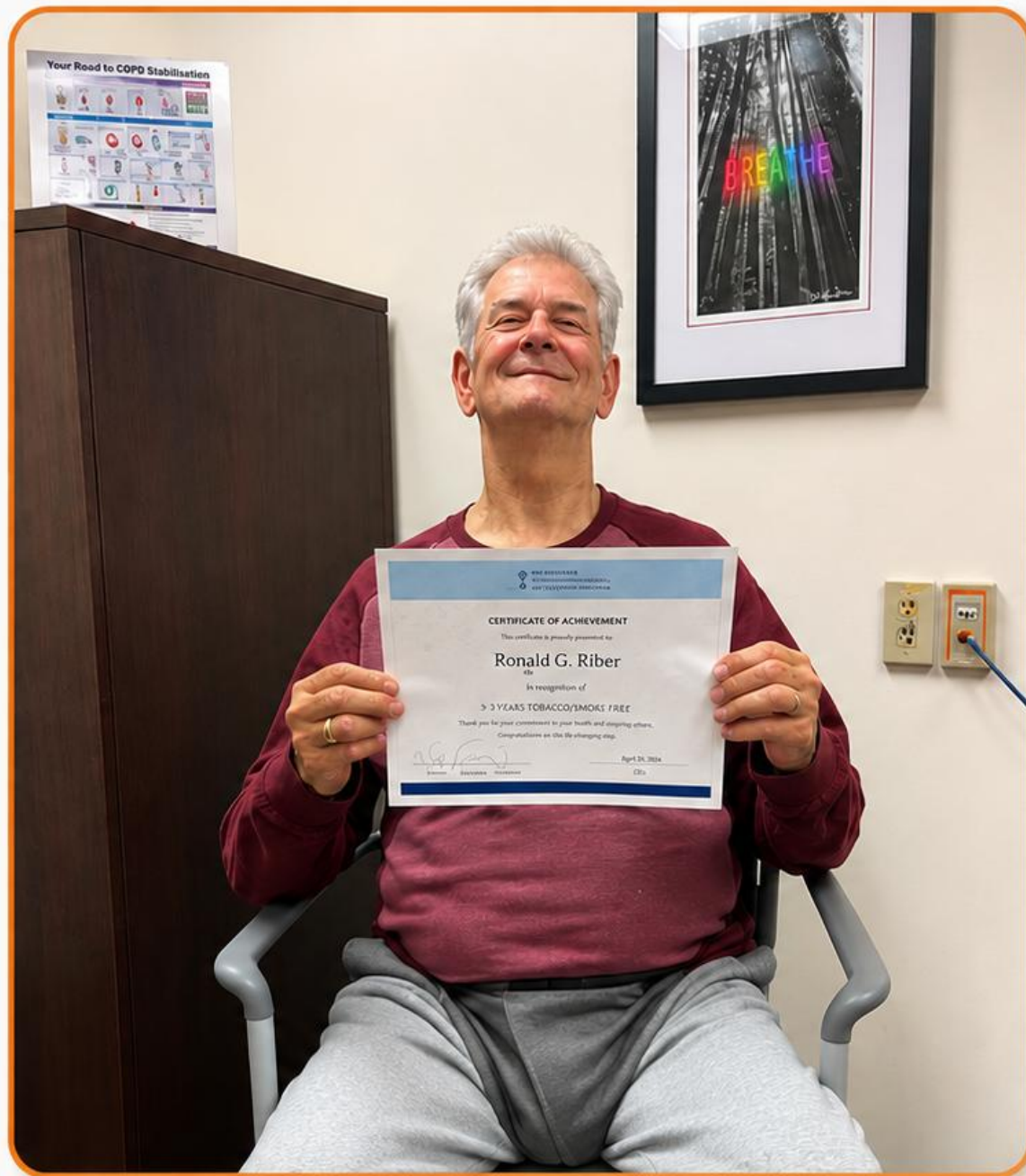
- **Tobacco Treatment:**
Chantix, Nicotine Lozenge



- >3 years Tobacco/Smoke Free



STRONGER LUNGS.
BRIGHTER FUTURE.





Descriptive Analysis of RT Guided Tobacco Cessation Outreach and Treatment

Mindy Conklin MRT, RRT-ACCS, RRT¹, Janak Deepesh MDP²

¹Pulmonary, VA Maryland Health Care System, Baltimore, MD, United States. ²Pulmonary and Critical Care, Univ. of Maryland, Baltimore, MD, United States.



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 enhance and enhance the tobacco cessation efforts

METHODS

- Workforce 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

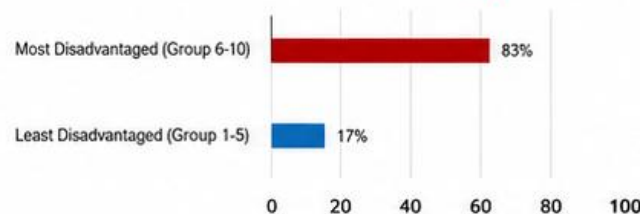
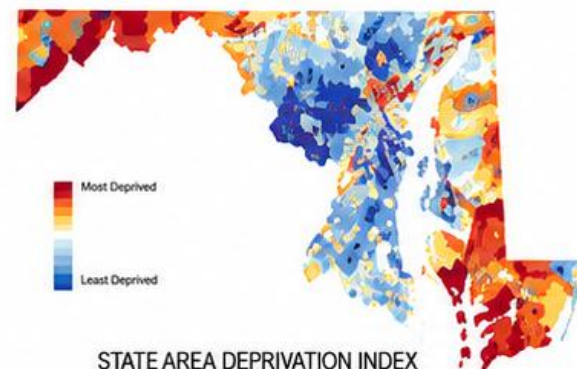
Demographic Information	Variable	No	%
Age (years), mean	63	23/92	
	Gender		
Race	Male	71	77%
	Female	21	23%
	Caucasian	47	51%
Pack Year, mean	Black	37	40%
	Other	8	9%
	53	36/107	
State Area Deprivation Index	Group 1-5	161	17%
	Group 6-10	299	83%

Outpatient Tobacco Cessation Counseling

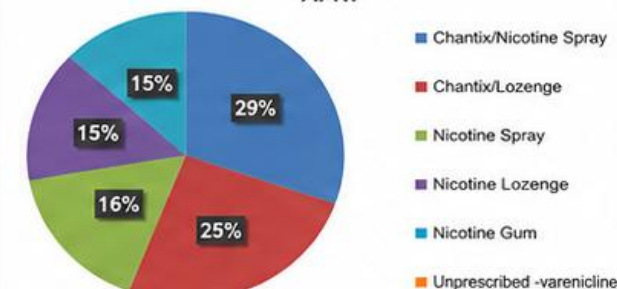
Demographic Information	Variable	No	%
Age (years), mean	64	89	
	Gender		
Race	Male	76	85%
	Female	13	15%
	Caucasian	34	38%
Pack Year, mean	Black	53	60%
	Other	2	2%
	64		
State Area Deprivation Index	Group 1-5	18	20%
	Group 6-10	71	80%

- Two-month follow-up data on 24 veterans seen in APRT tobacco treatment clinic shows 15 of 24 (63%) quit and 11 of 24 (46%) reduced cigarette use by 50%

Source: JOIN- IT, from San Diego



NRT Controller & Reliever Prescribed by APRT



References:

1. U.S. Department of Veterans Affairs. VA Tobacco Use and Cessation: Data and Resources. 2023. 2. Barnett PG, Nguyen TT, Biener L, Stead LF, et al. Outpatient tobacco cessation interventions for adults: A systematic review and meta-analysis. JAMA Intern Med. 2022;182(1):1-10. 3. Centers for Disease Control and Prevention (CDC). Smoking and Tobacco Use: Fast Facts and Data. 2023. 4. U.S. Department of Health and Human Services. The Healthcare Cost of Smoking – 2019. 5. Fiore MC, Jaén CR, Baker TB, et al. Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. 2008.

Tobacco Health Program

Five evidence-based strategies to treat tobacco use and dependence.



ASK
Ask about tobacco use at every visit.
Tobacco use assessment is the foundation of effective treatment. Identify and document tobacco users and former users.

ADVISE
Advise every tobacco user to quit.
A clear, strong, and personalized message increases motivation to quit.

ASSESS
Assess willingness to make a quit attempt.
Understanding a patient's willingness to quit helps gauge readiness and tailor the approach.

ASSIST
Assist in quitting.
Evidence-based interventions—such as counseling and medications—can significantly increase quit rates.

ARRANGE
Arrange follow-up contact.
Continuing support increases long-term success and helps prevent relapse.

REFER
Refer to specialized treatment.
Some patients benefit from additional expertise and resources.

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 650 veterans completed outpatient tobacco cessation counseling
- APRT's 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



Unequal Outcomes: Menthol Cigarettes and Reduced Varenicline Efficacy in African American Veterans



Mindy Conklin MRT, RRT-ACCS, RRT¹, Janaki Deepak MD²;

¹Pulmonary, VA Maryland Health Care System, Baltimore, MD, United States, ²Pulmonary and Critical Care, Univ of Maryland, Baltimore, MD, United States

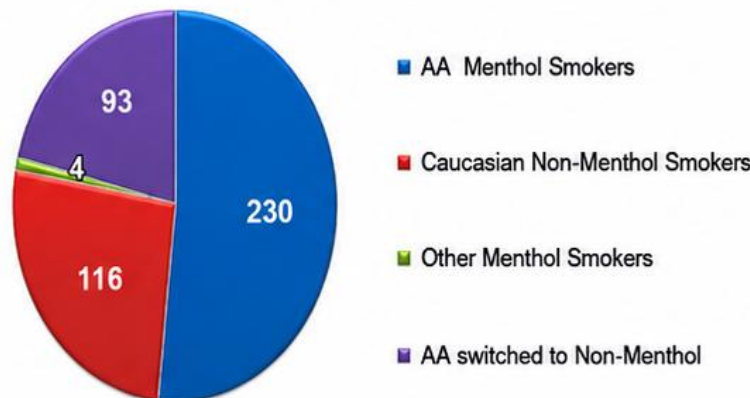
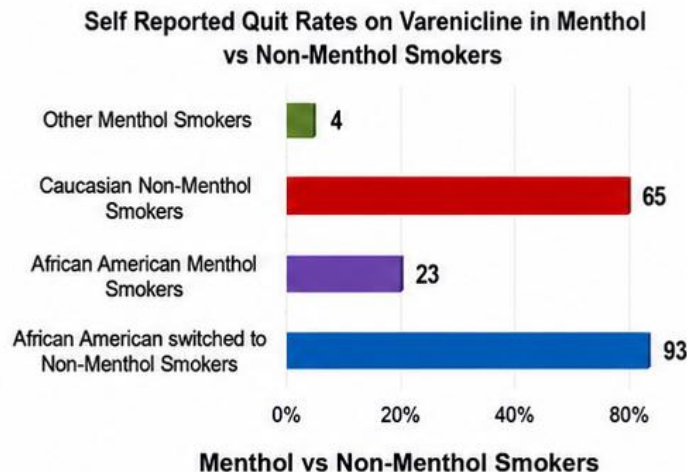
Background

- Varenicline is first-line pharmacotherapy for smoking cessation, however, its efficacy may depend on whether the patient is using menthol vs non-menthol cigarettes.
- There are racial differences in the use of menthol vs non-menthol cigarettes. For example, African American (AA) Smokers are more likely to use mentholated cigarettes. This may impact the effect of Varenicline in this population.
- We noted a pattern in the Advanced Practice Respiratory Therapist (APRT) Tobacco Treatment Clinic (TTC) which demonstrated varying responses to Varenicline based on cigarette type.

Methods

- A retrospective chart review was conducted on 350 patients seen in the APRT Tobacco Treatment Clinic. Veterans were initiated on combination therapy with Varenicline and nicotine replacement therapy. There was a subgroup of menthol users, that switched to non-menthol and was subsequently evaluated for quit rates.
- Clinical outcomes and self-reported quit rates were analyzed, with specific attention to cigarette type (menthol vs. non-menthol) and demographic patterns within the patient population.

Results



- Among African American menthol smokers who did not initially quit, switching to non-menthol cigarettes was associated with a substantial improvement in cessation rates, with 45% achieving abstinence after switching. This within-subgroup change was highly significant (McNemar's test, $p < 0.0001$).

Conclusions

- Among African American menthol smokers who did not initially quit, switching to non-menthol cigarettes was associated with a substantial improvement in cessation rates, with 45% achieving abstinence after switching. This within-subgroup change was highly significant (McNemar's test, $p < 0.0001$).



CANADA



MAINE

VERMONT

NEW HAMPSHIRE

MASSACHUSETTS

RHODE ISLAND

CONNECTICUT

NEW JERSEY

DELAWARE

MARYLAND

ATLANTIC OCEAN

NEW YORK

PENNSYLVANIA

OHIO

WEST VIRGINIA

VIRGINIA

NORTH CAROLINA

SOUTH CAROLINA

GEORGIA

FLORIDA

GULF OF MEXICO

LOUISIANA

MISSISSIPPI

ALABAMA

ARKANSAS

TEXAS

OKLAHOMA

KANSAS

MISSOURI

NEBRASKA

COLORADO

NEW MEXICO

ARIZONA

UTAH

NEVADA

CALIFORNIA

WYOMING

IDAHO

OREGON

WASHINGTON



0 100 mi
0 100 km



APAPP 2026

Las Vegas

Learning. Connecting. Advancing Respiratory Care.



CONNECTING

With peers and leaders in respiratory care.



LEARNING

Cutting-edge education that inspires clinical excellence.



ADVANCING

Our profession and the care we deliver every day.



Thank you

for the opportunity to learn,
collaborate, and grow together!



**STRONGER TOGETHER.
BETTER PATIENT CARE.**



“ Thank you for a well ran Sleep Clinic. You were very thorough. The education provided was great. The VA needs more of this ”

“ Keep doing what you're doing.
You are the BEST! ”

You are awesome. Thank you

“ My son is a RT,
you're FAMOUS ”

“ You're not like other providers.
You're something special. Thank
you! ”

“ I did not realize how food really tasted
until you helped me stop smoking. ”

“ Thank you for what you are doing for us veterans. You explained everything in a way I can understand. ”

“ I feel like a new person.
My breathing is better. Thank you ”

“ I STOPPED smoking thanks to you. ”

“ “You have taken the time with me to help me understand my COPD,
how to use my medications and you are the first person in 5 years to
actually put your hands on me, to look at me and listen to what I have
to say. Thank you.” ”

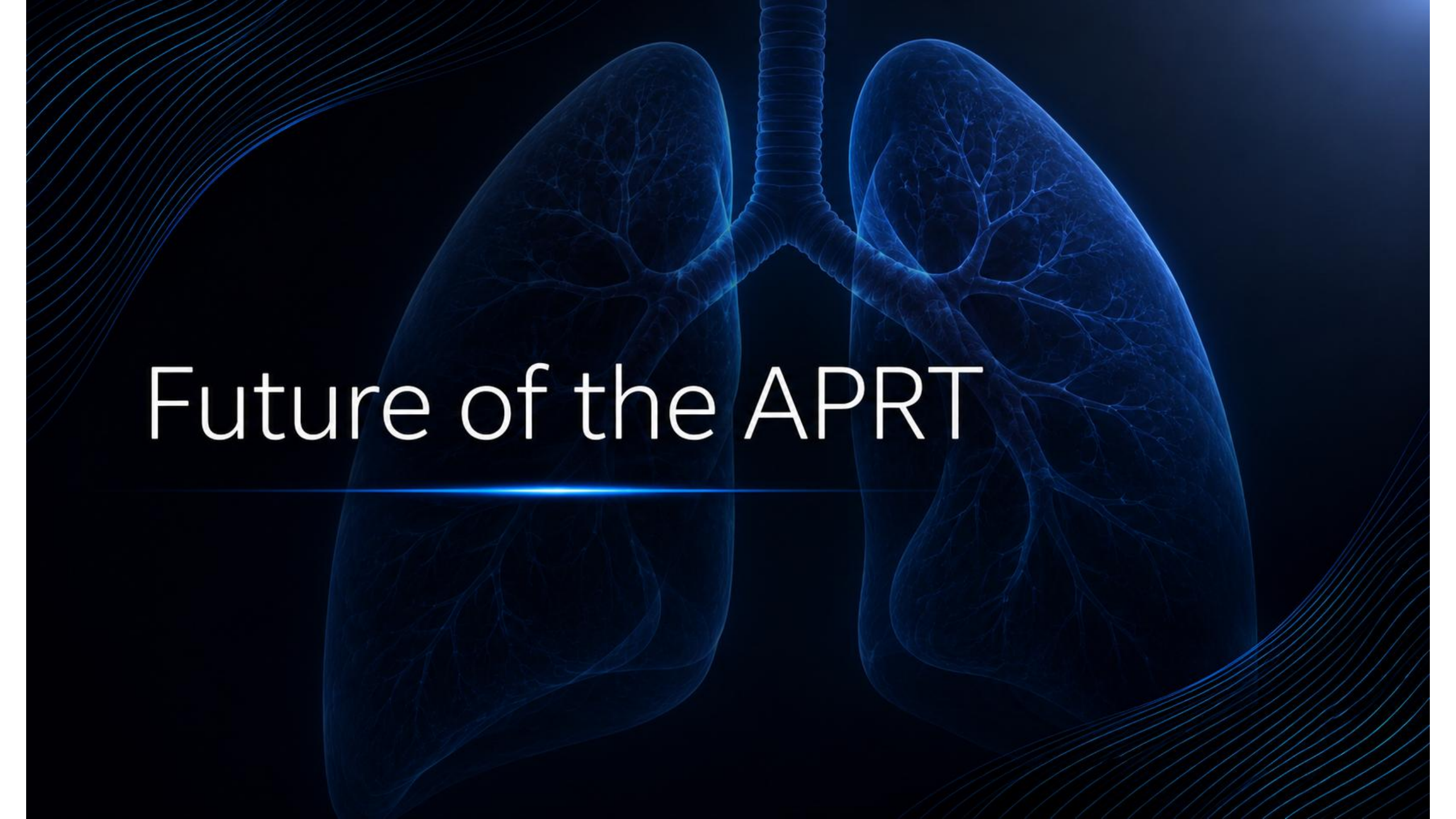
“ I can smell food.
Cigarettes really stink.
Thank you ”

“ You heard me. Thank you so much for that. ”

“ O-H! Thank you for caring ”

*“ I enjoyed our visit you were thorough and very easy
to listen to and glean information from, thank-you ”*

“ I understand my lung disease better now.
Thank you for taking the time to explain it
to me ”



Future of the APRT

AARC APRT Goals



1. Advocate and Educate on APRT

- Definition, Education requirements, Scope of Practice, license and credential



2. Develop more APRT programs

- AARC has set aside \$250,000 for the advanced of APRT



3. Legislation



4. CMS – Getting reimbursement for APRT services



5. Increase the number of RRTs with Doctorate degrees

AARC Advance RT Fund

- Those who have been funded (\$30,000) in the first round:
 - Ohio Society of Respiratory Care – Supporting advocacy efforts for legislative and regulatory initiatives for APRT licensure
 - Florida Society of Respiratory Care – Supporting advocacy efforts for legislative and regulatory initiatives for APRT licensure
 - University of Kansas- Support the development of an APRT program.



Licensure for an APRT?



Ohio

HB 253 – License Advanced Practice Respiratory Therapist



PASSED – UNANIMOUSLY



Is now in Health Committee of the Ohio Senate



North Carolina H71



Kentucky HB 709



Iowa & Texas – working on bill

OHIO WINS
for APRTs!

HB 253 3RD, FINAL PASSAGE
LIC. ADVANCED PRACTICE RESPIRATORY THERAPISTS

YEA 94		NAY 0		NV 5	
ANTANI	GALONSKI	LAROSE	SCHILLER		
BARNES	GEE	LIPPS	SCHMIDT		
BISHOFF	GERBERRY	LORT	SCHURING		
BLESSING	GRANBARI	MANCHESTER	SEITZ		
BOYO	HALL	MARTIN	SHERMAN		
BRENNER	HAMBLIN	MERRIN	SOBECKI		
BROWN	HICKS-HUDSON	MILLER	STEIN		
CARRUTHERS	HILLIER	MIRANDA	STOLTZFUS		
CHENEY	HOAGLAND	MORAN	STROM		
CIRINO	HOLLAND	O'BRIEN	SWOPE		
CLEMENTS	HOTTINGER	PATTON	TACKETT		
CUNNINGHAM	HOWSE	PAVIGLIANITI	UPCHURCH		
DEAN	HUMPHREY	PETERSON	VITALE		
DEMMEA	JARRELLS	PILlich	WACHTMANN		
DETNER	JOHNSON	RAY	WEINSTEIN		
DOLAN	KERN	RICHARDSON	WEST		
DOVILLA	KICK	ROBINSON	WHITE		
DUNGAN	KLAUS	ROMANCHUK	WIGGAM		
EDWARDS	KILLIAN	RUSSO	YOUNG		
FOWLER	ARTHUR KREBS	SANCHEZ			

SUB. H. B. NO. 253
LICENSE ADVANCED PRACTICE RESPIRATORY THERAPISTS

NOV 12, 2025
OHIO HOUSE OF REPRESENTATIVES

THE OHIO CHANNEL®

V-I-C-T-O-R-Y
94-0



THE OHIO SENATE

136TH GENERAL ASSEMBLY

My Ohio Legislature

Summary

Documents

Status

Votes

Committee Activity



Introduced
In House



In House
Committee



Reported By
Committee



Passed By
House



Sent To The
Governor



Introduced
In Senate



In Senate
Committee



Reported By
Committee



Passed By
Senate



Subjects

APRT



APRT Credentialing Exam?



No

There needs to be a significant increase in the number of individuals practicing as an APRT to support a credentialing examination.



NBRC has developed an outcome assessment exam.



REFERENCE:

The Foundation Supporting Future Assessments of Education Program Outcomes Among Providers of Advanced Practice Respiratory Therapy

Shaw R, et al. CHEST. 2025;167(1):202-210.



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.

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

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

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

The James Cancer Hospital and Solove Research Institute



SHE BELIEVED
SHE CONQUERED



I AM THE 1ST



APRT





RT SIDEBAR

— REAL TALK. REAL RESPIRATORY CARE. —

#1 Respiratory Podcast in the World

Platforms:



LinkedIn



TikTok



Ig



FB



YouTube



Spotify



EXPERT GUESTS

Leaders in respiratory care and beyond.



REAL DISCUSSIONS

Topics that matter to respiratory professionals.



STRONG COMMUNITY

Informing, inspiring and connecting our field.

POWERED BY

 **FeedSpot**

QUESTIONS?

Thank you!



Mindy.conklin@va.gov



Committed to Excellence.
Focused on Patient Care.