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# Times

A photograph of a woman and two children at a beach. The woman, Monique Ponce, is in the center, smiling broadly. She has sunglasses on her head and is wearing a blue tank top. To her left is a young girl, Amalia, wearing a yellow and blue life vest and smiling. To her right is a young boy, Diego, wearing a white neck brace and smiling. The background shows a rocky beach with other people in the distance.

**New RT  
Monique Ponce  
Speaks from  
Experience**

**How To  
Effectively  
TRAIN COPD  
PATIENTS**

**OSA Testing,  
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## AARC Strategic Plan

**AARC Vision/Mission Statement:** The American Association for Respiratory Care (AARC) will continue to be the leading national and international professional association for respiratory care. The AARC will encourage and promote professional excellence, advance the science and practice of respiratory care, and serve as an advocate for patients, their families, the public, the profession, and the respiratory therapist.

## AARC Strategic Objectives

- Validate the science of respiratory care and the value of the respiratory therapist (RT) in providing respiratory care by supporting, conducting, and publishing research information.
- Promote respiratory therapists as the best providers of respiratory care by assuring that the science that clarifies the value and role of the RT is provided to those stakeholders whose decisions and actions need to be guided by that information.
- Promote respiratory therapists and the American Association for Respiratory Care by developing and implementing promotion and marketing campaigns targeted to unique audiences.
- Assure the Association has the resources to meet the needs of its members and that the AARC has the needed financial, volunteer, and staff resources needed to accomplish the implementation of the strategic plan of the Association.

The complete version of the Association's Strategic Plan is available to AARC members online at [www.aarc.org/members\\_area/resources/strategic.asp](http://www.aarc.org/members_area/resources/strategic.asp).

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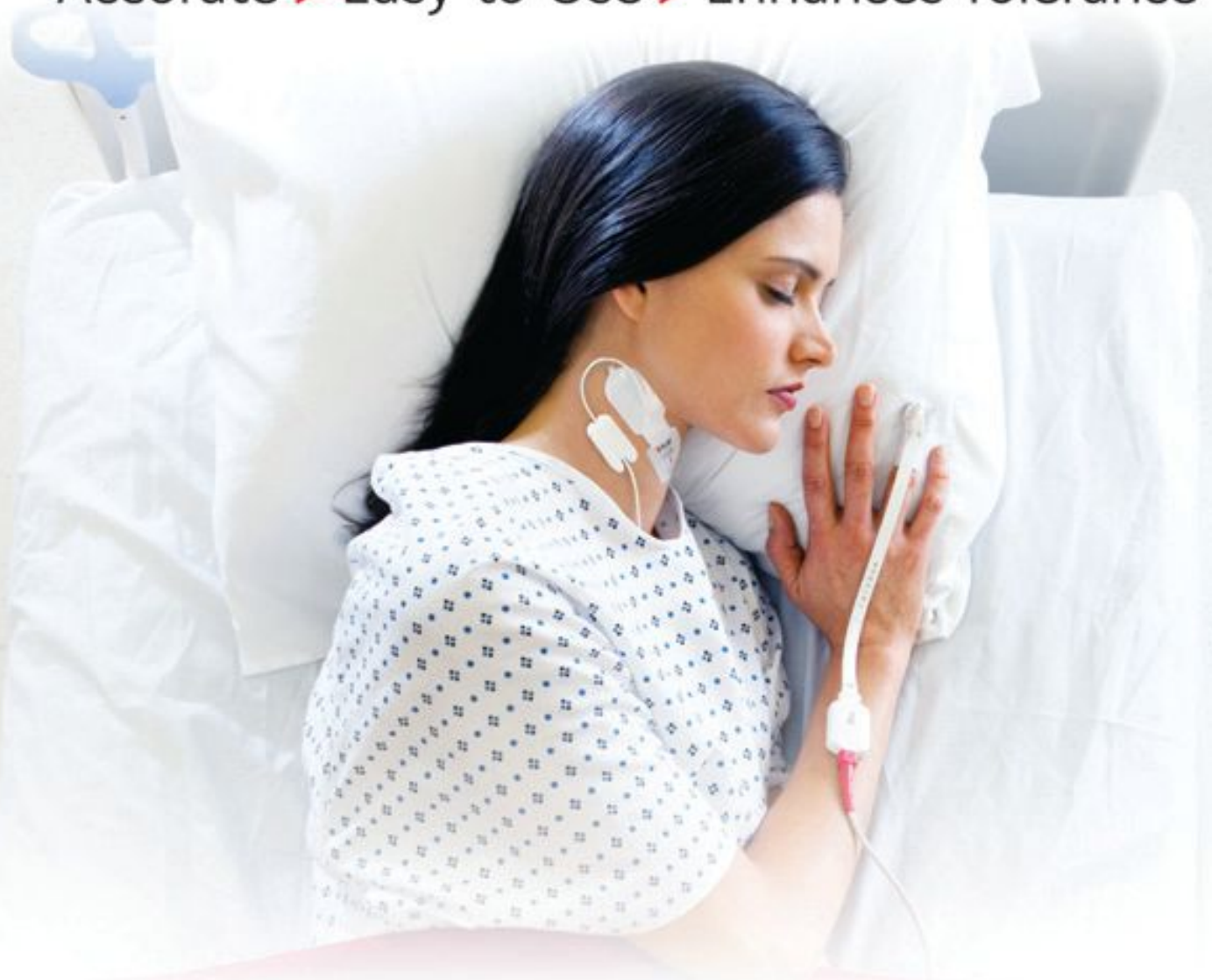
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## Maintaining Quality of Life for Portable Ventilator Patients Outside of the Hospital

by Joseph Lewarski, BS, RRT, FAARC

*Sing like no one's listening, love like you've never been hurt, dance like nobody's watching, and live like it's heaven on earth.*

– Mark Twain

### What is quality of life?

Quality of life is a phrase used so often in health care that I fear we risk becoming desensitized to it. It is a highly subjective phrase that is influenced by a myriad of variables, including but not limited to age, race, geography, culture, religious beliefs, socioeconomic status, and physical and mental condition. It is unique to the individual, extremely difficult to standardize, and highly challenging to effectively and objectively measure.

Although the term “quality of life” has meaning for nearly everyone and within every academic discipline, individuals and groups can define it very differently. The website dictionary.com defines quality of life (QoL) as “your personal satisfaction or dissatisfaction with the cultural or intellectual conditions under which you live.”<sup>1</sup> For patients with chronic illness and complex technology dependency, such as home mechanical ventilation (HMV), QoL is a very sensitive and personal issue. One individual’s routine, daily behavior is another’s major goal. For those with a disability, QoL may be associated with activities or achievements that may seem modest or routine for those not faced with the challenges of a disability or technology dependency.

### What is health-related quality of life?

The concept of health-related quality of life (HRQoL) and its determinants started to evolve in the 1980s and became more defined in the mid 1990s. As we began the transition into a more patient-centric health care deliv-

ery model, the concepts associated with measuring and monitoring HRQoL became more relevant. Today, HRQoL is integrated into many health care environments and processes.

HRQoL measures are intended to encompass those aspects of overall quality of life that can be clearly shown to specifically affect an individual’s physical and/or mental health. To consistently assess and measure HRQoL across a variety of conditions, activities, and environments of care, standardized survey tools have been developed.

The Short Form Health Survey (SF-36) was developed from the RAND Medical Outcomes Study and provides a set of generic, coherent, and easily administered QoL measures that are packaged into a 36-question survey.<sup>2</sup> The SF-36 is widely used in clinical research and throughout the health care continuum as a standardized means to measure the impact of care and interventions on the patient. The SF-36, along with a variety of disease-specific survey tools, are commonly used to help establish a HMV baseline HRQoL and track it as the patient’s condition changes. Additional QoL assessment tools that may be useful in gauging an HMV patient’s QoL include the Guyatt Chronic Respiratory Questionnaire and the St. George Respiratory Questionnaire, both of which have been used and validated in respiratory patients.

### Quality of life for home mechanical ventilation patients

Like many of the processes and procedures used in home care, there is not an abundance of objective science to serve as a guide for best practice. However, using the aforementioned standardized forms and other tools, there is some published research in the area of HMV and

### about the author...



Joseph Lewarski, BS, RRT, FAARC, is vice president of clinical affairs at Invacare Corporation in Elyria, OH.

QoL. Windisch et al used standard and disease-specific survey tools to present evidence that HRQoL is strongly influenced by the patient's underlying disease for those already receiving HMV, with the best HRQoL being reported in patients with kyphoscoliosis and the worst for those with COPD.<sup>3</sup> Markstrom and colleagues evaluated a group of invasive and noninvasive mechanical ventilation patients with neuromuscular and skeletal diseases for QoL and concluded HMV patients reported good perceived health despite severe physical limitations.<sup>4</sup> Both studies suggest that various disease- and patient-specific issues impact the perceived QoL for individuals requiring both invasive and noninvasive HMV.

### It takes a village

A less often discussed but equally important concern is the QoL of the family and caregivers of ventilator-dependent individuals. Accepting the responsibility for the care of a patient requiring HMV and other complex medical technology is a major undertaking, and for many families is truly a life-altering event. In many HMV cases, the immediate and extended family become the primary caregivers and are typically responsible for managing the patient 24/7. They provide this high level of care while also maintaining a household and often caring for other family members. This is especially true for parents caring for a child requiring HMV or other complex technology. Carnevale et al studied the stress in families of ventilator-assisted children living at home and determined that parental responsibility was highly stressful and sometimes overwhelming.<sup>5</sup> Having learned from my own experiences educating and working with ventilator-dependent children, the level of stress placed on the family is very high and in the most extreme cases results in the breakdown of the family.

### Care planning for QoL

There is no single criterion or set of goals that can promote the ideal QoL for a specific HMV patient. Factors that will influence a specific patient's QoL should be discussed and goals established with the patient, family, and caregivers at the start of the HMV process. HMV is considered one of the most comprehensive and technically complex medical technologies provided in the home; and as a result it presents numerous challenges for the home medical equipment provider, the patient, their family, and other caregivers.<sup>6</sup> Developing a patient-centric, transparent, patient- and family-specific plan of care that includes an explicit understanding of the QoL they are seeking and the realities of such is essential in laying the framework for a successful HMV experience.

As noted, QoL targets should be developed as part of an individualized plan of care. However, here are some commonly used goals that should be part of a HMV care plan:

- Develop a care plan with input from the patient, family, physician, and other key stakeholders.
- Provide education and training of the patient, family, and caregivers.
- Prevent infection.
- Prevent unplanned readmission.
- Use lightweight, portable ventilators and other supportive technologies that meet the patient's clinical and lifestyle needs, specifically selecting devices that enable the patient to be mobile. This may include meeting their needs at work, school, and travel.
- Develop a plan that ensures all stakeholders communicate regularly and effectively.
- Re-evaluate periodically using standardized QoL measures.

### Bring it home

A primary goal of all HMV programs is to ensure a safe and clinically appropriate environment of care. An equally important goal is to provide the patient and family the opportunity to live their lives to the fullest, defined under their terms when possible. Home care, including home mechanical ventilation, is intended to provide patients and families the resources, support, and technology needed to live with dignity and enjoy the highest quality of life possible. An organized and well-managed HMV program is one important part of the complex puzzle of achieving QoL for persons requiring ventilatory support. ■

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## A Better Night's Sleep for Scott: Testing and Treatment in a Special Population

by Debbie Bunch

**D**own syndrome is the most common genetic pattern of malformation in man, affecting between one in 700–800 live births.<sup>1</sup> People born with the condition have an extra copy of the 21st chromosome, which in addition to mental retardation causes a number of physical differences, including a narrow midface, large tongue, floppy muscle tone, tendency toward being overweight, and thyroid disease — all of which can put them at increased risk for obstructive sleep apnea (OSA).

In a study conducted by researchers from Johns Hopkins University in 2009, 94% of adults with Down syndrome had abnormal polysomnograms.<sup>2</sup> Moderate OSA with an apnea-hypopnea index (AHI) of more than 15 was found in 88%, and 69% were diagnosed with severe OSA with an AHI of more than 30. Despite these findings, only one of the 16 patients had been medically evaluated for the condition.

A similar study conducted in children with Down syndrome by investigators from the University of Cincinnati in 2006 found 57% of 56 children who had a sleep study between the ages of four to 63 months had abnormal study results.<sup>3</sup> When an elevated arousal index was considered, 80% had abnormal polysomnograms. Fifty-four percent of the children with abnormal results, however, had parents who reported no sleep problems in their children.

Clearly, OSA is a common and often under-recognized problem among children and adults with Down syndrome. But the question many providers might have is: Can these individuals be successfully tested in the average sleep lab and then treated with continuous positive airway pressure (CPAP)? Twenty-five-year-old Scott Carr is living proof that the answer is yes.

### No surprises, please

“Scott is a very routine guy who likes to know what’s going to happen and doesn’t like surprises,” says his mother, Rhonda Carr, who cares for her son at home in Oklahoma City, OK. He spends his days at the Oklahoma

Foundation for the Disabled, enjoying bowling on Mondays, a trip to Walmart on Tuesdays, tap dancing on Tuesdays and Wednesdays, a movie on Thursdays, and a dance till 9 p.m. on Thursday evenings.

Scott’s OSA was diagnosed about eight years ago after his mom noticed he was snoring loudly, moving around a lot during sleep, and tiring easily and even falling asleep during the day. While some of these symptoms could have been caused by other factors associated with Down syndrome, Rhonda was suspicious of OSA because it runs in her family. Her father suffered from severe sleep apnea back in the 1970s and 1980s, often falling asleep at his desk. Rhonda herself says she has the condition, and so does Scott’s older brother.

When Scott began to exhibit symptoms, she knew he needed further evaluation. “He was 17 years old when we went to the sleep lab at Integris Baptist Hospital,” she recalls. The testing, however, was not without its challenges. Scott didn’t like having the electrodes attached to his body, and even though the technician spent some time trying to explain to Scott what he was doing and why, the young man remained apprehensive. He also fought the application of the mask. Luckily, Rhonda had stayed in the lab in case Scott needed her. She tried to calm him down and eventually climbed into bed with him to get him back to sleep.

“He was kind of scared,” she says now. “I convinced him to put the mask on, and I lay down beside him so he would go to sleep so they could finish the test.” Since Scott was the only patient in the center that night, the staff gave Rhonda the other patient bed once Scott drifted off so she could get some sleep herself.

### A model patient

Scott received CPAP to treat his OSA based partly on his family’s history with the condition. Both Rhonda and her father had surgical procedures to correct their OSA, but her dad passed away due to complications just three days after the surgery. Rhonda’s own surgery had little or

no effect on her condition, leading her to opt for CPAP instead.

Given their experience during the polysomnography, however, Rhonda was concerned that Scott might not be able to adapt to his new CPAP unit. But those fears proved to be unfounded. After his diagnosis, Apria Health Care called to make an appointment for his mask fitting and to train the family on the use of the equipment. Rhonda believes that having seen his mother hooked up to the device helped to ease the way for her son. "Scott did not fight wearing the mask because I had already been wearing a CPAP mask for about five years."

Today, Scott is a model CPAP patient. Even a couple of bouts with pneumonia (which led his physician, Najwa Bahu-Baugh, MD, to add an oxygen hook-up to the CPAP system) hasn't fazed Scott. "He wears his mask every night," says Rhonda. "When he is ready to go to bed, he goes to his room and turns on his oxygen, then his CPAP, and puts on his mask and goes to bed." He's still using the same CPAP unit he started out with and gets a new mask every six to eight months. The CPAP unit even travels with him on family vacations.

The difference in his daytime behavior has been well worth the testing and treatment, says his mom. "Since he has had his CPAP, he wakes up more refreshed like he has gotten a good night's sleep." And that, of course, means more energy for bowling on Mondays, Walmart on Tuesdays, tap dancing mid-week, and those Thursday movies and dances. ■

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Rhonda and Scott Carr

Photos by Erica Carr



More information about [Down syndrome](#) is available on the Web.

# Patient Quality of Life: What Respiratory Therapists Can Do

by Helen M. Sorenson, MA, RRT, FAARC

A few years ago at an AARC meeting in San Antonio, TX, we were treated to a photograph of a COPD patient floating on her back in beautiful blue water, with her oxygen tank floating next to her. This image spoke to “quality of life” more effectively than books, articles, or presentations. It was real. Maintaining the best possible quality of life (QoL) should be the goal of every patient and should be supported by every respiratory therapist. We can’t create quality for them, but we can create situations, we can offer suggestions, and we can be supportive in their quest. We can also, as therapists and educators, help our patients see how important QoL is and provide vital information to guide them in the steps that can lead to living their lives to the fullest.

A diagnosis of COPD can be daunting, devastating, and depressing. Chronic means long term, a diagnosis of a disease that will not go away. What does go away is energy, the ability to participate in strenuous activity, and in many cases, self-esteem. These losses can affect the patient as much if not more so than the actual disease process. Gradual deconditioning further hinders the ability to join in activities that once were pleasurable to the individual. There are programs that can help our COPD patients regain some of their abilities, but not all COPD patients have access to them. When pulmonary rehabilitation programs are not available, not affordable, or not accessible, respiratory therapists can help fill the gaps. This article will provide information and suggestions on what we, as RTs, can do to help our patients achieve their best possible quality of life.

### Help patients learn

First, help patients learn about their disease and their medications. Pharmacotherapy for COPD can be complex. It generally includes both oral and inhaled medicine, in addition to supplemental oxygen therapy. Compliance to drug therapy in COPD patients, however, is not optimal. A 2010 publication revealed that among COPD patients during a three-month period of time, 45% of the 149 enrolled patients forgot their medicine at least once, 16% interrupted their drug regimen due to lack of perceived benefit, and about 50% of the participants changed the drug dosage themselves.<sup>1</sup> Inadequate medication management may affect QoL. If our patients really understand what drugs they are taking and why, adherence may improve.

### Help patients cope

Talk with patients prior to discharge after an acute exacerbation about QoL issues. Studies reveal a reduced quality of life after hospitalization for an acute episode.<sup>2-4</sup> Patients may be anxious to go home and get back to their “normal routines.” However, anxiety, dyspnea, fear of another exacerbation, or fear of being alone may hamper their actual activity. An awareness that QoL issues may be at risk may help prevent some harmful behaviors (remaining sedentary, resuming smoking, failing to take medicines). Provide patients with information

about the COPD Information Line, a telephone service operated by the COPD Foundation that is open weekdays from 9 a.m. to 9 p.m.<sup>5</sup> All of the Information Line volunteers are COPD patients. The call center provides guidance and referral information; it is not a substitute for personal medical attention. Being a volunteer

### about the author...



Helen M. Sorenson, MA, RRT, FAARC, is an associate professor with the department of respiratory care at the University of Texas Health Science Center at San Antonio, TX.



Patients are always happy to be provided with information.

pays \$10 per hour, but helping others may be a very good way of helping themselves and may add quality to their life.

### Help patients connect

Encourage adults with COPD to attend a support group or Better Breathers meeting. These meetings are not only informational, they are also a social outlet. Talking to others who are going through the same thing is very different from the COPD patients talking to us (their therapists) or to their physicians. We are not walking in their shoes, we can breathe without effort, and we can get dressed in the mornings without stopping to rest every few minutes. Most of them cannot. Support groups generally bring in speakers each month to provide some education. Most support groups are or have been associated with a pulmonary rehabilitation program, which are also greatly beneficial to COPD patients. A list of resources and support groups is available on the [YourLungHealth.org](http://YourLungHealth.org) website. Finding a support group for your patient and encouraging them to attend (offer to attend with them the first time) may make a big difference in their quality of life.

### Help patients find quality of life

A fairly new intervention that has been found to significantly improve quality of life for adults with COPD and bronchiectasis is the use of long-term humidification therapy (LTHT) in the home. COPD patients using high-flow (20–25 LPM) long-term humidification therapy for at least two hours a day were followed for a year as part of a randomized controlled trial.<sup>6</sup> Quality of life was assessed using the St. George Respiratory Questionnaire (SGRQ) at baseline, three months, and 12 months. COPD patients on humidification therapy were compared with other COPD patients receiving usual care. At both three months and 12 months, patients in the LTHT group had significantly improved QoL scores.<sup>6</sup> The extra humidification may enhance ciliary movement and mucus clearance.<sup>7</sup> Anything that incorporates airway clearance techniques to effectively improve mucociliary clearance in COPD



Support group patients and their spouses enjoy an information session.

can improve QoL.<sup>8</sup> Newer devices may make this possible for our patients.

Regardless of what you say to your patients, even talking to them will validate their existence. Many of our patients have lost hope — we need to give it back to them. Quality of life for our patients is not just a good thing, it is imperative both to them and to us. Keeping them at home and engaged, with a reason to wake up every morning to a new sunrise, is beneficial to everyone, including respiratory therapists. ■

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## Workers' Compensation

by Anthony L. DeWitt, JD, RRT, FAARC

**E**arly in the 20th century, state legislatures began to replace the tort system of employer liability for workplace accidents and injuries with a “no fault” system of workers’ compensation. This was paid for, in part, by employers who purchased insurance for their workers. The law imposed penalties for not insuring workers and made employers who failed to purchase insurance subject to damage claims by the state. Most businesses that employ more than one employee have some form of workers’ compensation insurance in place.

### Understanding the process

Workers’ compensation systems tend to use formulas that try to quantify the degree of injury and award two types of compensation (partial and permanent disability) as well as medical payments. Workers’ compensation is required to pay the hospital and physicians bills; but in most states the insurance company, not the employee, gets to pick the physicians and the hospitals. Thus, a workers’ compensation carrier can get by with sending a back injury patient to a family practice physician without any orthopedic or anesthesia training for pain management. The employee’s only recourse is to find a different physician and pay them out of his or her own pocket.

Similarly, workers’ compensation insurance pays workers for temporary disability and for permanent disability. The payments for temporary disability are usually not generous. They are designed to replace lost wages and may not be subject to the same degree of state taxation as regular wages. These temporary payments are about 65% of what the employee would normally get if they worked a 40-hour week. These payments stop when the physician certifies that the employee is well enough to return to work. Because they are not particularly generous pay-

ments, some employees also purchase temporary disability policies or receive this benefit from their employers. These policies normally kick in to cover things that workers’ compensation carriers do not.

Some injuries, however, and particularly back injuries, tend to have a chronic component that never fully heals. Just because a person is able to return to their job does not mean that they are completely well. Permanent Partial Disability payments are usually lump sum payments of an amount of money that approximates the value of the injury over the

worker’s expected work life. The formulas for payment are normally set by statute and sometimes depend on the values assigned by state commissioners.

Normally, to get the permanent disability payments it is necessary to hire an attorney; but most states cap attorney’s fees at 25% or less. The attorneys hire experts to “rate” the degree of impairment. There is a bit of gamesmanship in the rating process. The employee’s physician finds the patient unable to walk, and the workers’ compensation carrier’s expert is prepared to testify that the worker can run and win the Boston Marathon while wearing a 50-pound pack. An administrative law judge generally picks a range somewhere in the middle between the two experts to award the disability payments. The entire process can take a maddeningly long time.

### A case in point

But workers’ compensation law varies greatly by state, and in some states an employee cannot sue the corporate employer but can sue the co-employee. In *Burns v. Smith* (a Missouri Supreme Court case), an employee sued the owner of the business who was also his co-employee. Mr. Burns operated a cement truck. He disclosed a pressure leak on his pressure tank to his employer. The pressure tank held 400 gallons of water used to wash down

### about the author...



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the truck after a job, and it was pressurized with compressed air before leaving for the day's work.

The employer, although he could not really see what he was welding and described the welding process as being a "feeling around in the dark kind'a thing," welded the pressure tank and told Mr. Burns to "run it 'til she blows!" Unlike the nation's therapists, Mr. Smith did not appreciate the PV=nRT equation. The tank exploded after being pressurized and seriously injured Mr. Burns.

Under Missouri law, a co-worker can be liable if they do "something more" than simple negligence or they increase the danger to another worker. The Missouri Supreme Court imposed liability on the employer and three years later forced his insurer to pay for the damage in a separate case.

In some situations a worker may be injured by the negligence of a third person. For example, while employed by the hospital, a therapist is injured on a neonatal transport when the ambulance is broadsided by a pickup truck. The

worker is guaranteed workers' compensation benefits and can still sue the driver of the pickup truck in most cases. However, any money paid by the workers' compensation carrier may have to be repaid if the driver of the truck ultimately pays damages. This "subrogation" clause in most workers' compensation plans seems somewhat unfair to the employee but helps ensure that the victim does not get an undeserved "double recovery."

**Should you sustain a permanent injury at work, especially a back injury, it is a good idea to talk to a lawyer about your state's workers' compensation laws.**

**When you need a lawyer**

Many workers are unaware that workers' compensation insurance is paid by the employer whether there are any claims made or not and that the insurance is there to protect them. Whenever a therapist is injured at work and that injury results in any kind of permanent damage, especially if it is a back injury, it is often a good idea to talk to a lawyer to learn what the particulars of your state's workers' compensation laws are. Under every state's law, an employee cannot be fired for accepting benefits under workers' compensation. ■

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## Respiratory Drug Delivery: What If?

by Sam P. Giordano, MBA, RRT, FAARC

Recently, for the first time in several years, a new class of respiratory medicine was approved. Roflumilast. It's our first PDE 4 inhibitor. Many hope that it will be a breakthrough in controlling chronic pulmonary disease. It will not be an aerosol but rather a pill. It's pretty neat when you consider the well-documented difficulties we continue to face in matching pulmonary patients with the right medication, the correct delivery device, and then assuring they have the necessary training to deliver aerosol medications effectively. Not all health care professionals are as expert as you are in aerosol delivery. Study after study has described the persistent problem of inadequately trained health care professionals passing on that inadequate training to their patients.<sup>1</sup>

Wouldn't it be great if all respiratory-related medications were as easy to administer as a tablet or a capsule? Drug-delivery challenges would become a thing of the past. Also, the cost associated with aerosol drug delivery would be reduced since nebulizers, metered-dose inhalers (MDIs), and dry-powder inhalers (DPIs) would not be required. What a grand thing that would be... or would it? For most of us, it wouldn't be a problem; but for others who act in the capacity of what some of our colleagues refer to as a "neb jockey," this could be disastrous.

### What is a "neb jockey"?

I recently heard from a member and colleague, Tyler Richards, MBA, RRT. Tyler shared some of his concerns with me. I believe he speaks for thousands of our colleagues when he states that in too many hospitals RTs are looked upon as no more than neb jockeys.

I asked Tyler if he would define the term for me. Not only did he respond, but he also gave me permission to use his name because he wants our profession to evolve

to a higher level. He, like many of you, wants RTs to realize their full value to our patients. Here's his definition of the infamous neb jockey: "a respiratory therapist who is limited to administering nebs without regard to the respiratory care professional's opinion or whether it has any therapeutic benefit to the patient and without regard to the other knowledge and skills that an RT possesses."

Well, folks, if this definition is representative of our practices, I have a question: Why would we be needed if all medications were to evolve to capsule or tablet form?

The short answer is that the neb jockeys have an expiration date stamped on them just as if they were a quart of milk. Our health care system doesn't need people to babysit nebulizers. Our health care system doesn't need respiratory therapists who cannot or will not utilize their depth and breadth of knowledge and training to administer care or to provide attending physicians with essential feedback that will guide decision making when initiating, switching, or discontinuing clinical interventions.

While many of us have waxed *ad nauseam* over the need for respiratory care professionals to be both caregivers and utilization gate keepers of that care, this duality of purpose has not made it through 100% of our practice. It actually tracks along with the less than 100% acceptance of patient-driven protocols.

Warning, you may have heard this before: "Without protocols we diminish our ability to fully leverage our education and training on behalf of our patients, physicians, and employers." As you go about your duties, think to yourself: If I wasn't needed to deliver this medication, what could I do to justify my existence in acute care?

### about the author...



Sam P. Giordano, MBA, RRT, FAARC, serves as AARC executive director. He can be reached at (972) 243-2272 or [giordano@aacrc.org](mailto:giordano@aacrc.org).

### What is a respiratory care professional?

What else should we be doing? Let's look at some unmet needs:

- We need to empower patients through education about their disease and treatment.
- We need to improve patient adherence to medication regimens.
- We need to educate patients and families to recognize and employ healthier behaviors, especially smoking cessation.
- We need to educate family caregivers who provide support for our patients in the home to help comply with physicians' orders.
- We need to teach both patients and family members to recognize exacerbations sooner and avoid that emergency department visit or avoidable readmission to hospitals.

Did you notice there was one thing missing from my “laundry list”? I didn't mention anything about drug delivery. Yes, drug delivery is a very important component of what we do. But I also see a role for respiratory therapists even if there were no drugs delivered via aerosol. You are experts in respiratory care. You are well educated and perfectly positioned to reject the role of a neb jockey. It's an insult to our profession to reduce well-trained therapists to such a role. But sometimes in order to change, we have to step up and make a case for that change, not just for us but for our patients. Many who read this column have already done so, but we are judged by our lowest common denominator. So you have a dog in this fight too!

Health care provider employers are looking for multi-skilled professionals. Our health care system will have no place for persons who only provide care. No, we must all “walk and chew gum” at the same time. Just think about all the education that we can impart to our patients while they are hospitalized. Every time you go into their rooms to provide a treatment, you should assure that their technique guarantees optimum drug delivery and is tightly tuned with the therapeutic goals for the patient. However, what we often miss when we don't engage these patients and their families is the ability to have these teaching moments with a captive audience. Why not communicate with your patients about some lung health education? Why not train and re-train them on devices such as MDIs and DPIs that you know they will use once they are discharged from the hospital when this latest exacerbation is resolved? Why not truly empower our patients and their family caregivers to succeed?

What would success look like? Exacerbation rates would decline, as would physician office visits, emergency department visits, and hospital admissions and avoidable readmissions. Do you think your value and respect for you as a professional would increase from all members of the health care team? Would your future be better assured? Of course!

### How do we all operate on a higher level?

It all begins with strong physician support. This support can then be leveraged into administrative support. But in order to gain such support, we must document our ability to execute the full bundle of services previously described. Those of you who are managers need to gear up for another round of cost cutting. Pressure will be placed on us to do more and to do it faster. That's how corners get cut.

With our physician allies, we must hold out for quality over quantity. We must employ protocols; we could knock down some of that quantity just by eliminating treatments that you know are no longer necessary. The process needs to be dynamic because our patients are dynamic, so we must be ready to step up care — or back it down — based on assessments of your patients and building a system that permits you to share those assessments with attending physicians.

This is a perfect time to challenge some of the old ways that die so hard. I recall many decades ago that inhalation therapists were referred to as “tank jockeys.” Our doom as a profession was predicted before we even got started. But we evolved beyond a basic level by raising our practice to a higher level and documenting our value by meeting unmet needs of our patients, physicians, and employers. This is a tried and true formula; and to those of you who use the formula, use protocols, and operate at that higher level, I commend you.

It bears repeating that we are judged by the lowest common denominator in our profession. So it behooves all of us to help our colleagues step up by gathering objective evidence of the value of the multi-faceted approach. We have a perfect opportunity coming down the road in the Affordable Care Act. Hospitals now, more than ever, will be put under the looking glass and paid for performance — including their ability to empower chronic-disease patients to succeed post discharge.

Give it some thought. Work with your teams and set about making a plan that will bury “neb jockeys” — and all other jockeys, I might add, except those who ride horses — forever. ■

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# MSRC's Top 10 Ideas for Engaging State Society Members To Contact Congress

by Teena Culhane, BHK, RRT

**F**or the past two years, the Michigan Society for Respiratory Care (MSRC) has been the top Political Advocacy Contact Team (PACT) in generating support from respiratory therapists and patients to contact members of Congress regarding our Medicare Respiratory Therapy Initiative (H.R. 941). Once our legislation is passed, physicians will have much more flexibility in hiring qualified RTs, which will provide greater access to care for pulmonary patients. With qualified RTs working in a physician's office, these patients may benefit from the many disease management strategies we provide, that is, tobacco-dependence education, proper respiratory device and medication use, asthma, sleep apnea and COPD management, and pulmonary rehabilitation program referrals.

As a new advocacy strategy in preparation for our annual "Day on the Hill," the AARC launched a Virtual Lobby Week to ramp up the number of congressional contacts to Washington, DC. This year, the AARC's goal was to have RTs and supporters from across the nation send 10,000 letters/emails between Jan. 1 and Mar. 31. I am pleased to announce that the AARC exceeded our goal by approximately 500 messages. A special **"thank you"** to those who took those extra few minutes during their very busy schedules to take action.

During the Virtual Lobby campaign, Michigan was the No. 1 state society for the second year in a row: 11% of the total number of messages sent came from our state, with 310 activists sending 1,192 emails/messages. We are very proud of our accomplishments; but with approximately 1,200 MSRC members, we have a lot of work ahead of us to increase the number of activists in our state.

How did we accomplish this? Here are some of the ideas we have implemented in the Michigan Society that have led us to our successful standing:

**1 State conferences/annual meetings/educational events are a great way to spread the word.** Ask your PACT member or state society president to spend a few minutes addressing the attendees regarding current legislation (in this case, the

Medicare Respiratory Therapy Initiative). The more information people have, the more likely they will be to get involved. If your state society sends email blasts to your membership when action is needed, share this information with the attendees. General emails often may be overlooked and left unopened. If members are aware that emails will be sent to them requesting their action, they may be more proactive. In the past, we have used email subject headings such as "We Need You to Take Action" or "Your Help Is Needed," which help grab the attention of the recipient.

**2 Set up a "legislation" or "RT current affairs" booth at your next event.** Have handouts available for members regarding current legislation and issues. In March 2010, our PACT team set up a booth in our exhibit hall at our annual meeting and obtained

over 200 "Waiver Signatures." What are Waiver Signatures? It is a simple paper that allows the MSRC to contact Congress on their behalf for one year. This process proved to be beneficial when we used

### about the author...



Teena Culhane, BHK, RRT, is the pulmonary rehabilitation program coordinator at Beaumont Hospital in Royal Oak, MI. She also serves the Michigan Society for Respiratory Care as co-chair of its professional development and legislative committees.

the signatures obtained in 2010 to send emails this past March prior to our DC Day on the Hill. This is slightly more time consuming than having members send the emails themselves, but it will guarantee that the contacts have been made (our PACT representatives divide up the list and send emails when needed). And don't forget the students — they can send emails too. For our upcoming fall conference in October, we are going to add a check box to our conference registration forms where attendees can indicate whether they would like the MSRC to continue sending emails of support to the Hill on their behalf.

**3 Start with your state society's board of directors, committee members, and (if your society has them) your district or chapter representatives.** It is difficult to get the general membership engaged if the society leaders are not. If possible, separate your members into their home locales and have your district representatives or assigned society leadership send a personal email to members in their areas encouraging the RTs to participate in contacting Congress. This often makes a greater impact than receiving a generic email blast from your state society.

**4 The easier the better.** Due to extremely busy work schedules we all have, it is especially challenging for RTs to find the time to get involved. At your next staff meeting, if appropriate, take a few minutes to briefly discuss current respiratory therapy legislation, the importance of how it can affect our profession, and how quick and easy it is to have their voices heard by Congress. If possible, set up a designated computer in your staff workroom linked to the AARC's Capitol Connection with a sign that reads "Take Action — Your Help Is Needed to Contact Congress." Another idea to increase RT staff involvement would be to enter the names of those who participate into a raffle for a prize drawing (\$5 voucher for the cafeteria, movie passes, etc.).

**5 Don't stop with respiratory therapists.** The AARC's Capitol Connection has written specific letters that can be used by pulmonary patients, their caregivers/family/friends, pulmonary physicians, and respiratory therapy students. Receiving communication from those who are not RTs but by those who will be impacted the most by the passing of H.R. 941 can be very powerful in the eyes of Con-

gress. A few years ago, when lobbying Congress to pass the Medicare Pulmonary Rehabilitation benefit (successful, by the way) we had several patients send personalized, handwritten letters to their House of Representatives member, asking for him/her to support the pulmonary rehabilitation bill. When our PACT team met with the legislative aides from those particular House offices, we received recognition for each and every one of those patient letters.

**6 Another great way to reach those patients and caregivers is to contact local "Better Breathers Clubs."** Check with your local hospital or pulmonary rehabilitation program for the schedule of these meetings. Most of these groups have guest speakers where you or someone from your state society or even a PACT representative could brief the attendees on the importance of the bill. If you are unsure whether there are any groups in your area, check with the American Lung Association; they typically list these types of meetings on their website for your particular area. At our facility, we have over 50 patients attending our Breathers Club every month.

**7 Try contacting your own member of Congress back in their district office (members always have several local offices).** The objective is to set up an appointment to discuss our initiative with your member of Congress while they are in town. If one of your congressmen/women plays a key leadership role in Congress or happens to be a committee chair, your state society may want to seriously consider making this a goal to accomplish.

In Michigan, Congressman Dave Camp is the chairman of the very powerful Committee on Ways and Means, which oversees and makes changes to the federal Medicare program. Recently, AARC's Director of Government Affairs Cheryl West, MHA, contacted the Michigan PACT to ask for our assistance. She and AARC's Director of Legislative Affairs Miriam O'Day (who is based in DC where all of the action is) sensed that Rep. Camp would require some "push" from his constituents back here in Michigan in order to consider supporting H.R. 941. In response to this request, we initiated our state action plan. The first thing we did was to contact those MSRC members living in Congressman Camp's district and urge the RTs to take action by using Capitol Connection to email his office. We also contacted two pulmonary reha-

bilitation programs in Camp's jurisdiction and encouraged patients and their caregivers to do the same. If you have a pulmonary rehabilitation program nearby, invite your member of Congress (or even his local staff who handle health issues) to visit the facility. This strategy has worked very well for us in the past and provides the congressman and/or staff insight into the daily struggles that our pulmonary patients face each and every day.

**8 Become a member of your state society and AARC.** Encourage co-workers to do the same. There is a wealth of knowledge on the AARC website that can be useful to you as you carry out your responsibilities as a respiratory therapist.

**9 Get back to the basics.** Grassroots lobbying means citizens are proactive and exercise the constitutional right to contact their own legislators to voice their view point, educate, and try to persuade a policy or law maker. Sound familiar? This is a process that we at the MSRC have been practicing for quite some time and will continue to do so. Ever wonder where the term "grassroots" originated? I did, so I searched the Web for it: In 1912, Sen. Albert Beveridge of Indiana referred to the Progressive Party

as "this party has come from the grass roots. It has grown from the soil of people's necessities."

**10 Keep going!** Our Day on the Hill has come and gone for one more year, but in Michigan our efforts did not stop when we returned home. Our PACT representatives, with support from the MSRC, feel as though the time following our visit is the most crucial. While in Washington, DC, we "set the stage." Now we need to keep the momentum going. AARC's Federal Government Affairs Committee Chair Frank Salvatore, MBA, RRT, FAARC, describes our continued efforts in Michigan as, "Your state hasn't stopped with the Virtual Lobby Week in March... I have taken note of the continued efforts on the part of the MSRC."

Our plans for the remainder of the year are to keep moving forward by encouraging the voters in Congressman Camp's district to contact his office asking for his support of H.R. 941, the Medicare Respiratory Therapy Initiative. We are currently in the process of setting up an appointment in Congressman Camp's district office and will invite him to visit one of our pulmonary rehabilitation facilities. In September, we are

planning an additional educational event in Congressman Camp's district where we will target additional constituents and potential supporters and encourage them to let Congressman Camp know how they, his constituents, feel about H.R. 941. In October, the circle begins again. The MSRC will be holding our annual Fall Conference and, of course, that provides us with yet another opportunity to inform our attendees about current legislation and to collect additional names/signatures.

Does all of this take time and dedication? Absolutely. Knowing that what we are doing right now is making a difference in the future of our profession and impacting the lives of so many people with lung disease makes it all worth it. And now, it is your turn to make a difference. ■

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# Partnering with Your Patients To Reduce Hospital Infections

by Douglas S. Laher, MBA, RRT

**I**t happens all of the time. Patients being cared for in the hospital setting see things that just do not seem right. A physician doesn't wash his hands. A nurse not wearing gloves. A respiratory therapist leaving the room while the patient is receiving an aerosol treatment. While the patient knows something is not right, they far too often remain silent to the events they just witnessed.

And it's not just the caregivers. Even when the patient doesn't feel quite right — abnormal heart palpitations, a lightheaded feeling, or blurred vision — they'll often stay quiet. Whether it's a passive personality or the patient succumbs to the alleged expertise of the health care provider, they'll often stay quiet when they should be speaking up.

What patients often fail to realize is that they have "rights" when receiving health care. Not only do they have a right to be informed about their care, the right to refuse care, or the right to be treated with courtesy and respect, they also have the right to be listened to, to participate in their own care, and to be heard when they suspect something is not right.

### Patients should speak up

Fortunately for patients, The Joint Commission takes these rights very seriously and has created a campaign to ensure patients are aware of their rights. This campaign, titled "Speak Up," encourages patients to help prevent health care errors by becoming more informed and involved in their treatment. Patients are urged to take this proactive role by vocalizing concerns, asking questions, and providing input into their care.<sup>1</sup> The campaign was launched in 2002 and covers more than 15 "Speak Up" initiatives. But this year The Joint Commission started creating "Speak Up" videos that en-

courage patients to speak up about their health care needs and medical treatment just as they would in everyday life at the grocery store, gas station, or movie theatre. In March, The Joint Commission released the first of four year-to-date videos titled "Speak Up: Prevent Errors in Your Care." The second video, "Speak Up: Prevent the Spread of Infection" was released in April; the third, "Speak Up: Take Medications Safely," was released in May; and the latest release is "Speak Up: At the Doctors Office." These videos, roughly 60–90 seconds in length, are available for viewing through the Joint Commission website ([www.JointCommission.org/speakup.aspx](http://www.JointCommission.org/speakup.aspx)), on their YouTube account ([www.youtube.com/user/TheJointCommission](http://www.youtube.com/user/TheJointCommission)), or on the AARC Times "digimag" version of this issue.<sup>2</sup>

Hospitals know that when patients "speak up" and are active partners in their care, it's a win-win scenario for everyone involved. For the patient, they receive better care, are likely to spend fewer days in the hospital, and are apt to develop better self-management skills. Hospitals benefit as well. Publicly reported quality metrics are likely to improve, which leads to brand loyalty and ultimately enhanced reimbursement for health care.

There are many factors that influence the reimbursement a hospital receives. The Centers for Medicare and Medicaid Services core measures and readmission data are just a few of the notable performance metrics that influence payment for rendered services.

Another very important metric not to be overlooked is health care-associated infections (HAIs). It is estimated that one out of every 20 hospitalized patients will contract an HAI.<sup>3</sup> These avoidable infections generate attributable costs to the U.S. health care system in excess of \$10 billion per year. Hitting closer to home

### about the authors...



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for the respiratory therapy community: Attributable costs associated with ventilator-associated pneumonia is approximately \$1.5 billion, costing hospitals as much as \$28,000 per case.<sup>4</sup>

Fortunately for patients, one of the “Speak Up” initiatives from The Joint Commission is the “Speak Up: Five Things You Can Do to Prevent Infection.” This initiative lists the following as steps patients can take to minimize the spread of infection:

1. Wash your hands.
2. Make sure your caregiver washes their hands and wears gloves when appropriate.
3. Cover your nose and mouth when you cough or sneeze.
4. Avoid close contact with others when you do not feel well.
5. Stay current with vaccinations.

### Educate your patients to “speak up”

As health care providers, respiratory therapists actively share this information with patients at almost every encounter and during discharge instructions. But what other situations are there for RTs to educate patients regarding “speak up” opportunities?

Many organizations place signage in patient rooms instructing them to remind/ask their caregiver to wash their hands in the event the patient does not witness the procedure. Not only is handwashing expected upon arrival to the room but upon departure as well.

Pressure ulcers are another source of HAIs. On the surface, RTs may not feel this is an important aspect of the care they provide. On the contrary, concerns over pressure ulcers around the ears (for patients wearing nasal cannulas) and on the bridge of the nose (for patients wearing bi-level PAP/CPAP masks) are a very real and legitimate concern. Patients may not necessarily be aware of these risks and are likely to not mention concerns to their care provider when they occur. This poses an opportunity for the respiratory therapist to educate the patient and family members of these risks before the treatment is initiated. Patients should be encouraged to “speak up” as they sense discomfort or soreness in these areas.

The same can be said for the mechanically ventilated patient. While there may be a lack of opportunity to educate the patient prior to intubation, family members

and friends should be educated on any hospital protocol utilized for VAP prevention. Family members should expect to see the head of bed in excess of 30° (and if not, should be given a valid reason why not). Ventilated patients should undergo a daily “sedation vacation” and routine oral care. Effort should be made to minimize breaks in the circuit and to ensure sterility during suctioning. This information should be communicated to patients and their families at the onset of mechanical ventilation and should be encouraged to “speak up” when they fail to see these steps taken or done improperly.

Before patient discharge, all five of the steps highlighted in the Joint Commission campaign should be emphasized to the patient. Patients should be mindful to wash their hands, as should their family and friends, and any home health providers. They should stay away from other sick individuals and do the same when they don’t feel well. From a respiratory perspective, they should absolutely stay current with vaccinations, most notably pneumonia and influenza.

Upon discharge, patients should also be encouraged to “speak up” when they need refills on medications, to contact their physician when symptoms persist, to request antibiotics when appropriate, and to ask questions about medication delivery technique when it is not properly shown to them or they do not understand.

In the end, it is often the patient who is forgotten when developing care plans, establishing treatment regimens, or arranging for discharge. When patients are overlooked and not included in their own care, errors take

place and sentinel events are more likely to occur. It is for that reason that patients should be included early and often when establishing care plans. Patients should be educated on what to expect and encouraged to “speak up” when things don’t seem “just quite right.”

### What RTs can do

Respiratory therapists play an instrumental role in the care of all patients with cardiopulmonary disease. Infections, health care associated or not, are a prime source of complications with these patients. Therefore, RTs must be vigilant to educate patients regarding their disease and their treatment. Encourage patients to ask questions and voice concerns when appropriate, for it is through

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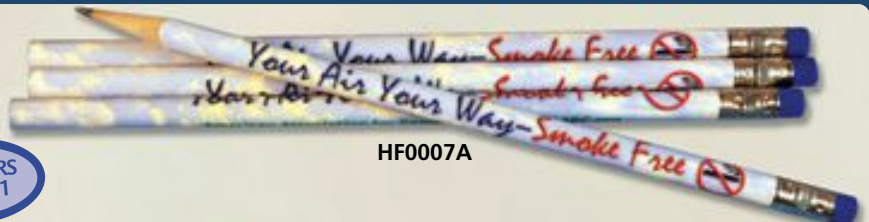
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# The Challenge of Effectively Training COPD Patients

by Robert Messenger, BS, RRT, CPFT, and Joseph Lewarski, BS, RRT, FAARC

**T**raining a COPD patient to self-administer medications or to use a medical device to support their needs at home can often be a difficult and challenging endeavor due to the many age, disease, and socio-economic variables. These efforts could be better rewarded if we applied the principles of adult education. Unfortunately, few health care professionals are educated, trained, and experienced adult educators. Understanding the demographic, psychosocial, and clinical complexities of the COPD population and applying the principles of adult education can turn these training sessions into highly effective, positive experiences for both the patient and the respiratory therapist.

Many health care providers often view patient education as a very basic, simple, inherent component of routine patient care, yet it is anything but basic and simple. Patient education on effective self-management is fast becoming a critically important component of the transition of care as patients move swiftly from one point of care to another, most often from high levels of professional support (hospital) to low levels of support (home).

One provision of the recent health care reform legislation has hospital administrators seeking more efficient ways to ensure that certain patient populations, including those with COPD, receive appropriate and effective patient education. Section 3025 of the “Patient Protection and Affordable Care Act” mandates that beginning in 2015, hospitals will be financially penalized when COPD patients are readmitted within 30 days of discharge — a situation that can cost each hospital millions of dollars.<sup>1</sup> As a result, hospitals will be fo-

cusings more clinical resources to ensure that COPD patients are proficient in medication self-administration, recognition of early signs of exacerbation, and understanding how to use their home oxygen system, aerosol device, positive airway pressure devices, as well as other home respiratory and medical equipment. The current

and pending health care policy changes are also encouraging home care providers to improve the effectiveness of their patient education activities. The financial impact of competitive bidding, along with the 36-month cap on oxygen reimbursement, have created an economic climate in which the very survival of these businesses hinges on finding ways to reduce costs. Included in these cost-reduction efforts is the elimination of repeat visits to patients’ homes due to inadequate first-pass training.

### Learning styles

Regardless of an individual’s age or the presence of disease, the process of learning is slightly different for each of us. There are several varied learning styles that are largely based on how we receive and process environmental stimuli.<sup>2</sup> The importance of recognizing these styles is that they offer guidance on the most effective approach to teaching an individual. These styles can

be generalized into *visual*, *auditory*, and *kinesthetic* styles. As the names imply, visual learners prefer to learn through pictures, images, and facial expressions. Auditory learners focus more on what they hear and discuss. Kinesthetic learners prefer a hands-on approach to learning. The challenge that we face as patient trainers is that we may habitually gravitate to the instructional ap-

### about the authors...



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proach that is most suited to our own learning style. On one hand, this can be very effective when instructing a patient who learns the way that we do, but on the other hand it can lead to frustration and a poor outcome if our instructional approach does not match the patient's learning style. To avoid frustration and poor outcomes, we need to look for and recognize the individual characteristics that offer insight into an individual's learning style.

Visual learners like to see what they are learning, though they often will close their eyes to visualize or remember something. They tend to take numerous detailed notes, and they benefit from illustrations and presentations that use color. They may prefer learning by observing a demonstration, such as how to properly sequence breathing with MDI actuation.

Auditory learners need to hear but don't necessarily need to be looking at the instructional material to learn it. They may learn by reading aloud and remember by verbalizing lessons to themselves. These learners may benefit from a concise description of the steps involved in adding medications to a nebulizer.

Kinesthetic learners learn through activity. They rely on what they can directly experience. They speak with their hands and often can remember what was done but have difficulty recalling what was said or seen. They may best learn how to add medication to a nebulizer by actually handling the items and going through the physical steps.

### Principles of adult training

Regardless of age or learning style, adult training is directed by the following guiding principles first described by Malcolm Knowles.<sup>3</sup>

First, adults are goal oriented. We need to start each instructional session by providing the patient with a practical reason why they should pay attention. They need to know how the training will benefit them. For instance, we could say: "Today I am going to teach you how to use an inhaler. Being able to use an inhaler the right way will help you breathe better."

Second, adults are relevancy oriented; they need to understand the importance of each step. "The reason it is important to use a spacer is that it helps to get the med-

icine into your lungs instead of it ending up on the back of your throat."

Third, adults learn best when they practice, perform, and work with new knowledge. Using a metered-dose inhaler (MDI) filled with placebo will allow a guided patient to work from improper to proper technique and then to reinforce what they have learned through repeated practice.

Finally, adults are practical. They want to know what they need to know but are not necessarily interested in a lot of background information. Training should focus on what the patient needs to be able to do along with just enough theory to justify why they need to do it.

### Unique challenges of training COPD patients

COPD patients with a history of acute and chronic hypoxemia are especially hard to train. The prolonged and persistent hypoxia they have experienced reduces cognitive performance, making even the simplest training a chal-

lenge. In a study matching both the age and education of 340 COPD patients with 99 control patients, deficits in memory were found to be directly related to the severity of disease.<sup>4</sup> In fact, the most severe patients, the ones hospital and home care respiratory therapists see most often, demonstrated neuro-cognitive performance deficits as high as 61% compared to the control group. Obviously, where chronic hypoxemia is present, supplemental oxygen should be initiated. Unfortunately, the ini-

tial administration of oxygen has no immediate impact on cognitive performance.<sup>5</sup> Also, the limited research available on the restorative effects of long-term oxygen suggests that prolonged administration is necessary before significant reversal of cognitive deficits can be realized. One study suggests that meaningful improvement in cognitive function can be achieved after six months of oxygen therapy for at least 18 hours per day.<sup>6</sup>

For instruction to be effective, it must be designed to meet the language and comprehension characteristics of the trainee. So what do we know of our patients that will help us hone our instructional approach? To start, the American Lung Association reports that 80–90% of COPD patients are or were cigarette smokers;<sup>7</sup> and according to the Centers for Disease Control and Prevention (CDC), there is an inverse relationship between smoking prevalence and education.<sup>8</sup> In fact the CDC reports that the

Understanding the demographic, psychosocial, and clinical complexities of the COPD population and applying the principles of adult education can turn training sessions into highly effective, positive experiences for both the patient and the RT.

prevalence of smoking in persons with less than a high school education is 32%, a rate that is almost 2.5 times that of college graduates, with a smoking prevalence of 13%. Although not always the case, this tells us that much of the time we should gear our training sessions to a lower education/grade level. Little good will come from telling the typical COPD patient that “regular ambulation with supplemental oxygen results in improved outcomes related to morbidity and mortality.” The use of such technical language may convey a clear message to other health care professionals but may be of little meaning to the patient. Even worse, complex clinical and technical language may serve to turn them off from anything else we say. We are much better off telling them that “taking a walk each day while using your oxygen will help you live a longer, healthier life.”

Another characteristic that we need to consider is age. Not all COPD patients who need training are starting on long-term oxygen therapy, but this event does offer age-related insight. The average age of a COPD patient when they start on long-term oxygen therapy is  $74 \pm 8$  years.<sup>9</sup> We should expect these patients to exhibit some age-related reduction in both visual and auditory acuity. Consider, for instance, that our pupils shrink as we get older. As a result, people in their 60s need three times more ambient light for comfortable reading than those in their 20s.<sup>10</sup> Also, reductions in hearing result from changes in the middle ear — an effect that smokers are more prone to experience — and higher frequency sounds are the first to be affected.<sup>11</sup> Age-related changes to visual and auditory acuity warrant considerations for effective training. Attention should be paid to the following visual considerations when teaching the elderly.

#### Visual considerations:

- Always face the patient directly when speaking.
- Ensure that there is plenty of light with no glare.
- Minimize distractions such as TV, radio, and other interruptions.
- When possible, incorporate other forms of sensory input, such as touch.
- Special attention needs to be given to written materials:
  - Use a large type size — minimum 12 points.
  - Thicker letters are easier to read.
  - Don’t use a variety of type in a single piece.
  - Use a lot of white space (always double space).
  - Contrast is important — dark ink on light paper is best.
  - Write at a maximum of a fifth- to sixth-grade reading level.

The best way to determine the reading level of written material is to use any one of the several accepted and tested methods. These methods include the Fry Readability Formula, SMOG (Simple Measure of Gobbledygook) Formula, the Flesch-Kincaid Grade Level Index, and SAM (Suitability Assessment of Materials). An Internet search for readability level will provide insight into these and other methods for determining the reading level of written material. All of these methods generally rely on formulas that account for two factors:

1. The number of difficult words (usually words with three or more syllables) in a sample — difficult words mean more syllables in the sample and a higher grade level.
2. The average length of sentences — longer sentences with more words than in the average sentence translate to a higher grade level.

The Flesch-Kincaid Grade Level Index is used extensively and can be accessed from the Spell Check option in *Microsoft Word*. Along with visual changes, we also need to be concerned with reductions in auditory acuity. Attention should be paid to several auditory considerations when training.

#### Auditory considerations:

- Keep your face visible to the patient.
- Enunciate clearly and slowly in a low-pitched voice.
- Use shorter sentences.
- Repeat and rephrase important areas of instruction.
- Avoid the use of slang words and phrases that can be confusing and result in mixed understanding.
- Eliminate background noise.

Out of a desire to be courteous, some elderly patients with hearing deficits may give the false impression that they understand what is being said to them. They can be quite adept at recognizing visual cues and reacting with what would be considered appropriate affirmative responses. Asking the patient open-ended questions will help both in determining if what has been said has also been heard. Questioning also serves to reinforce training through active patient participation.

#### **RTs need to recognize and adapt**

Respiratory therapists provide many vital services in the care of their patients, including training them to

(continued on page 69)



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When Monique Ponce, who recently graduated from the respiratory therapy program at El Camino College in Torrance, CA, was growing up, she did all the things other kids did — even water sports. But Ponce wasn't like all the other kids. Diagnosed with congenital central hypoventilation syndrome (CCHS) at 12 months of age, she has always relied on a diaphragm pacing system to ensure she continues to breathe.

A rare genetic disorder, CCHS affects the ability of the brain to control breathing, causing patients to severely under-breathe during sleep and often affecting daytime respiration as well. Ponce had plenty of experience with respiratory care growing up, but her interest in becoming a respiratory therapist really started after she had children of her own. When she became pregnant at age 24, she was only the fourth CCHS patient documented to do so and didn't believe she would pass the condition to her unborn child. But after Amalia, now nine, was born, she was diagnosed with CCHS. When Diego, age

**Ponce believes her personal experience with respiratory problems will make her a better therapist. "I understand how it feels to have a lifelong condition, so I have compassion for my patients."**

five, came along a few years later, so was he.

### Inspired to succeed

With three people in her family relying on respiratory technology, Ponce found herself spending lots of time in hospitals; and during Amalia's stay at Children's Hospital of Los Angeles (CHLA) to have her pacers implanted at age four and a half, she began talking to the RTs there about the profession. When Diego spent a week at the facility for a bout of pneumonia at 18 months, she continued the discussion with the therapists in the emergency department and ICU.

But she says it was her involvement with the CCHS Family Network that really led her to pursue a degree in the profession.

"I was a guest speaker at their conference in Florida in June 2008. I went with my mom and Amalia," she recalls. "They wanted me to share my story with the other parents and also talk to the teenagers about living on their



**Monique Ponce and her kids don't let congenital central hypoventilation syndrome stop them from doing the things they love.**

own.” She says it was awesome to share her experiences with these families, and she was honored when so many of them came up to tell her that she was an inspiration to them.

“After that trip, I started looking into RC programs in my area and what it would take for me to get into one and graduate a caring, competent respiratory therapist,” she continues. “I decided to meet with faculty and staff at El Camino College to see if it would be a good fit for me. The faculty and staff at the college were very supportive and encouraged me to pursue my education at El Camino, and I am glad I did!”

**It's a small world**

Ponce believes her personal experience with respiratory problems will make her a better therapist. “I understand how it feels to have a lifelong condition, so I have compassion for my patients,” she says. “I understand that they might be sad or depressed.” When the occasion

seems right, she will even share a little of her own medical history with them. “One of my patients and her brother at CHLA had cystic fibrosis,” she recalls. “While she was doing the vest and her breathing treatment I told her a little about my kids and me — that we’re patients there also. We connected because she had a little two-year-old son there with her.”

On another day, she had a COPD patient who was resisting the use of her bi-level PAP. Ponce told her that she is now using bi-level PAP at night, as well, due to a problem with her pacer connection. (Her last surgery was 18 years ago, and she is currently awaiting approval from her insurer to replace the internal receivers and possibly the electrodes connected to her phrenic nerve). She agreed with the woman that it can be uncomfortable but explained why she uses it anyway. “I was trying to encourage her.”

She’s also learned what a small world it really is for someone with as rare a condition as hers. “When I was finishing my pre-clinical classes, I spoke to Dr. Salomay



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Corbaley, one of the professors in the El Camino RC program.” She had previously worked at CHLA and Little Company of Mary, where Amalia was born, and told Ponce about a former CCHS patient there who had shut off her pacer machine while she was sleeping and coded. Dr. Corbaley said she helped to resuscitate the woman, who subsequently was intubated and placed on a ventilator, and then learned that she had a daughter with the same condition.

“I said, ‘That was me!’ and she responded, ‘No way, that was over seven years ago,’” says Ponce. “It was strange hearing that story from someone else’s point of view.” Ponce also met an RT during her clinical rotations at Little Company who took care of Amalia when he was working in the NICU at CHLA and remembered her due to her rare condition.

#### Medical miracle family

Like her own parents, Ponce is determined that Amalia and Diego live their lives to the fullest, despite their need for high-tech medical care. “Amalia uses her pacers and pulse oximeter every night. Once in awhile I have to increase the settings on her machine if she has a stuffy nose, but her numbers are usually good. If her O<sub>2</sub> drops below 95, it’s usually positional, so we turn her and make sure the leads are in the right place,” says her mom.

As of this writing in late spring, Diego is still being managed using a tracheostomy, ventilator, and pulse oximetry, but he is scheduled to have pacers implanted soon. “We change the trach every three to four weeks, and he helps me,” says Ponce. “He takes the old one out, I wash the stoma and his neck, and then we put the new one in. He thinks it’s funny when he has it out because the stoma makes a horn sound.”

Both kids attend regular school and are involved in a lot of activities. Amalia loves singing, dancing, and acting (her mom says she memorizes everyone’s part, not just her own); and Diego is into monster trucks, dinosaurs, and the computer. Both have also taken karate classes, and the whole family goes camping every summer.

Amalia has asked a few times why she has to be different. “She just wants to be like the other kids,” says Ponce. “I tell her we are special and a medical miracle family — that we’re lucky to be alive and so healthy.” ■



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All active and life members of the American Association for Respiratory Care will soon vote for the candidates running for 2012 officer and director positions in the AARC leadership on an online secure website. Note the sidebar on the next page for special instructions.

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Manager, Respiratory Care  
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**Thomas Malinowski, BS, RRT, FAARC**  
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**Gerilynn Connors, BS, RRT, FAACVPR, FAARC**  
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**Robert Krach, RRT-NPS**  
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*All AARC election candidate information is available beginning Aug. 15 and voting opens Sept 2, at*

*[www.aarc.org/member\\_services/election12/](http://www.aarc.org/member_services/election12/).*

*Vote online at this secure election site and make a difference in your profession!*

AARC members have the important responsibility of choosing individuals to lead the profession and our professional association. All of the candidates are introduced briefly here in *AARC Times*.

Only active and life members of each specialty section may vote for the chair of their respective sections.

A biographical sketch about each candidate, and their answers to questions posed by the AARC Elections Committee, are available for your review on the secure election website at [www.aarc.org/member\\_services/election12/](http://www.aarc.org/member_services/election12/). The actual voting site will not be activated until **Sept. 2, 2011**, and voting will continue through **Oct. 3, 2011**. All AARC members who are eligible to vote will sign on with their member number and password.

If you cannot access the website, contact the AARC office to request a ballot: AARC Elections Committee, 9425 N. MacArthur Blvd., Suite 100, Irving, TX 75063-4706, (972) 243-2272, Fax (972) 484-2720.

The election secure website includes a ballot for you to cast your vote for each candidate. Please be sure to read through all the biographical information and questions the candidates have answered online before proceeding to the ballot Web page for casting your votes. Your thoughtful consideration of this information before voting will help ensure the most qualified people are chosen to lead your professional association next year. ■

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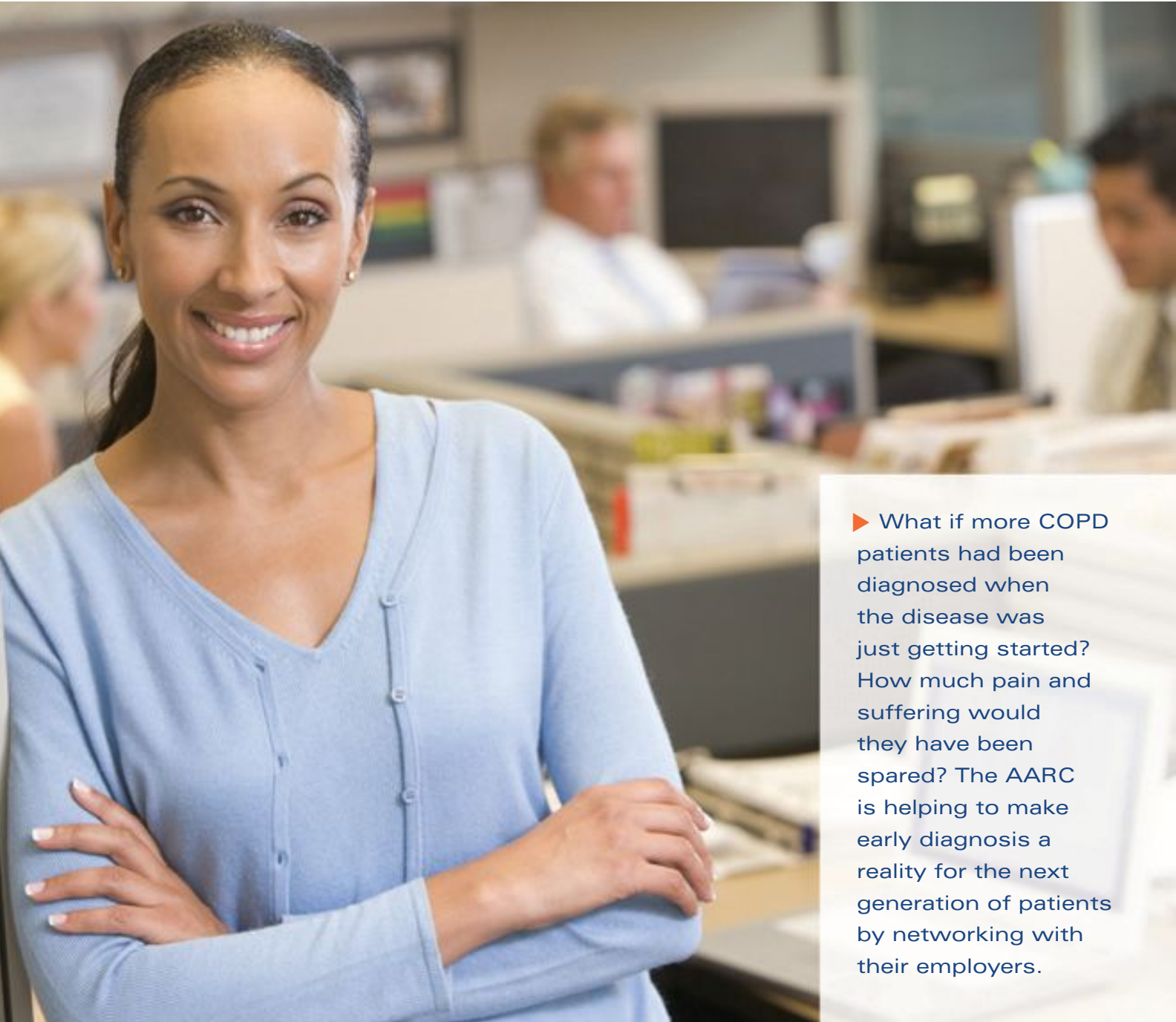


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## DRIVE4COPD Revs Back Up with New **Adopt-a-Company** Initiative



► What if more COPD patients had been diagnosed when the disease was just getting started? How much pain and suffering would they have been spared? The AARC is helping to make early diagnosis a reality for the next generation of patients by networking with their employers.

## The AARC's latest contribution to this nationwide campaign targets the workplace.

About this time last year, the AARC was introducing members to a brand new campaign called "DRIVE4COPD" that was launched with the ambitious goal of screening a million people for the condition using a simple, five-question population screener. Spearheaded by the largest collaboration of celebrities, advocacy groups, and corporate partners ever assembled to work together to raise awareness of COPD, the campaign was

**All the form letters, template emails, and COPD educational materials you need to take part in the AARC's Adopt-a-Company DRIVE4COPD campaign are online at [www.AARC.org/DRIVE4COPD](http://www.AARC.org/DRIVE4COPD).**

a roaring success. The "1 million people screened" goal was reached shortly after the first of this year, and the campaign itself was named PR Week's 2010 Healthcare Campaign of the Year.

AARC members

played a significant role in these accomplishments. From Maine to California, you reached out to your communities during health fairs, RC Week activities, lobbying events, and more, contributing over 55,000 completed screeners to the 1 million total — more than any other group in this nationwide campaign. We also held a friendly competition of our own to see which AARC state society could bring in the most screeners, and West Virginia and Pennsylvania took top honors.

This spring we increased our involvement in this ongoing campaign by asking AARC members to sign on to an Adopt-a-Company initiative designed to introduce the concept of COPD screening in the workplace. Statistics show the dire need for an initiative of this type: Nearly 70% of people living with COPD today are still actively employed, and these workers cost companies up to four times more in health care costs than the average employee.

Identifying more workers at earlier stages in the disease is a win-win-win situation. People at risk for COPD win because they end up

getting the treatment they need to minimize the effects of the condition. Employers win because their employees are healthier. And RTs win because our involvement shows the world that respiratory

care does indeed care. The next few pages explain everything you need to know to get involved in the Adopt-a-Company campaign.



## ADOPT-A-COMPANY, EXPLAINED

The AARC's new **Adopt-a-Company Drive4COPD** initiative is based on the simple premise that, if given the opportunity, most employers would be happy to minimize the significant health care costs associated with undiagnosed COPD by including COPD screening in their annual health risk assessments (HRAs) and/or wellness initiatives. We launched the program in May to correspond with the fact that most companies complete their HRA process in the late spring-early summer.

AARC members who signed on to participate provided their companies with a template HRA request letter and customized materials to educate their employees about COPD and encourage them to complete the screener and talk to their physicians about the results. This fall, AARC members will be using customized materials and onsite clinical staffing support to host a screening event at their company in support of either the Great American Screen Off on Nov. 4, National Respiratory Care Week Oct. 23–29, COPD Awareness Month in November, or World COPD Day on Nov. 16. ■

## Q + A with Danica Patrick

Racecar driver and **DRIVE4COPD** spokesperson Danica Patrick recently took time out of her busy schedule to talk with us about what's happening with the campaign this year and how she believes our new Adopt-a-Company initiative will help to bolster the overall effort.



**Q** It's been about a year since we last spoke to you — how is everything going with DRIVE4COPD?

**A** Everything is rolling along really well. We reached our one-millionth screener, which was the goal that we had set for ourselves. And we're up to a million and a half already this year. So things are going very well.

**Q** Last year AARC members screened more than 50,000 people through all sorts of events. We're hoping they'll all have a special event related to COPD in the fall. Based on your experience with DRIVE4COPD, what advice would you give RTs about how to best engage the community with COPD information and screenings?

**A** Well, I think the most important thing for people to know is that it's a progressive disease and that when you do nothing about it you continue to get worse. So I think that's an incredibly good program to get people to go out into local communities and raise awareness of this disease that kills more people than breast cancer and diabetes combined. Of the 24 million people who have it, half of them don't even know it. So awareness is the key right now.

**Q** Right, and a lot of them are still working, which is why we wanted to get employers involved.

**A** Absolutely. This disease usually kills people before they're 70 years old. It took my grandma before 70. A lot of people work that long, so it's important for people who might still be busy to realize that their health is of the utmost importance; and no matter how hard they work, if they're not healthy enough to do anything once they're done working, it's kind of all for naught. They don't have a retirement to enjoy.

**Q** A lot of people, like you say, have to keep working longer than they thought they would these days, so it's even more important to keep healthy.

**A** Exactly.

**Q** What's your role going to be in DRIVE4COPD for the rest of this year, and why did you choose these activities to focus on?

**A** The screener truck is going to a lot more NASCAR races and they're screening people at the races, which is great. For myself, I just like to raise awareness wherever I go and with whomever I talk to, whether it's through conversation or interviews or tweeting — you know, just getting people to take the screener and take action with their health, or their family's health or their friend's health, which could be something that's in need more than their own. We have a lot of stuff like that going on throughout the year — including doing interviews like this to promote awareness so that people just start to take notice and start to do something about it.

**Q** What kind of response have you gotten from people when you talk about DRIVE4COPD?

**A** So many people are appreciative of the work that I've done, and that everyone else has done, to raise awareness for their disease. A lot of people are just happy (to get the information) because their mother has it, or their grandma has it, or their brother has it; and maybe it's too late for them, but maybe it's not. Of course, it is going to take some time before we notice that more people overall are being treated for COPD and have less horrible side effects. You have to stay at it until this happens.

**Q** COPD has certainly gotten a lot of attention through DRIVE. I know your grandmother suffered from the disease for many years before she passed away. What do you think she'd think about DRIVE4COPD and, especially, all the time and attention you've given to it?

**A** Well, I'm sure she'd be proud. I'm sure she would be glad that something that was unfortunate for her could perhaps be a positive for the world and for those who take action with their health. I'm sure part of her would wish that she knew about this disease and that there was a campaign like this out there decades ago when she was getting ill. But most of all, I think she'd be proud.

**Q** Well, we're sure she would be. Is there anything else you'd like to add, or any additional advice you'd like to give AARC members as they work with employees at the companies they adopt this year?

**A** I think that one other thing they can tell them is that if they're not going to do it for themselves, they need to do it for their families. They need to take action with their health and talk to their doctor, because I know with my grandma, she was sick and my grandpa ended up having to take care of her the whole time because you get to the point where you can't walk anymore, you can't breathe. My grandma was on oxygen 24 hours a day. So, if you feel like maybe you're not reason enough, maybe it's enough to think about the rest of your family and the people who will end up taking care of you and seeing you suffer. So do it not only for yourself but the rest of your family. Try to get everyone to take the five-question screener on the website at [www.DRIVE4COPD.com](http://www.DRIVE4COPD.com). ■

## 5 Great Ideas *for the* FALL SCREENING EVENTS

The Adopt-a-Company initiative is not only designed to get companies to incorporate COPD screening into their HRAs and/or wellness programs, but also to establish a connection between the company, its employees, and the respiratory therapists in their community.

What kind of events will AARC members be holding at companies this fall? The sky's the limit as far as activities are concerned, but here are five ideas to help build excitement about the campaign:



1. Set up a booth in the company lobby or other central location where employees can stop by to fill out the COPD screeners, pick up educational materials on COPD, have a spirometry test, and ask questions of qualified respiratory therapists. Ask the company to send out an email in advance letting employees know you'll be there and encouraging them to participate.



2. Organize a 5K race, walk-a-thon, or other fun event for employees under the DRIVE4COPD banner and use the occasion to have RTs screen everyone in attendance. Also, hand out educational materials and offer PFTs.



3. For smaller companies, you might host a "lunch and learn" session where a respiratory therapist can provide a short talk on COPD and the importance of early detection, then hand out the screeners to the audience to complete and return. Ask a local restaurant to supply the food in return for co-branding on the event.

4. For larger companies, or those whose employees work several different shifts, set up a DRIVE4COPD screening table in the cafeteria and offer fun giveaways or small bags of home-baked goodies to employees who stop by to fill out the screeners.



5. Conduct a "one-on-one" campaign by having respiratory therapists go around to employee workstations and personally ask them to fill out the screener. Reward employees who agree to participate with a small treat or fun giveaway. Be sure to introduce yourselves as respiratory therapists and provide a short, simple explanation of why you are there and what the screener will tell them about their lung health. ■



## Other 2011 DRIVE Activities

The AARC's Adopt-a-Company initiative joins several other DRIVE4COPD programs underway this year:



### Pinwheel Promise:

This program is encouraging Americans to take the "Pinwheel Promise" to recognize the signs and symptoms of COPD and then commit to passing the promise along to four others in their lives.

**DRIVE4COPD Monument:** Celebrity ambassador Michael Kalish has created pinwheel art that's being toured around the country to catapult the campaign into the national spotlight.

**PitStop Events:** Professional racecar drivers are signing pinwheel icons and placing them on their cars, and PitStop events are taking place at race tracks to drive screenings.

### Tune Up for COPD Songwriting Competition:

The Country Music Association held a contest to encourage people to write songs about COPD, and the winner was featured at the CMA Music Fest in Nashville in June. ■



## National Captains Lead the Way

Helping lead the charge for the AARC's Adopt-a-Company project are three national captains who are coaching and encouraging other members to take the steps to get involved. While this year's program does not contain a competition among the state societies, these three respiratory therapists excelled as state captains in last year's program. This year, they'll be helping spearhead the DRIVE4COPD campaign to new heights of community involvement.

Meet our captains and help them spread the word about COPD.



**WHO:** Chuck Menders, BA, RRT

**WHAT:** Director of Respiratory Care

**WHERE:** Charleston Area Medical Center, Charleston, WV

**WHY:** Only half of the estimated 24 million Americans with COPD have been diagnosed. The other 12 million remain unaware, undiagnosed, and untreated. Getting involved with our new DRIVE campaign is an easy and effective way for respiratory therapists to reach out as professionals and bring this information to the community.



**WHO:** Shawna Strickland, PhD, RRT-NPS, AE-C

**WHAT:** Director, Respiratory Therapy Program

**WHERE:** University of Missouri, Columbia, MO

**WHY:** The Adopt-a-Company program provides respiratory therapists with an opportunity to reach a large number of people with information about COPD and how it can impact their lives. Using the tools provided by the DRIVE4COPD campaign, our RTs and students can make a significant impact on the overall health of our communities.



**WHO:** Curt Merriman, RRT, CPFT

**WHAT:** Vice President Marketing/Sales

**WHERE:** C.O.R.E. Respiratory Services, Lakeville, MN

**WHY:** Last year the AARC, through the efforts of each state, was able to screen 50,000 people for COPD with the DRIVE4COPD five-question screener. This year we are seeking out RTs to take on the new DRIVE with the Adopt-a-Company campaign. This is another unique way RTs can take a lead in bringing about COPD awareness, identifying those at risk, and providing vital education and information about the disease. Those with COPD appreciate our profession and professionalism; let's take it to another level and find those who are at risk and get on board with the new DRIVE!

## Why We Got Involved...

These statistics tell the story of why the AARC decided to step up and do more to identify COPD earlier in the disease process:

- **COPD is the fourth leading cause of death** in the United States, but many people who may be at risk have never even heard of it.



- **The disease kills more people each year** than breast cancer and diabetes combined.
- **Seventy percent of people living with COPD** are in the workforce, and the disease impacts workplace productivity, so early COPD screening and detection is critical.

- **An estimated 24 million Americans** may have COPD, but as many as half of them remain undiagnosed.

## ...and What We Get in Return

As a result of our involvement in the national DRIVE4COPD campaign last year, AARC spokesmen were featured in 32 media outlets reaching more than 1.5 million people. That kind of “good press” goes a long way not just to raising awareness of COPD, but also to letting the general public know more about the respiratory therapists who play such a valuable role in the care of people suffering from the disease. Our Adopt-a-Company initiative will reinforce the messages we sent in 2010. It will also:

- **Strengthen relationships** between hospitals/college RC departments and local companies.
- **Highlight the critical role RTs play** in COPD to their hospitals and communities.
- **Provide RTs with a way to fulfill** community service requirements and show value to their own organizations.
- **Facilitate efforts to engage RC students** in community service at the beginning of their careers.
- **Highlight the value and impact** of AARC members in COPD education and awareness to other influential DRIVE4COPD partners. ■

## The National DRIVE4COPD Team

The AARC is in good company as a partner in the national DRIVE4COPD campaign. Here are the celebrity ambassadors, partnering organizations, and corporate drivers who have joined us in raising awareness of this chronic lung condition:

- Race car driver Danica Patrick  
*(see our interview with her on page 38)*
- Country and western star Billy Ray Cyrus
- Country and western star Patty Loveless
- Monument designer Michael Kalish

- NASCAR
- The Country Music Association
- The COPD Foundation
- The COPD Alliance
- The U.S. COPD Coalition
- Boehringer Ingelheim
- HealthNet

- 3M
- Ford
- Duane Reade
- Office Depot
- Pfizer
- Piedmont Hospital
- Ralphs

- Sprint
- Winn-Dixie





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# AARC CON

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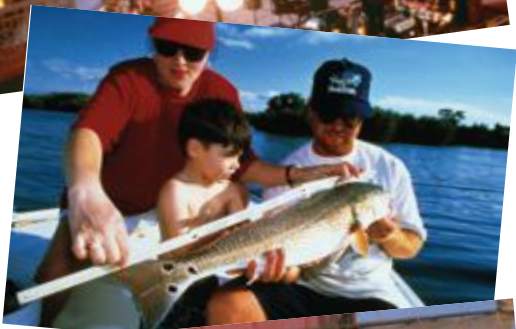
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# gress

& Exhibition



**And here are just some of the featured events in 2011:**

■ **New Horizons -**

**The Ventilator Liberation Process:**

Learn from the world's leading experts about the latest evidence on weaning patients from mechanical ventilation; from the role of non-invasive ventilation and tracheostomies, to ventilator weaning modes and utilization of protocols. Dazzle your physicians back home by sharing this evidence-based research while it's hot off the press!

■ **Respiratory Care Today -**

**N. American vs. European Perspective:**

Be sure to attend this symposium to learn how clinical practice differs between N. America and Europe as it relates to mechanical ventilation and NIV. Does the N. American approach to managing these patients measure up to our friends from across the pond? Attend this symposium to find out!

■ **2011 Year in Review:**

Established leaders in the field will review published manuscripts from 2011 covering all aspects of Respiratory Care from Education to Management to Pulmonary Rehabilitation and Long Term Oxygen Therapy. Stay current on all areas important to your practice by attending one of the premier symposia of the entire Congress.

Find out more at [www.AARC.org/education/meetings](http://www.AARC.org/education/meetings)

# BUDGETING FOR AARC CONGRESS



## Who:

Mikki Thompson, MS,  
RRT, FAARC

## What:

Director of Respiratory  
Care

## Where:

South Miami Hospital,  
Miami, FL

## AARC Member Since:

1981

## Two RC managers explain why it is not too soon to ask employers for funding

**Wait a minute!** Did you read this headline correctly? Budgeting for the 2012 AARC Congress? Aren't we still awaiting AARC Congress 2011 in Tampa, FL, this November?

The answer to all three of those questions is **yes**. While we have yet to convene for our 57th annual meeting in Tampa this Nov. 5–8, most facilities are already looking ahead to the 2012 budgeting cycle. That means now is the perfect time to lay the groundwork for your attendance at the 58th AARC Congress to be in New Orleans, LA, next year, Nov. 10–13. In the following interview, two managers who regularly acquire funding for the annual meeting share their strategies on gaining administrative support — and what they believe you can do to increase the chances that your facility will set aside the funds for you and some of your staff to attend.

**AARC Times:** Why is it important for people who want their hospitals to fund their attendance at the 2012 Congress to request funding well before the end of 2011? When do you, personally, request your funding, and why?

**Mikki Thompson:** We begin our budgeting process around May for the upcoming new year, which starts Oct. 1. I find that if it's not budgeted for, it won't happen in most cases.

**Doug Orens:** Requests for funding made in advance generally have a better opportunity to be granted based on the economic climate of the institution.

Ideally, these funds are requested as part of the upcoming year's operating budget.

**AARC Times:** With budgets tight in many places, what can people do to increase the chances that their attendance at the AARC Congress will be covered?

**Thompson:** Inform your administrator that we are looking for updated, evidence-based therapy and best practices, plus the chance to interact with RTs from other states throughout the country to be the best and stay on top of national changes that affect our services, especially as they are changing so rapidly today.

# 2012 IS UNDERWAY NOW!



## Who:

Doug Orens, MBA, RRT

## What:

Director of Respiratory Care

## Where:

Cleveland Clinic,  
Cleveland, OH

## AARC Member Since:

1974

**Orens:** We strongly support covering our staff who are engaged in any educational activity at the AARC Congress, whether that is a lecture, OPEN FORUM abstract presentation, or workshop.

**AARC Times:** How well have these strategies worked in your situation?

**Thompson:** They have worked well when we have staff willing to go. Sometimes I try to get people to share rooms in order to cut costs, but I give an education day to go. They also need to commit to coming back and presenting what they've learned to our department.

**Orens:** We have been very fortunate in acquiring funding for our staff members who are participating in any educational endeavor at the AARC Congress.

**AARC Times:** In many cases, leaders will only be seeking funding for their own attendance; but as you've both already noted, it is good to take staff along to these meetings as well. What do you think staff RTs can receive from the experience, and what advice do you have to help other leaders convince their bosses that staff attendance is important and should also be funded?

**Thompson:** Tie it into a career advancement program and also a type of succession program for new and also aspiring RT leaders.

**Orens:** The Congress offers many opportunities to obtain first-hand knowledge from leaders of our profession on a wealth of cutting-edge topics. It is an opportunity to experience different points of view on many topics, both clinical and non-clinical. This acquired knowledge can be shared with the respiratory care staff or other members of the health care team.

**AARC Times:** What are the top two or three methods you, personally, have used to acquire funding for your staff to attend; and how many staff members do you usually take with you to the Congress? What do you

require of these staff members when they return, and what benefits have accrued to your department/program as a result of their attendance?

**Thompson:** I promote staff attendance by saying that since we are a magnet hospital for nurses, we also strive to be a respiratory department that goes above and beyond for patient care and quality. We are the patient advocates for our patients with asthma, COPD, and other respiratory conditions. We don't want to bury our heads in the sand; and in order to keep abreast, RTs need to have updated information that is given at our national meeting.

We can also tap into a respiratory therapy fund through our hospital foundation that is dedicated to staff education. Sometimes two or three people can go; one if we're experiencing a slow financial year.

**Orens:** We have always promoted participation in educational activities as a way for staff to attend the Congress. Through the years, we have had anywhere from four to 12 staff attend. We ask the attendees to share their experience with staff who did not attend. One of the many benefits of attending is networking and developing a list of contacts — and most importantly, making some good friends.

**AARC Times:** If you do take staff along, how do you decide which ones to take? What advice would you give to staff members who would like to be among the chosen few?

**Thompson:** They need to be in the career ladder program. After that, it's "first come, first served" for staff in good standing with performance evaluations. Staff should express their interest to their leaders. They can increase their chances by stepping up as great professionals and getting involved with department quality, safety, and patient care concerns.

**Orens:** For us, active participation at the Congress is the way to go. ■



# Industry Watch

## California, Utah researchers report good results for mini-vent

A miniature, easy-to-carry ventilation system with a simple nasal mask may help COPD patients become more active, according to research conducted at medical centers in California and Utah. "The results from this study suggest that miniature ventilation systems with non-sealing, low-profile nasal masks may offer a new option for improving activity limitation in COPD patients," Chris Garvey, FNP, MSN, MPA, manager of pulmonary and cardiac rehabilitation at Seton Medical Center in Daly City, CA, was quoted as saying. Garvey and his colleagues presented a paper on the new device at the recent American Thoracic Society conference in Denver, CO.

## Linde RSS takes REMEO® ventilation into three new facilities

Ventilator-dependent respiratory patients in three skilled nursing facilities in the Western United States now have a better chance of going home earlier after the addition of cutting-

edge respiratory treatment and standards of care in their facilities. Livingston, TN-based Linde RSS is providing its REMEO® ventilation and weaning services to two facilities in Utah and one in Idaho. "We're excited and proud that Linde RSS was selected as the respiratory provider," said Gene Gantt, RRT, REMEO business development manager. "This is also the first entrance of our REMEO ventilation services in Western United States, which establishes a footprint for our future expansion."

## Discovery Laboratories featured in market research report

World Street Fundamentals has highlighted Discovery Laboratories for its focus on developing surfactant therapies to treat respiratory disorders and diseases. The company's KL4 technology produces a synthetic, peptide-containing surfactant that is structurally similar to pulmonary surfactant, a substance produced naturally in the lung and essential for survival and normal respiratory function. In addition, its cap-

illary aerosol-generating technology produces a dense aerosol with a defined particle size to deliver its aerosolized KL4 surfactant to the lung. The company is developing its products, Surfaxin (lucinactant), Surfaxin LS, and Aero-surf, to address respiratory conditions affecting pediatric populations.

## ImThera Medical concludes OSA study

ImThera Medical Inc. has concluded its Phase I and II protocols for the European Pilot study of the aura6000™, a neurostimulation device for treating OSA. According to the company, results include significant improvements to the patient's apnea hypopnea index, oxygen desaturation index, and sleep quality. "ImThera's therapy is safe and shows substantial OSA reduction and sleep improvement in a majority of patients," principal investigator Dr. Daniel Rodenstein was quoted as saying. He presented the data at the recent American Thoracic Society conference in Denver, CO. In other news, the company received the 2011 North American Frost & Sullivan

Award for Technology Innovation for the aura6000™.

## MAQUET receives 510(k) clearance for portable heart-lung support system

According to MAQUET Cardiovascular, the FDA has granted the company 510(k) clearance to market its CARDIOHELP System in the United States as a cardiac- and/or respiratory-assist device for up to six hours. The CARDIOHELP System is the world's smallest portable heart-lung support system, providing extracorporeal life support to replace or support a patient's circulation and respiration. The product, which includes the HLS Advanced Tubing Set, is the first support system approved for both ground and air transport and is expected to be commercially available in the United States later this year.

## Kimberly-Clark's Education Bus on the roll again

The Kimberly-Clark Education Bus is a one-of-a-kind mobile classroom that offers highly topical, accredited clinical edu-

cation courses to hospitals across America. The courses provide clinicians with additional knowledge on critical issues in health care (e.g., sterile processing, operating room best practices, health care-associated infections, ventilator-associated pneumonia, surgical site infections, and prevention of the spread of airborne infections. This year, the bus includes new learning and demo areas. Last year, the bus visited 79 locations in the United States and Canada, including stops at tradeshows and conferences.



### AG Industries acquires SP Medical

AG Industries has acquired SP Medical LLC, a Superior Products Company and manufacturer of home health care products. The acquisition will expand the product and capability portfolio of AG Industries, allowing customers to access an expanded range of products direct from the manufacturer. SP Medical will be relocating its manufacturing and sales offices to St. Louis, MO. "Our business model has always been to truly partner with our OEM and home health care products

customers," Michael Amann, vice president and COO of AG Industries was quoted as saying. "There is no middleman between us, giving our customers cost saving, quality enhancement, and operational advantages."

### CareFusion launches compact ventilator for the home

CareFusion recently introduced the LTV<sup>®</sup> 1100 ventilator, designed to improve the mobility of patients with spinal injuries or neuromuscular diseases who require continuous ventilation in the home. According to the company, the ventilator offers features common to ventilators used in hospital ICUs but in a small, durable package that enables all-day portability for active, ambulatory patients. For patients with chronic ventilatory failure, the LTV 1100 ventilator enables noninvasive positive pressure ventilation to help reduce the risk of respiratory infection, improve voice function, and enhance quality of life, according to CareFusion.

### Covidien announces transitions

Covidien has announced that Jose (Joe) E. Almeida, president of Covidien's Medical Devices business segment, will succeed Richard J. Meelia, who will retire as president and CEO effective July 1. Meelia

will serve as non-executive chairman of the board for a transition period of up to a year. Almeida joined the company in 1995 when it was Tyco Healthcare and was appointed to his current position in the medical devices segment in 2006. Covidien products are sold in over 140 countries.

### Cook Group loses founder

William A. Cook, founder of the Cook Group global network of companies, passed away in April following a long battle with heart failure, leaving behind a long legacy in the medical device industry. Cook Medical pioneered many of the medical devices now commonly used to perform minimally invasive medical procedures throughout the body. Tracheostomy supplies familiar to RTs include the Ciaglia Blue Rhino<sup>®</sup>, the Cook Spectrum<sup>®</sup>, and the Rapiscope<sup>®</sup>.

### Cheetah Medical announces study results for noninvasive PH system

Results from a study validating Cheetah Medical's noninvasive NICOM<sup>®</sup> system for use in patients with pulmonary hypertension were presented at the 2011 American Thoracic Society conference in Denver. In this study, the Cheetah Medical NICOM<sup>®</sup> Noninvasive

Cardiac Output & Hemodynamic Monitoring System was used to monitor the hemodynamic performance of 25 PH patients. University of Chicago researchers compared the results obtained with NICOM to those obtained with two gold-standard invasive methods — the pulmonary artery catheter, also known as Swan-Ganz catheter, and the Fick method. The NICOM system provided equally accurate and precise measurements but was completely noninvasive.

### Hamilton Medical gets top user satisfaction scores


Hamilton Medical reports that its ventilation systems have earned top user satisfaction ratings in all categories in every MD Buyline<sup>™</sup> Quarterly User Satisfaction Report since January 2010. Hamilton Medical credits the accomplishment to the intuitiveness of its ventilator platforms; advanced technology features such as ASV, PV Tool, the Dynamic Lung, and the integration of esophageal manometry and capnography; and dedicated staff who are available to users 24/7.

**Brief submissions and photos for this column may be sent to Marsha Cathcart, AARC Times editor, at [cathcart@aacr.org](mailto:cathcart@aacr.org). ■**

# Marketplace

Featuring information on products and equipment from manufacturers


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# Celebrate your profession during Respiratory Care Week 2011 October 23<sup>rd</sup> through 29<sup>th</sup>

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# RC Currents

IN THE NEWS

## ► AARC DigiMags Deliver a More Convenient Reading Experience

If you're like a lot of folks these days, you do most — if not all — of your reading online. The AARC is on board with the concept. We've been offering a DigiMag version of *AARC Times* for about a year now, and this spring we took *RESPIRATORY CARE* into the digital age as well, with not only a DigiMag format but also an HTML format that allows you to click through to all the resources cited in the Journal articles.

If you're one of the many AARC members who are still waiting patiently for their AARC publications to show up in the mailbox, here are some great reasons to check out our electronic versions:

1. You get your DigiMags days sooner than you get your paper copies. That means you can catch up on the latest in the world of respiratory care at the same time as all of your media-savvy colleagues.
2. The DigiMags are archived on [www.AARC.org/resources](http://www.AARC.org/resources) (for *AARC Times*) and [RCJournal.com](http://RCJournal.com) (for *RESPIRATORY CARE*). No more digging through piles of old magazines to find the one you want.
3. You can connect immediately to advertisers, to the AARC, to staff, because links are built in from the pages of the DigiMag direct to the sources you want to reach. ■



## AARC Members Testify at Senate Hearing

AARC members James Ginda, MA, RRT, AE-C, and Patricia Resnik, MBA, RRT-NPS, FACHE, testified recently before a joint hearing of the Senate Subcommittee on Clean Air and Nuclear Safety and Subcommittee on Children's Health and Environmental Responsibility, bringing the respiratory therapist's perspective to the topic of "Air Quality and Children's Health."

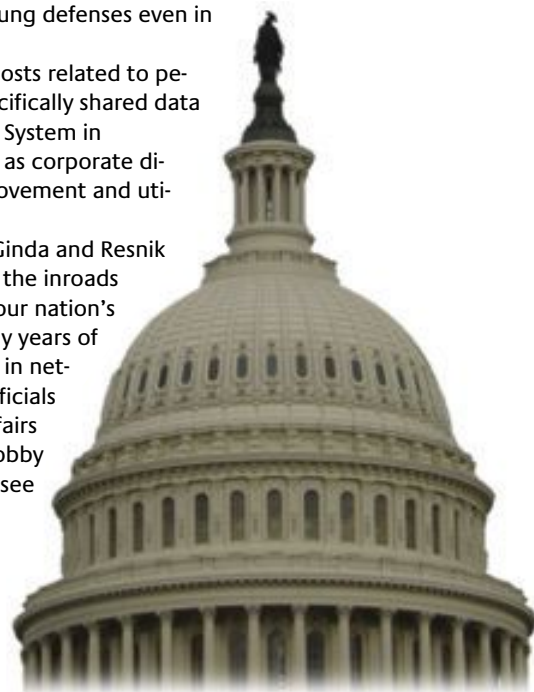
The hearing was spurred by ongoing debate in Congress on pollution standards. Under requirements of the Clean Air Act of 1990, the Environmental Protection Agency will be updating air pollution standards for mercury, ground level ozone, and other pollutants over the next couple of years. Following a ruling from the Supreme Court, the agency is also setting standards to address air pollution linked to global warming.

With the help of the AARC's executive office staff, Ginda and Resnik prepared five-minute oral testimonies aimed at educating the subcommittee members about the link between air quality and childhood asthma.

Ginda, who is a supervisor of respiratory care at Kent Hospital in Warwick, RI, specifically addressed airborne toxins and how they impact the respiratory system, noting that particulate matter is composed in part of black carbon fine particles, which can make their way past the upper airway lung defenses even in healthy individuals.

Resnik spoke about the costs related to pediatric asthma care and specifically shared data from Christiana Care Health System in Delaware, where she serves as corporate director of performance improvement and utilization management.

The testimony given by Ginda and Resnik is just one more example of the inroads our profession is making in our nation's capital and reflects the many years of work the AARC has invested in networking with our elected officials through our government affairs staff and our annual PACT Lobby Day. Read the full story and see Senate videos online at [www.aarc.org/headlines/11/06/senate\\_hearing/](http://www.aarc.org/headlines/11/06/senate_hearing/). ■



## RTs Involved in Making Medication Recommendations to Prescribers

The AARC recently conducted an informal Web-based survey to learn how hospital RTs are involved in making recommendations regarding the initiation and adjustment of medications. The survey went out to 663 members who reported working as a manager or director of a hospital department. Responses were received from 238, for a response rate of 35.9%. Results showed:

- On average, each department had 41.4 RTs who were providing medication to patients.
- On average, 66.8% of RTs per department were recommending aerosolized medications to prescribers to initiate therapy.
- On average, 73.9% of RTs per department were recommending adjustments to prescribers for existing aerosolized medication treatment plans.
- On average, 29.4% of RTs per department were recommending non-aerosolized medications to prescribers.
- 94.5% of respondents said RTs in their department are encouraged to make aerosolized medication recommendations to prescribers to initiate therapy.
- 98.7% of respondents said RTs in their department are encouraged to make recommendations to prescribers on adjusting existing medication treatment.
- 50% of respondents said RTs in their department are encouraged to make recommendations to prescribers for non-aerosolized medications. ■



## Read the Rest of the Story at AARC.org

- Share mechanical ventilation adjunct protocols — [www.aarc.org/headlines/11/06/adjunct\\_protocols.cfm](http://www.aarc.org/headlines/11/06/adjunct_protocols.cfm)
- Association members participate in new government-funded VAP bundle initiative — [www.aarc.org/headlines/11/06/ventilator\\_bundle.cfm](http://www.aarc.org/headlines/11/06/ventilator_bundle.cfm)
- AARC joins colleagues in concern over Rehberg amendment — [www.aarc.org/headlines/11/06/tobacco\\_bill/](http://www.aarc.org/headlines/11/06/tobacco_bill/)

## Enter the 2011 AARC Photo Contest

*AARC Times* is looking for creative members to enter our monthly Photo Contest. Winners will receive a free one-year membership renewal and have their submittal entered into our Photo-of-the-Year Contest with the chance of it being chosen to appear on the February 2012 cover. For instructions and guidelines, select the *AARC Times* icon on [www.AARC.org](http://www.AARC.org) and click on the "Photo-of-the-Year Contest" link. Deadline is Sept. 10, 2011. ■



## Plan Now for Respiratory Care Week Oct. 23–29

Circle the dates on the calendar and start thinking about your plans for Respiratory Care Week this October to recognize and honor the respiratory care profession. Send an announcement to your hospital newsletter and tell a success story. Do something special to acknowledge group or individual contributions in 2011. Plan an event with your rehab patients. Or participate in the DRIVE4COPD Adopt-A-Company campaign. The official RC Week website at [www.AARC.org/rcweek](http://www.AARC.org/rcweek) is loaded with great ideas, resources, links, and tools to make planning easy. ■

## Industry Profile: Nonin Medical

Nonin Medical Vice President of Vital Signs Tricia Haydon answers your questions about the company and the role it plays in providing quality care to patients.

**AARC Times:** How long has your company been in business, and what kinds of devices do you manufacture?

**Tricia Haydon:** Nonin Medical invented finger pulse oximetry, and the Nonin name and Onyx® brand are recognized as the gold standard in pulse oximetry. Nonin Medical, which is based in Minneapolis, has been designing and manufacturing noninvasive medical monitoring solutions for 25 years. In fact, Nonin is derived from the word, “noninvasive.” Our spot-check, continuous- and overnight-monitoring pulse oximetry products help clinicians assess oxygen desaturation and pulse rate, which is useful data in assessing patient conditions and managing chronic disease.

Our products are used with patients ranging from neonates to adults. During the past five years, Nonin has expanded its monitoring solutions to include capnographs, which provide exhaled CO<sub>2</sub> measurements of respiratory distress, and cerebral oximeters, which are used in perioperative procedures. Our pulse and cerebral oximeters, capnographs, sensors, software, and accessories are sold in 125 countries, and



Tricia Haydon

more than 100 OEM partners have integrated our oximetry technology for use in hospital, sleep, EMS, and home care settings. Nonin products are proven accurate in the widest range of patients and settings and are rugged, reliable, and lead- and latex-free.

**AARC Times:** What projects or new features are you working on for the future?

**Haydon:** The key to Nonin’s success is our ability to apply innovative signal processing and sensor-design technologies to create products that are accurate and reliable in the most challenging of patients, including those with low perfusion, motion, and dark skin. Nonin continues to focus on developing next-generation technology with expanded clinical applications and varied product designs to make it easier, more cost effective, and accessible to monitor the widest range of patients and settings. As the population

ages, we are finding that there is a large population of very sick patients outside of the traditional acute care setting. To meet continuum-of-care demands, we are continuing to leverage our core technologies to meet expanded patient, parameter, and connectivity needs.

**AARC Times:** How do your products improve patient care, and how does this impact the respiratory therapist?

**Haydon:** Because our pulse oximetry devices provide proven accuracy in the widest range of patients and settings, respiratory therapists know they can rely on the oxygen desaturation and pulse-rate data they are receiving. It is the challenging patient populations like those with chronic diseases, including COPD, congestive heart failure, and asthma, who require the most accurate data to allow for better and

faster decision making. Because Nonin devices are easy to use, clinicians benefit from having Nonin's products at their fingertips; and their patients experience greater peace of mind with improved compliance when monitoring chronic diseases, even at home. We are honored that so many respiratory therapists and clinicians recommend Nonin pulse oximeters by name to their patients when home monitoring is required.

**AARC Times:** Do respiratory therapists work for your company and, if so, in what capacity? How has having respiratory therapists impacted your product line?

**Haydon:** Yes, Nonin Medical employs the expertise of respiratory therapists in a variety of roles, including as sales people and clinical specialists, and in marketing. Having respiratory therapists on staff allows us to better understand the clinical world they work in as well as the patient needs. We are able to develop more practical, value-added solutions that directly benefit both respiratory therapists and the patients they treat.

Respiratory therapy staff members also help Nonin make industry advancements, such as gaining reimbursement for a class of devices. Our on-staff RTs have even helped Nonin influence national policy change, including the U.S. federal aviation law that now allows patients to fly with oxygen tanks onboard commercial aircraft.

**AARC Times:** How do you expect the economy and health care reform to affect how you develop new respiratory care technology over the next two years?

**Haydon:** Technologies that are cost effective and provide the greatest amount of versatility and connectivity are going to be in highest demand. We have solutions in a variety of forms and functions that meet these needs, and we continue to evolve our product and technology-development road maps to address the changing clinical arena, such as combining and expanding parameters so we can provide the clinician more information from a simpler yet more connected device. Nonin also focuses on cost effectiveness by evaluating the cost of ownership over the life of the device, not just the expense of purchasing it. Nonin's warranty, durability, and accuracy place our products among the most cost-effective solutions available. And with the introduction of products that are Bluetooth® enabled and Continua™- and Microsoft® HealthVault™-certified, Nonin is leading the way in simplifying the exchange of data to not only lower health care costs but also increase clinician convenience and patient independence.

**AARC Times:** Where do you see the respiratory device industry heading?

**Haydon:** As health care continues to move into the post-acute care and home care settings, education and clinical support will become even more important. Clinical environments will require different technology, communication, and product capabilities. Nonin has always been on the forefront of addressing these needs and providing value-added services to assist respiratory therapists, including clinical support and patient education.

We believe that respiratory therapists will continue to play a critical role in managing the quality of life of the globally aging population by supporting patients with chronic respiratory disease. Through this process, technology and devices will need to become more flexible and versatile in their design, more innovative in technology applications through expanded parameters, and more sophisticated through the introduction of communication modalities like wireless data transmission, memory, and alarm management.

Nonin continues to enhance all facets of our work in the respiratory community through our ongoing product development and cost-effectiveness initiatives, as well as value-added and educational services. We look forward to our ongoing collaboration with the AARC and its members. ■

## RT Student Members: Send Us Your Stories and Editorials

*AARC Times* is always looking for good stories from AARC student members that relate special experiences and give the RT student perspective on the respiratory care profession they have chosen as a career. We have published the stories of several student members in *AARC Times* this year, and we continue to encourage you to share your experiences.

Have you volunteered at a summer asthma camp or helped organize the DRIVE4COPD program in your state? Have you advocated for respiratory therapy in your state capitol or on Capitol Hill? Maybe you and your RC student friends have collaborated to build a house with Habitat for Humanity. Perhaps you witnessed a life-saving event outside the hospital setting or experienced something that took your breath away. Whatever the story, we would like to review it.

If you have a story to tell, please contact *AARC Times* Editor Marsha Cathcart at [cathcart@aacrc.org](mailto:cathcart@aacrc.org) and include in the subject line, "Student Member Story." Be sure to give us your full name, AARC member number, a brief description of the story subject, and why you would like to have it published. Then attach a Word document of the story. We hope to hear from you soon! ■

# Pulmonary Rehabilitation: Choosing the Path to Healthy Living

by Darlene Dieterich, CRT, LPN



Smoking + Environmental Exposures = COPD. That is the formula that changed the life of 58-year-old Bob Drafahl. The results of pulmonary function testing confirmed his diagnosis of moderate-to-severe COPD.

After hearing the news, Bob said, "Something had to change. I was not ready to be on oxygen this early in my life. I was not sure how to deal with COPD." His physician recommended pulmonary rehabilitation, and Bob's journey began.

When we first met Bob, we learned that his occupation exposed him to the lung irritants of gas, fumes, dust, chemicals, and asbestos. He was having difficulty completing his work-related responsibilities. Completing activities of daily living were becoming more difficult because of his fatigue, shortness of breath, and impaired walking. Bob's wife knew he needed help when he was unable to uncover their small home pool without "gasping for air."

At the time of his admission to the pulmonary rehabilitation program, Bob was still smoking cigarettes. Realizing that smoking was contributing to his shortness of breath, he vowed to stop. With the help of medications, a tobacco-dependence treatment program, and constant support, Bob remained true to his word and quit. More importantly, he became a role model at his workplace.

**Bob Drafahl is living life to its fullest despite COPD, thanks to the help he received from Darlene Dieterich and her colleagues in pulmonary rehabilitation.**

He was also instrumental in helping a number of his co-workers quit their smoking habit before being forced to retire early to avoid the occupational exposures and prevent further lung damage.

To his credit, Bob has remained smoke free! He recently celebrated his one and a half year anniversary. He says that smoking cessation has made his life healthier and his wife and family a lot happier. The reminder of having to use two inhalers daily and carry a rescue inhaler has provided him with an incentive to "not smoke and keep breathing." Bob successfully completed his rehabilitation program, meeting and exceeding his goals. "During the sessions of pulmonary rehabilitation, I learned what I have, how to deal with it, and what to do to survive," he says.

Exercise is an essential part of our pulmonary rehabilitation program, and Bob has become a true advocate for the benefits it can deliver. "Along with all the information given and hand outs, exercise was a high priority," he says. "Without exercise your body and lungs must work harder to do everyday tasks we take for granted."

Even though Bob has now been discharged from the program, he still talks the talk and walks the walk. He has become a regular gym member. "Because I need to stay physically active, I try to exercise an hour every day of the week," he says. "I'm not ready to give up on life. With a little effort on my part and what steam I have left, I plan on going on for a long while." Bob has not had an upper respiratory infection for the past 18 months, which he credits to his regular exercise activity.

Pulmonary rehabilitation is not a short course from which patients can walk away. They must continue to be in the driver's seat, practicing the self-help skills they have learned and living out the necessary lifestyle changes. Since continued compliance is a major goal, Bob provided support to our recent graduates by offering them this advice: "After all the dedicated work that the people of pulmonary rehabilitation have done, it is now our choice of what lifestyle we will follow. Either go to the gym and exercise to keep your body strong and healthy or go back to a lifestyle of doing very little and being worse off than you were before." ■

Darlene Dieterich works in the pulmonary rehabilitation program at the Great River Center for Rehabilitation and Clinics at Great River Medical Center in West Burlington, IA.

## Asthma Rates on the Rise

According to the latest findings from the Centers for Disease Control and Prevention, the number of Americans with asthma grew by 4.3 million from 2001 to 2009. The greatest growth was seen in black children, who experienced a nearly 50% increase in disease prevalence. Asthma was linked to 3,447 deaths in 2007 or about nine deaths per day. Other findings from the report include:

- One in 12 people (about 25 million, or 8% of the population) had asthma in 2009, compared to one in 14 (about 20 million, or 7%) in 2001.
- More than half of people with asthma had an asthma attack in 2008.
- About one in 10 children and one in 12 adults had asthma in 2009. Women were more likely than men to have asthma, and boys were more likely than girls.
- Asthma cost the United States about \$3,300 per person each year from 2002 to 2007 in terms of medical expenses, missed school and workdays, and early deaths.
- Medical expenses associated with asthma increased from \$48.6 billion in 2002 to \$50.1 billion in 2007. Total asthma costs grew from about \$53 billion to about \$56 billion, for around a 6% increase.
- About 40% of uninsured people and 11% of insured people with asthma could not afford their prescription medicines.
- 59% of children and 33% of adults who had an asthma attack missed school or work because of asthma in 2008. On average, children missed four days of school and adults missed five days of work.
- In 2008 less than half of people with asthma reported being taught how to avoid triggers; 48% of adults who were taught how to avoid triggers did not follow most of the advice they received. ■



## ► Strange But True...

**Superbugs:** Canadian scientists identified drug-resistant staph bacteria in bedbugs found on three patients who were living in a downtrodden Vancouver neighborhood. While there was no evidence that the bugs had spread their MRSA bacteria, the researchers believe that since bedbugs cause itching, transmission could occur.

**Smog-eating Aluminum:** Alcoa has developed an aluminum architectural panel coated with titanium dioxide that it says is capable of combining with sunlight to break down pollutants such as smog into harmless matter that rain can simply wash away.

**Crossing Out Pain:** British researchers have found that crossing your arms across the middle of your body confuses areas of the brain devoted to right and left maps of external space, leading to a lower sensation of pain. In experiments, people perceived less pain from a pin prick when their arms were crossed. (March 28 issue of *Pain*)

**There's an App for That:** A new smart phone app is helping physicians diagnose stroke. ResolutionMD Mobile allows physicians to review brain-scan images with nearly the same accuracy as that available at a full diagnostic workstation.



**Anti-aging Shortcut:** Studies have shown restricted calorie diets lead to longer life for everything from worms to monkeys, and researchers believe the same could be true for humans. But in our super-sized world of food, cutting 30% of calories out of the diet is not doable for most folks. Now scientists are investigating several synthetic and natural compounds that might help people achieve the same results without starvation by triggering the same biochemical mechanisms that occur when cells are partially starved of nutrients. Among the prospects: resveratrol, a substance found in red grapes and wine. (June issue of *ScienceNews*)

## Nominate an AARC Member for “Success Stories” or “Interesting People”

Do you know an AARC member who would be a good choice for one of our “people” features in “RC Currents”? If so, provide this information to the editor at the address below: the member's name, job title, place of work, city, and state; why you think they should be featured; and their contact information. Send to: Editor Marsha Cathcart, cathcart@aacrc.org with “Success Stories” in the subject line. ■

## Video Games Help Make CF Treatments Fun



Kids like video games, but they generally don't like their respiratory treatments. Several years ago, Peter M. Bingham, MD, an associate professor of neurology and pediatrics at the University of Vermont, decided to reconcile the two by creating a special video game system for children with cystic fibrosis (CF) that uses a digital spirometer as the controller. He also turned to AARC members Catherine Brady, RRT, and Darick Duquette, RRT, for help and advice.

"About four years ago, I was approached by Dr. Bingham to teach him some breathing techniques via the video game he was creating to help kids get more out of their treatments," says Brady, who works with Duquette at Fletcher Allen Health Care (FAHC) in Burlington, VT. "He was concerned about motivating patients who really needed to do their treatments." She assisted him in the early stages of the game creation, teaching various huffing techniques to the Champlain College computer programming students who were developing the games. She enjoyed watching the students play the games they created and believed they would be helpful to CF patients. In one, the player's breath drives a race car down a track and allows the player to

**Darick Duquette and Catherine Brady brought their RC skills to bear on a video game system for kids with cystic fibrosis.**

fill the car up with gas and wash it. In the other game, the player uses the spirometer to blow slime off of animals to uncover treasures.

After the game was developed, Dr. Bingham approached Duquette, who had recently joined the staff at the Pediatric Cystic Fibrosis Center at FAHC, to ask if he could help teach kids with CF how to use the spirometer to play the games. The physician also wanted Duquette's help in selecting patients for a study he was planning to conduct on the use of the games in kids with CF.

Duquette says playing the games was not as easy as it looked — at least for him. "I practiced playing the games, at times getting dizzy from blowing into the spirometer too frequently. This only seemed to be an issue for me and not the children." He also found it challenging to coordinate the computer controls with the forced exhalation, but the kids picked

it up with no problem after just a couple of practice sessions.

Duquette had to read up on the study protocol as well so he could be sure he was instructing each patient in exactly the same way. That study (which was conducted among 13 children ages 8–18 who underwent pulmonary function tests and then participated in a game phase and a control phase for two to four weeks each) has now been completed and was presented by Dr. Bingham at the recent Pediatric Academic Societies annual meeting in Denver, CO.

Results showed few of the children were completing the recommended amount of huffing prior to the study. During the study huffing increased markedly, although similar increases were seen in both the game and control phases. Dr. Bingham speculates that having access to both the computer and spirometer during both phases focused the children on using the spirometer to complete the recommended forced exhalations. The children did, however, show a greater improvement on vital capacity tests only during the game phase, leading the physician to believe they were

practicing their breathing skills more often when they had access to the games.

Both Brady and Duquette believe spirometer-driven computer games could help with the care of children with CF. "I think if the kids are 'playing' this video game as an adjunct or in place of therapy, they are probably getting a good treatment," says Brady. "If a child fights his treatment or only does it half-heartedly the 'normal' way, and performs this video game enthusiastically and correctly, he is getting a good treatment and learning something in the process."

Duquette says the kids loved the games and played them more than the required amount of time. The only negative comments he heard were from the older kids, who noted that the games didn't measure up to the action video games they usually played, but they still benefited from the experience. "I believe what the video game accomplished was to teach CF children how to do a forced exhalation that could have produced a cough and mimicked huff coughing," says the RT. "But more importantly, it got the children to learn better spirometry technique."

He sees a future for the games in his own CF center as well. "As this study was progressing, the pulmonologist in the clinic and I started talking about possibly using this game in our four- and five-year-olds to help get better and earlier FEV<sub>1</sub> results that could be trusted as accurate." ■

## ► Transitions

**Geoff Neilson** has been named president of a newly created respiratory care strategic business unit at ResMed that will focus on COPD. He was formerly vice president of the company's ventilation strategic business unit. (Photo 1)



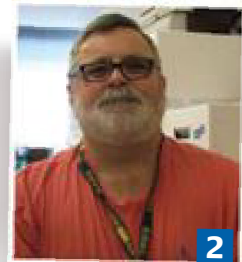
1

**Leslie Flater, RRT**, has received the 2011 Father Klimek Healing Presence Award from Sacred Heart Hospital in Eau Claire, WI. The award is the highest honor bestowed by the hospital on a hospital colleague.

**Fran Ahel, RRT, AE-C**, has received the Living the Mission award from Texas Health Harris Methodist Hospital Hurst-Euless-Bedford in Bedford, TX.

**Anthony Kordack** passed away on May 2 in Lancaster, OH. He was president and CEO of the Ohio Rehab and Diagnostic Center.

**George M. Barton, RRT**, passed away on April 11. He was a graduate of Northwest Mississippi Community College and the Methodist School of Respiratory Therapy. At the time of his death, he was the director of cardiopulmonary services at Saint Francis Hospital-Bartlett in Bartlett, TN. (Photo 2)



2

We welcome news about AARC members. Submit job changes, awards, and death notices online at [www.AARC.org/transitions](http://www.AARC.org/transitions). ■

## CLSI Issues New Pulse Oximetry Guideline

The Clinical and Laboratory Standards Institute (CLSI) has issued a revised guideline on pulse oximetry to provide guidance on the related physiology, technical operation, and limits of the technology.

"Pulse oximetry; approved guideline-second edition" (POCT11-A2) **Bow** addresses standard precautions, pulse CO-oximetry, data trending, device interfaces, and patent ductus arteriosus and intercardiac shunt detection. Illustrations of a revised depiction of the schematic representation of light transmission through tissue, transmittance and reflectance sensors, and a pulse-oximetry plethysmograph tracing are included as well. The new guideline is available at [www.clsi.org](http://www.clsi.org).

AARC members Bruce Toben, RRT-NPS, CPFT; Gregg L. Ruppel, MEd, RRT, FAARC; and Brian Walsh, RRT-NPS, RPFT, FAARC, served as advisers to the seven-member international committee that developed the update. (Diagnostics Specialty Section members can read more about it in the Summer issue of their *Bulletin*.) ■

## Honoring Military RTs

If you are a respiratory therapist currently serving your country in the military, *AARC Times* would like to publish a story and photo about your service or deployment.

Please go online at [www.AARC.org/go/mm](http://www.AARC.org/go/mm) where you will find an online form you can fill out to provide information about your service and deployment. You can also download your photo there.

Once we receive your information, we may use it to prepare an “RC Currents” story about your service in the military. The AARC honors those who serve, and we would like to share your story with your respiratory care colleagues here and abroad. ■



## Too Many Parents Forego Flu Shots for Asthmatic Kids

Influenza is responsible for many asthma attacks in children, so vaccination is essential. But some parents still aren't following recommendations calling for their children to receive the annual flu shot.

Researchers from C.S. Mott Children's Hospital surveyed 237 parents of asthmatic children last year to find out why some parents don't follow through on vaccination recommendations. Results showed 70% of the parents had vaccinated their asthmatic child for influenza during the past season and 65% were planning to vaccinate during the upcoming season.

Several differences in opinion related to asthma and the flu vaccination were noted between the parents who did and did not follow through with vaccination. Specifically, 72% of parents who vaccinated believed that getting a viral infection could lead to an asthma attack compared to only 53% of those who didn't vaccinate.

Twenty-six percent of parents who vaccinated were worried about vaccine side effects versus 60% of non-vaccinators. Getting sick from the vaccine itself was cited as a worry for 13% of vaccinating parents compared with 41% of non-vaccinating parents.

The study was presented at the American Thoracic Society conference in Denver, CO, earlier this year. ■



## Research May Lead to New Treatments for Sepsis

Investigators at Case Western Reserve University School of Medicine believe adjusting a genetic factor called Kruppel-like transcription factor 2 (KLF2) at key stages in the development of sepsis could improve survival rates.

Located inside immune cells known as macrophages, KLF2 normally maintains immune cells in a quiet state. However, during the first phase of sepsis, low oxygen levels and high amounts of bacterial products cause the level of KLF2 to be reduced, essentially opening the gate for macrophages to release noxious products that kill the bacteria. But when sepsis moves into the second phase, marked by low body temperature and blood pressure, tissue damage, and a cascade of organ shutdowns, this promotion of inflammation can cause shock and death.

The researchers are now looking for compounds that could reduce the amount of KLF2 in the first phase of infection and bolster levels in the second phase. The study was published in the May 27 issue of *Immunity*. ■

## Study Uncovers Genes Related to CF Severity

A new study conducted by researchers working with the North American Cystic Fibrosis Consortium has uncovered two regions of the genome that affect the severity of cystic fibrosis.

The research was based on samples from 3,467 patients, including unrelated patients and related patients and their parents. The researchers used the FEV<sub>1</sub> as the measure of disease severity, then looked for common variations that were more frequently associated with severe cases of CF. A region encompassed by two genes on chromosome 11, and a second region on chromosome 20, were both found to be related to disease severity.

“We already know which gene causes CF, but to a large extent that gene does not by itself explain how severe the condition will be,” Garry Cutting, MD, a professor of pediatrics at Johns Hopkins was quoted as saying. “Now we’ve discovered new genes that influence the course of disease and may enable prediction of disease severity and, most importantly, the customization of treatments for patients with unfavorable genetic modifiers — this is the realization of individualized medicine.” The investigators published their findings in the May issue of *Nature Genetics*. ■



## Contribute to Writer’s Corner

*AARC Times* is currently considering brief stories from AARC members for publication in the Writer’s Corner section of “RC Currents.” Submissions should be under 500 words and contain a cover letter with the member number, contact information such as phone and fax numbers, and email address. Send submissions to [cathcart@aacr.org](mailto:cathcart@aacr.org) with “Writer’s Corner” in the subject line. ■

## Web Watch

Covidien has launched *Conscientious Collaboration*, an online resource ([www.covidien.com/collaboration](http://www.covidien.com/collaboration)) to promote the importance of ethical and clinically meaningful collaboration between health care professionals and the medical device and pharmaceutical industries. Open communication with its customers and partners enhances innovation and helps ensure improved patient outcomes. ■

## Do Amenities Trump Quality?

In crowded hospital markets, amenities like private rooms with great views, hotel-style meal service, and massage therapy may be luring patients to facilities with lower quality of care. That’s the key finding from a new study conducted by University of Southern California researchers.

The investigation builds on previous research conducted by McKinsey and Company in 2007 that showed only 20% of patient choice in health care facilities was based on clinical quality, while 41% was based on nonclinical experiences. Overall, patients would choose a hospital with amenities over a hospital without those perks.

In the current study, researchers found Medicare patients with pneumonia would travel farther away from home to acquire care in a hospital with more amenities.

The only patients in the study who appeared more likely to choose clinical quality over amenities were those experiencing emergent heart symptoms. Those patients still opted for hospitals with the best clinical reputations. The research was covered in an April issue of *Hospitals & Health Networks*. ■





# New Members

## Welcome to the AARC

### U.S. Members

#### A

Cobb, Vanessa, Moundville, Al\*  
Gray, Regan, Prattville, Al\*  
Head, Jeff, Gadsden, Al\*  
Morgan, Dashelle, Phil Campbell, Al\*  
Watkins, Christopher, Phenix City, Al\*

Currier, David, Ozark, Ar\*  
Harvey, Virgil, Cabot, Ar\*  
Kidd, Charles, Jonesboro, Ar\*  
Poynter, Barry, North Little Rock, Ar

Buchanan, Karen, Phoenix, Az  
Daly, Julie, Golden Valley, Az\*  
Enderle, Marcia, Lake Havasu City, Az\*  
Goats, Barbara, Gilbert, Az\*  
Guerrero, Mireles, Fort Defiance, Az\*  
Harrison-Shreeve, Georgette, Phoenix, Az  
Hart, Karen, Apache Junction, Az\*  
Kayfish, Jeffrey, Golden Valley, Az\*  
Levy, Nicholas, Surprise, Az  
Maldonado, Henry, Glendale, Az  
Martinez, Ronald, Gilbert, Az\*  
Midura, Lindsey, Mesa, Az  
Nelsen, Brenda, Laveen, Az  
Olson, Gabriela, Casa Grande, Az  
Richardson, Julie, Mesa, Az\*  
Sandoval, Yessica, Queen Creek, Az\*  
Sifuentes, Desiree, Tucson, Az\*  
Sleight, Steve, Surprise, Az  
Toffolo, Paula, Tucson, Az\*  
Valderrama, Gloria, Casa Grande, Az\*  
Venable, Brian, El Mirage, Az  
Wooddell, Derik, Mohave Valley, Az\*

#### C

Abenojar, Dann August, Union City, Ca\*  
Alsisto, Ferdinand, Chula Vista, Ca\*  
Antanesian, Rafael, Antelope, Ca\*  
Barnes, Ricki, Tulare, Ca\*  
Barron, Monique, Santee, Ca\*  
Bell, Joan, Oceanside, Ca\*  
Bendinelli, Beth, Carpinteria, Ca  
Billiard, Shalia, Lemon Grove, Ca  
Bueno, Ronnie, Bellflower, Ca\*  
Callahan, Jessica, Irvine, Ca\*  
Cheriyana, Tina, Ontario, Ca\*  
Collins, Cheryl, Concord, Ca\*  
Cook, Kenneth, Canyon Country, Ca\*  
Diwa, Elizabeth, San Diego, Ca\*  
Donohoe, Nadia, Irvine, Ca\*  
Ernststein, Jeff, Lompoc, Ca\*  
Fong, Myron, San Francisco, Ca\*  
Ginsberg, Ben-Philip, Fresno, Ca\*  
Gordon, Robin, Castro Valley, Ca\*

Heria, Karen, Carson, Ca  
Hu, Xudong, Fremont, Ca\*  
Kong, Keng, Oakland, Ca\*  
MacTaggart, Joanne, San Leandro, Ca\*  
McGinley, Joshua, San Marino, Ca  
Murray, Matthew, Livermore, Ca\*  
Nguyen, Tom, Fremont, Ca  
Pabelona, Andi, Lakewood, Ca\*  
Peoples, Amber, Stockton, Ca\*  
Pham, Josh, San Jose, Ca\*  
Phongsvej, Linda, North Hollywood, Ca\*  
Ramirez, Carol, Bloomington, Ca\*  
Rzodkiewicz, Mary, Hemet, Ca\*  
Sanborn, Natalie, Santa Cruz, Ca\*  
Seldow, Timothy, Sacramento, Ca\*  
Smith, Shawn, Chula Vista, Ca\*  
Speedie, Sacha-Mae, San Dimas, Ca\*  
Steffani, Monique, La Mirada, Ca\*  
Stemen, Daniel, Monrovia, Ca\*  
Sung, Christopher, Montclair, Ca  
Vegahuerta, Miguel, Corona, Ca\*  
Washington, George, Brea, Ca\*  
Werth, Justin, Ventura, Ca\*  
Woodford, Tara, La Canada, Ca\*  
Yuan, Wenqin, Dublin, Ca\*  
Zhang, Kun, San Jose, Ca

Brown, Carl, Franktown, Co  
Ebel, Brittani, Johnstown, Co  
Moore, Ginger, Highlands Ranch, Co

Austin, Kira, Bridgeport, Ct\*  
Barros, Anthony, Cheshire, Ct\*  
Bennett, Adam, New Haven, Ct\*  
Boulanger, Katrina, Jewett City, Ct\*  
Brothers-Mason, Tonia, Ellington, Ct  
Galiatsatos, Nikolaos, Waterbury, Ct\*  
Hayes, Claire, West Simsbury, Ct\*  
Martin, Tyson, Bristol, Ct\*  
Silva, Brooke, Bristol, Ct  
Sumeersarnauth, Inga, Stafford Springs, Ct

#### D

Savage, Gretchen, Middletown, De\*

#### F

Abelard, Jean, Tamarac, Fl  
Aleus, Yvenante, Orlando, Fl  
Alvarez, Lina, Orlando, Fl  
Barbara, Terra, Spring Hill, Fl  
Bonacic, Mark, Apopka, Fl\*  
Bookholt, Karen, Windermere, Fl  
Caamano, Natalie, Kissimmee, Fl  
Corish, Jody, New Smyrna Beach, Fl\*  
Dangleis, Donetta, Sarasota, Fl\*  
Diaz, Monica, Clermont, Fl  
Dillard, Denisa, Orlando, Fl  
Enfinger, Nancy, Crestview, Fl\*  
Escarpio, Omar, Miami, Fl\*

Eustace, Debra, Kissimmee, Fl  
Fidelus, Marjorie, Fort Lauderdale, Fl  
Fleming, Tiffany, Orlando, Fl  
Fleurimon, Hollenda, Orlando, Fl  
Gentry, Josh, Lakeland, Fl  
George, Lethisha, Brandon, Fl  
Gonzalez, Lisa, Palm Coast, Fl\*  
Guzman, Emynette, Orlando, Fl  
Hermina, Stacy, Cape Coral, Fl\*  
Hernandez, Jennifer, Orlando, Fl\*  
Hicks, Carrie, Altamonte Springs, Fl\*  
Hopper, R Keith, Riverview, Fl\*  
Ives, Alison, Winter Garden, Fl  
Lawal, Benediccta, Orlando, Fl  
Learmond, Nicole, Pompano Beach, Fl  
Leckler, Lisa, Orlando, Fl  
Loiacono, Evan, Maitland, Fl  
Manic, Anirudh, Sunrise, Fl\*  
Maydong, Daisy, Orlando, Fl  
McCormick, Nicole, Davenport, Fl  
Moore, Joyce, Casselberry, Fl\*  
Morris, Charles, Saint Cloud, Fl  
Muir, Marie-Eve, Orlando, Fl  
Murphy, Renee, Pensacola, Fl\*  
Mussen, Gail, Plantation, Fl\*  
Nelson, Caroline, Jay, Fl\*  
Nguyen, Phuong, Tampa, Fl  
Osterling, Marie, Melbourne, Fl  
Pierre, Jose, Pembroke Pines, Fl  
Plummer, Roger, Lauderdale Lakes, Fl  
Prawdzik, Donna, Orlando, Fl  
Ramos, Saylen, Longwood, Fl  
Reed, Kevin, Tampa, Fl  
Ritchie, Shelly, Orlando, Fl  
Rose, Justin, Jacksonville, Fl\*  
Ruiz, Sara, Orlando, Fl  
Saimpreux, Emmanuelle, Orlando, Fl  
Saunders, James, Clermont, Fl\*  
Shollenberger, Sara, Bonita Springs, Fl\*  
Solson, Sharona, Tampa, Fl  
Soto, Marilyn, Pinellas Park, Fl  
Spainhoward, Lynne, Orlando, Fl  
Sperry, Michelle, Winter Park, Fl\*  
Springfels, Roger, Gainesville, Fl\*  
Still, Toby, Newberry, Fl\*  
Strand, Andrea, Kissimmee, Fl  
Tillison, Lisa, Gotha, Fl  
Villa, Daniel, Pembroke Pines, Fl  
Zaccaro, Vincent, Ocoee, Fl

#### G

Beasley, Michele, Chatsworth, Ga\*  
Champagne, Brenda, Naylor, Ga\*  
Cook, Stephanie, Ellijay, Ga\*  
Cooper, Erica, Brunswick, Ga\*  
Fazendin, Kevin, Albany, Ga\*  
Fortner, Lisa, Trenton, Ga\*  
Foster, Andrew, Hinesville, Ga\*  
Fraser, Samantha, Braselton, Ga  
Gayton, Patricia, Canton, Ga\*  
Jackson, Abraham, Cuthbert, Ga\*

Jackson, Jada, Acworth, Ga\*  
 McCoy, Christopher, Columbus, Ga\*  
 McGowen, Jayme, Dublin, Ga  
 McKelvey, Terrie, Columbus, Ga\*  
 Miklos, Margarette, Lawrenceville, Ga\*  
 Murphy, Jennifer, Evans, Ga\*  
 O'Donnell, Genevieve, Hampton, Ga\*  
 Oliver, Gary, Atlanta, Ga\*  
 Payne, Amy, Dublin, Ga  
 Pierce, Lisa, Augusta, Ga\*  
 Skinner, Dixie, Hamilton, Ga\*  
 Stephen, Alia, Marietta, Ga\*  
 Stokes, Beverly, Athens, Ga\*  
 Turner, Sheila, Ellerslie, Ga\*  
 Wheaton, Blair, Cairo, Ga\*

Tiongson, E Francis, Tamuning, Gu\*

## H

Silverio, Neil, Aiea, HI\*

## I

Davis, Jessica, Des Moines, Ia  
 Merryman, Jennifer, West Des Moines, Ia\*  
 Schmidt, Brittany, Des Moines, Ia  
 Showers, Rachael, Council Bluffs, Ia

Aubuchon, Janet, Bonners Ferry, Id\*  
 Ronquillo, Sabrina, Meridian, Id\*

Abraham, Gino, Des Plaines, Il\*  
 Alqam, Mohammad, Chicago, Il  
 Anane, Sandra, Chicago, Il  
 Atkins, Angelica, Chicago, Il  
 Barry Jr, Joseph, New Lenox, Il\*  
 Boyd, April, Swansea, Il  
 Carr, Megan, Chicago, Il\*  
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 Crocker, Alexander, Lacon, Il  
 Devous, Christine, Gilman, Il  
 Gonzalez, Noemi, Chicago, Il\*  
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 Hassan, Mohamed, Chicago, Il  
 Haymon, Joana, Hazel Crest, Il  
 Holdshteyn, Lyudmyla, Chicago, Il  
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 Iwinski, Lillyan, Montgomery, Il\*  
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 Madu, Onyebuchi, Lansing, Il  
 McCree, Lashawn, Matteson, Il\*  
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 Michel, Dominique, Chicago, Il  
 Norieko, Gerry, Palos Heights, Il  
 O'Leary, Joy, Chicago, Il\*  
 Ocampo, Evana, Oak Lawn, Il\*  
 Patel, Poonam, Chicago, Il  
 Philip, Anup, Morton Grove, Il\*  
 Phillips, Arla, Chicago, Il  
 Romero, Carlos, Chicago, Il  
 Shaw, Chanice, La Grange Park, Il  
 Shopitan, Ayodeji, Alsip, Il  
 Slobodyan, Mariya, Chicago, Il\*  
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 Thomas, Jacob, Chicago, Il\*  
 Thomas, Smitha, Niles, Il  
 Thomson, John, Tinley Park, Il  
 Traylor, Darryl, Chicago, Il

Truevillian, Adell, Chicago, Il\*  
 Velasquez, Carmen, Romeoville, Il  
 Venida, Jorge, Northlake, Il  
 White, Sarah, Grayslake, Il\*  
 Williams, Debra, Chicago, Il

Blessinger, Yvonne, Evansville, In\*  
 Bradburn, Cortney, Parker City, In  
 Davis, Lisa, Muncie, In  
 Delgado, Gabriel, Marion, In  
 Freeman, Nichole, Liberty, In  
 Harville, Salina, Albany, In  
 Keith, Abbey, Wabash, In  
 Lampkins, Vanessa, Indianapolis, In  
 Leflore, Barbara, Muncie, In  
 Melton, Judy, New Castle, In  
 Moore, Myken, Alexandria, In\*  
 Musser, Jami, Richmond, In  
 Oakley, Summer, Richmond, In  
 Pickup, Patricia, Marion, In\*  
 Smith, Karmekio, Indianapolis, In  
 Wilson, Kendra, New Castle, In

## K

Carson, Jessica, Kansas City, Ks\*

Black, Michael, Louisville, Ky\*  
 Jones, Connie, Somerset, Ky\*  
 Lee, Sharilynn, Louisville, Ky\*  
 Logsdon, Terry, Ft Thomas, Ky\*  
 Maccaferri, Gina, Louisville, Ky  
 Mann, Robert, Owingsville, Ky\*  
 Whitenack, Darrell, Pembroke, Ky\*

## L

Begnaud, Stuart, Jennings, La  
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 Greggs, Tiffany, Shreveport, La  
 Hazeur Harris, Vealer, Bossier City, La  
 Howard, Marion, Shreveport, La  
 Jackson, Louella, Shreveport, La  
 Jasmin, Angela, Prairieville, La  
 Moore, Jacqueline, Shreveport, La  
 Morgan, Linda, Bossier City, La  
 Naquin, Tiffany, Thibodaux, La  
 Porche, Jennifer, Houma, La  
 Taylor Sweezer, Michelle, Shreveport, La  
 Taylor, Delphine, Shreveport, La  
 Williams, Chuma, Pleasant Hill, La  
 Williams, Pamela, Shreveport, La\*

## M

Cusano, Michael, Haverhill, Ma\*  
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 Torgersen, Christina, Marshfield, Ma

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 Duvall, Caroly, Easton, Md\*  
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 Grotz, Kimberly, Abingdon, Md\*  
 Guy, Willis, Fort Washington, Md\*  
 Panneerselvam, Shanmugam, Adelphi, Md\*  
 Pitts, Sharon, Saint Leonard, Md\*  
 Powell, Pamela, Mitchellville, Md\*  
 Randall, Janice, Hagerstown, Md\*  
 Sims, David, Baltimore, Md\*  
 Tasin, Dwayne, Takoma Park, Md\*  
 Touzeau, Tara, Churchton, Md\*

McGlone-Dedian, Cheryl, Scarborough, Me\*

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 Bulin, Louise, Taylor, Mi\*  
 Cureton, Charles, Detroit, Mi\*  
 Iyer, Mahalaxmi, Troy, Mi  
 Keene, Robin, Swartz Creek, Mi\*  
 Knepp, Jeffrey, Royal Oak, Mi  
 Kreiner, Kelly, Shelby Twp, Mi  
 McCauley, Tracey, Maple City, Mi\*  
 Moore, Kellie, Ida, Mi\*  
 Nikollaj, Lizabeth, Sterling Heights, Mi  
 Preston, Bradley, Grand Rapids, Mi\*  
 Shambaugh, Karen, Ann Arbor, Mi\*  
 Stephens, Amy, Cedar Springs, Mi\*  
 Vaidic, Michael, South Lyon, Mi\*  
 Walker, Zandrea, Detroit, Mi\*

Floryance, Charlene, Rochester, Mn\*  
 Krippner, Jenni, Hutchinson, Mn\*

Burton, William, Florissant, Mo\*  
 Kaur, Novjot, St Louis, Mo\*  
 Lanning, Vicki, Kansas City, Mo\*  
 Rakey, Erin, Eureka, Mo\*  
 Schnepf, Sarah, St Joseph, Mo\*

Bennett, David, Olive Branch, Ms  
 Davis, John, Dennis, Ms\*  
 Matthews, Rosikeo, Olive Branch, Ms\*

Dean, Angela, Missoula, Mt\*  
 Petre, CJ, Billings, Mt\*  
 Rojas, Shawnalee, Butte, Mt\*

## N

Allen, Ray, Asheville, NC\*  
 Dail, Cindy, Kinston, NC\*  
 Draughn, Michael, Winston Salem, NC\*  
 Duty, Etta, Shannon, NC\*  
 Fountain, Joyce, Angier, NC\*  
 Hamilton, Dan, Winston Salem, NC\*  
 Hartsell, Candace, Salisbury, NC\*  
 McEntire, William, Cullowhee, NC  
 Payne, Nicky, Walnut Cove, NC  
 Raynor, Amy, Franklinton, NC\*  
 Ruiz, Sharon, Hope Mills, NC\*  
 Salzer, Wanda, New Hill, NC\*  
 Simmons, Scott, Mooresville, NC\*  
 Stephens, Patricia, Elon College, NC\*  
 Van Den Berg, Susara, High Point, NC\*  
 Whaley, Robert, Vanceboro, NC\*  
 Williams, Amanda, Newton, NC\*  
 Wilson, Tony, Asheville, NC\*

Butcher, Zachary, Central City, Ne  
 Donnelly, Ashley, Auburn, Ne  
 Ellingson, Jennifer, Kearney, Ne  
 Hebbert, Mark, Hastings, Ne  
 Hope, Sarah, Fremont, Ne  
 Revoy, Elise, Omaha, Ne  
 Seiffert, Cory, Scottsbluff, Ne  
 Seiler, Kathleen, Omaha, Ne\*  
 Zuhlke, Nicole, Sterling, Ne

Davison, Sarah, Lee, NH\*

Agyemang, Richmond, Glassboro, NJ\*  
 Cua, Bryan, East Brunswick, NJ\*  
 Fajardo, Perlita, Clementon, NJ\*  
 Gregory, Tracey, Williamstown, NJ  
 Lipman, Susan, Freehold, NJ\*  
 Mwangi, Martha, Newark, NJ\*  
 Rivera, Felicia, Salem, NJ  
 Wandycyz, Anne, Red Bank, NJ\*  
 Wypych, Iwonna, Bernardsville, NJ

## New Members

Ahady, Khatira, Albuquerque, NM\*  
Bune, Cynthia, Espanola, NM\*  
Melquist, Patricia, Rio Rancho, NM  
Turner, Doug, Gallup, NM\*  
Turner, Karl, Albuquerque, NM

Arnett, Gail, Henderson, Nv  
Baguisi, Rosalyn, Las Vegas, Nv  
Balbastro, Dianna, Las Vegas, Nv  
Ballan, Kenny, Las Vegas, Nv  
Barcinas, Yuka, Las Vegas, Nv  
Burns, Lois, Yerington, Nv  
Cabrera, Ronald, Las Vegas, Nv\*  
Cogliano, Kelley, Reno, Nv\*  
Cooley, Joel, Las Vegas, Nv  
Cunningham, Subrina, Las Vegas, Nv  
Cushman, Mary, Las Vegas, Nv  
Dagenet, Vanessa, Carson City, Nv\*  
De Lara, Zarah Jane, Las Vegas, Nv  
Del Carmen, Joyce, Las Vegas, Nv  
Geliberte, Eunice, North Las Vegas, Nv  
Goodhart, Walter, Las Vegas, Nv\*  
Hess, Carlene, Las Vegas, Nv  
Kozak, Stephanie, North Las Vegas, Nv  
Maier, Catherine, Henderson, Nv\*  
Manguray, Sean, Henderson, Nv\*  
Penafior, Maria Theresa, North Las Vegas, Nv  
Rufo, Hyacinth, Las Vegas, Nv  
Teller, Lianna, Las Vegas, Nv  
Trinidad, Leizel, Las Vegas, Nv  
Wilhelm, Kimberly, Las Vegas, Nv\*  
Wright, Donald, Las Vegas, Nv\*

Ackerman, Judy, Mineola, NY\*  
Adornetto, Holly, Clarence Center, NY\*  
Anderson, Rasheeda, Bronx, NY\*  
Aponte, Monique, New Windsor, NY\*  
Barrezueta, Kathleen, Croton on Hudson, NY\*  
Berube, Martine, Troy, NY  
Brown, Amy Lynn, Batavia, NY\*  
Cavaluzzi, Nicholas, Endwell, NY  
Charlemagne, Stephanie, Brooklyn, NY\*  
Clarke, Camile, Bronx, NY\*  
Cordero, Madelyn, Bronx, NY\*  
De Leon, Carmen, Bronx, NY\*  
Degen, Kim, Port Jefferson Station, NY\*  
Demarco, Barbara, Niagara Falls, NY  
Farry, Patrick, West Seneca, NY\*  
Foster, Amanda, East Amherst, NY\*  
Gala, Jack, Spencerport, NY  
Galdon, Diana, Snyder, NY\*  
Gaussaint, Dieuve, Brooklyn, NY\*  
Gentile, Gerald, West Hempstead, NY\*  
Henry, Janine, West Islip, NY\*  
Iannello, Lance, Lancaster, NY\*  
Jordan, Olivia, Bronx, NY  
Kempkes, Paul, Lancaster, NY  
Klelds Guthrie, Suzette, Mount Vernon, NY  
Krasko, Gennadiy, Brooklyn, NY  
Logiudice, Nicholas, Delevan, NY\*  
Maier, Kevin, Pittsford, NY  
Matsekha, Yegor, Rockaway Beach, NY  
Meakens, Aargo, Bronx, NY\*  
Morlock, Patricia, Clarence Center, NY\*  
Pirone, Colleen, Mount Sinai, NY\*  
Poles, Mena, Brooklyn, NY  
Reynolds, Margaret, Cheektowaga, NY  
Roberto, Karen, Depew, NY\*  
Roberts, Diane, Sterling, NY\*  
Schofield, Jessica, Van Etten, NY  
Schreiber, Evalyn, Buffalo, NY\*  
Seipel, Danielle, Cowlesville, NY\*  
Shin, Jungsun, Hartsdale, NY\*  
Stoodley, Melissa, Watertown, NY\*  
Tusinski, Mary, Niagara Falls, NY\*  
Walsh, Michelle, East Amherst, NY\*  
Watts, Karen, Brooklyn, NY\*

### O

Bradley, Elizabeth, Belpre, Oh  
Dilucia, Jeanette, Northwood, Oh\*  
Gauthier, Jeff, Dayton, Oh\*  
Holliday, Jayne, Kettering, Oh  
Jordan, Sheila, Bainbridge, Oh\*  
Jordan, Sheila, Wilmington, Oh\*  
Keene, Mary, Beavercreek, Oh  
Marianne, Grabowski, Aurora, Oh\*  
McHale, Ann C. G., Lowell, Oh  
Murphy, Mary Kathryn, Troy, Oh\*  
Nicholas, Charles, Lakewood, Oh  
Noble, James, Dayton, Oh  
Richards, Tyler, Newark, Oh\*  
Robinette, Kelley, Bellville, Oh\*  
Sagraves, Anita, Huber Heights, Oh\*  
Sieger, Amanda, Marysville, Oh\*  
Smith, Elizabeth, Medora, Oh\*  
Snell, Andrea, Akron, Oh\*  
White, Jeanine, Bexley, Oh\*

Adams, Kelli, Ponca City, Ok\*  
Dorris, Branden, Hardesty, Ok\*  
Ford, Larry, Midwest City, Ok\*  
Ramsey, Larry, Norman, Ok\*  
Rooks, Helen, Yukon, Ok\*  
Sparks, Melissa, Guymon, Ok\*  
Swanson, Christopher, Yukon, Ok\*  
Weger, Jason, Norman, Ok  
Wilson, Jessica, Tulsa, Ok\*

Arnold, Simon, Portland, Or  
Becker, Brandie, Portland, Or  
Bilodeau, Aimee, Portland, Or  
Bulza, Alexandra, Portland, Or  
Curtis, Chelsea, Portland, Or  
Donalson, Peggy, Molalla, Or  
Gardner, Shelia, Portland, Or  
Hanson, John, Portland, Or  
Hodut, Magdalena, Portland, Or  
Kullowatz, Taylor, Portland, Or  
Miller, Chris, Portland, Or  
Offerman, Dawn, Portland, Or  
Pandey, Vibhuti, Medford, Or\*  
Parsley, Richard, Fairview, Or\*  
Rodgers, Carlee, Warrenton, Or\*  
Rose, Jamey, Portland, Or  
Savinskiy, Anastasiya, Portland, Or  
Shoop, Camela, Portland, Or  
Taylor, Kelley, Gresham, Or\*  
White, Lief, Portland, Or  
Wilkins, Renee, Beaverton, Or\*

### P

Albers, Randlee, New Albany, Pa  
Baker, Jeffrey, Lawrenceville, Pa\*  
Baxter, Brenda, Willow Grove, Pa\*  
Belawske, Michelle, Canton, Pa  
Black, Jane, Lebanon, Pa\*  
Burton, Eric, Philadelphia, Pa\*  
Craigle, John, East Berlin, Pa\*  
Jackson, Deborah, Salladasburg, Pa  
Klenk, Dore, Spring City, Pa\*  
Korah, Sherin, Philadelphia, Pa\*  
Kosar, Mary Beth, Zion Grove, Pa\*  
Koval, Brian, Canton, Pa  
Long, Alison, Myerstown, Pa\*  
Mann, Tymika, Elkins Park, Pa\*  
Marton, Nicole, Erie, Pa\*  
Schalles, Miranda, Driftwood, Pa  
Shirlow, David, West Chester, Pa\*  
Southworth, Casey, Wellsboro, Pa  
Spencer, Felicia, Columbia Cross Roads, Pa

Staib, Emily, Riverside, Pa  
Stiller, Andrea Michelle, Oil City, Pa\*  
White, James, Smithfield, Pa\*  
Zandbergen, Colleen, Edinboro, Pa\*

### R

Broccoli, Joseph, North Smithfield, RI\*

### S

Hunt, Cynthia, Gray Court, SC\*  
Mack, Belita, Simpsonville, SC\*  
Mathews, Sharon, Simpsonville, SC\*  
Parsons, Mary Beth, Simpsonville, SC\*

### T

Abraham, Daise, Chattanooga, Tn\*  
Barnett, Robin, Lawrenceburg, Tn\*  
Bentley, Virgil, Marksburg, Tn\*  
Davis, June, Millington, Tn\*  
Mounts, Jason, Gallatin, Tn\*  
Roy, John, Harrogate, Tn\*  
Schaefer, Donna, Drummonds, Tn\*  
Standifer, Patricia, Morristown, Tn\*  
Stonecipher, Katrina, Chattanooga, Tn\*  
Twiggs, Marvin, Chattanooga, Tn

Ausmus, Dinah, Fort Worth, Tx\*  
Broussard, Douglas, Buda, Tx\*  
Christensen, Charissa, Lewisville, Tx\*  
Deguzman, Janet, Austin, Tx\*  
Farmer, Timothy, San Marcos, Tx\*  
Fennell, Maria, Mansfield, Tx  
Forgrave, Kenneth, Odessa, Tx\*  
Gardner, Kenneth, San Antonio, Tx\*  
Ghahri, Susan, Dallas, Tx  
Goode, James, Victoria, Tx\*  
Graham, Reed, Rowlett, Tx  
Grogan, Charlotte, Beaumont, Tx\*  
Hall, Catherine, New Braunfels, Tx\*  
Herrera, Imelda, Odessa, Tx\*  
Hull, Terry, Austin, Tx\*  
Jesudason, Donald, Pearland, Tx\*  
King, Matt, Austin, Tx  
Lopez, Juanita, Canyon Lake, Tx\*  
Martin, Carolyn, Pearland, Tx  
McCown, Kristen, White Oak, Tx\*  
McQuire, Celeste, Weslaco, Tx\*  
O'Neal, Michael, Anna, Tx\*  
Sanchez-Delgado, Gina, Cibolo, Tx\*  
Sherwood, Kymberly, Angleton, Tx  
Snyder, Tina, Dallas, Tx\*  
St Germaine, Karen, Amarillo, Tx\*  
Stricklan, Lindsay, San Marcos, Tx  
Vera, Corina, Round Rock, Tx\*  
Williams, Robin, Katy, Tx\*

### U

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Foltynowicz, Jacqueline, Smithfield, Ut\*  
Humphreys, Allysen, Ogden, Ut\*  
Jasper, Jennifer, Ogden, Ut  
Jensen, Sean, Morgan, Ut  
Kingsbury, Justin, West Valley City, Ut\*  
Lobato, Nisha, South Weber, Ut  
Schmid, Linden, Bountiful, Ut\*  
Seaman, Rebecca, Bountiful, Ut  
Stoddard, Nathaniel, Layton, Ut  
Wallace, Kristen, Taylorsville, Ut

# BE A PART OF THE AARC NOW!

## Your Membership Makes A Difference

### ACTIVE MEMBER

An individual is eligible if he/she lives in the U.S. or its territories or was an Active Member prior to moving outside its borders or territories, and meets ONE of the following criteria: (1) is legally credentialed as a respiratory care professional if employed in a state that mandates such, OR (2) is a graduate of an accredited educational program in respiratory care, OR (3) holds a credential issued by the NBRC.

### ASSOCIATE OR SPECIAL MEMBER

Individuals who hold a position related to respiratory care but do not meet the requirements of Active Member shall be Associate Members. They have all the rights and benefits of the Association except to hold office, vote, or serve as chair of a standing committee. The following subclasses of Associate Membership are available: Foreign, Physician, and Industrial (individuals whose primary occupation is directly or indirectly devoted to the manufacture, sale, or distribution of respiratory care equipment or supplies). Special Members are those not working in a respiratory care-related field.

### STUDENT MEMBER

Individuals will be classified as Student Members if they meet all the requirements for Associate Membership and are enrolled in an educational program in respiratory care accredited by, or in the process of seeking accreditation from, an AARC-recognized agency.

**SPECIAL NOTICE** — Student Members do not receive Continuing Respiratory Care Education (CRCE) transcripts. Upon completion of your respiratory care education, continuing education credits may be pursued upon your reclassification to Active or Associate Member.



## Membership Application

Please read the eligibility requirements for each of the classifications to the left, then complete the form. All information requested must be provided, except where indicated as optional. See **side 2** for more information and fee schedule. Please sign and date application on **side 2** and type or print clearly. Processing of application takes approximately 15 days.

**You may apply or renew instantly on-line by going to <https://secure.aarc.org/membership/>**

Active    Associate (Foreign)    Associate (Physician)    Associate (Industrial)    Special    Student

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Social Security No. (last four digits only) \_\_\_\_\_ Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone No. ( \_\_\_\_\_ ) \_\_\_\_\_ Email Address \_\_\_\_\_

You are automatically assigned to a state society based on your **home address**. If you wish to be assigned to a different state society, please indicate which state that is here: \_\_\_\_\_

**Work Information:** Place of Employment \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone No. ( \_\_\_\_\_ ) \_\_\_\_\_

Preferred Fax No. ( \_\_\_\_\_ ) \_\_\_\_\_ Preferred Email Address \_\_\_\_\_

Preferred Mailing Address:    Home    Business

Have you ever been or are you currently in the military?    Yes    No

### For Student Member (Required)

School/RC Program \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone No. ( \_\_\_\_\_ ) \_\_\_\_\_ Program Director \_\_\_\_\_

Expected Date of Graduation   Month \_\_\_\_\_ Year \_\_\_\_\_

Please answer these questions to help us design services and programs that meet your needs.

### Primary Job Responsibility (check one only)

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Clinical Specialist     | <input type="checkbox"/> Director of Clinical Education | <input type="checkbox"/> Director                            | <input type="checkbox"/> Disease Manager               |
| <input type="checkbox"/> Diagnostic Technologist | <input type="checkbox"/> Instructor/Faculty/Professor   | <input type="checkbox"/> Medical Director                    | <input type="checkbox"/> Manager                       |
| <input type="checkbox"/> Marketing               | <input type="checkbox"/> Nurse                          | <input type="checkbox"/> Owner                               | <input type="checkbox"/> Other                         |
| <input type="checkbox"/> Program Director        | <input type="checkbox"/> Patient Educator               | <input type="checkbox"/> Pulmonary Function Technologist     | <input type="checkbox"/> Product Management            |
| <input type="checkbox"/> Sales                   | <input type="checkbox"/> Supervisor/Coordinator         | <input type="checkbox"/> Sleep Technologist/Polysomnographer | <input type="checkbox"/> Sleep Technologist/Specialist |
| <input type="checkbox"/> Staff Therapist         | <input type="checkbox"/> Student                        |  |  |

### Type of Business

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> DME/HME                         | <input type="checkbox"/> Educational Institution  | <input type="checkbox"/> Home Health Agency      | <input type="checkbox"/> Long Term Acute Care/Rehab |
| <input type="checkbox"/> Manufacturer/Distributor/Pharma | <input type="checkbox"/> Military                 | <input type="checkbox"/> Hospital                | <input type="checkbox"/> Other                      |
| <input type="checkbox"/> Physician's Office              | <input type="checkbox"/> Skilled Nursing Facility | <input type="checkbox"/> Sleep Lab Free Standing | <input type="checkbox"/> Sleep Lab Hospital Based   |
| <input type="checkbox"/> Student                         | <input type="checkbox"/> Temp                     | <input type="checkbox"/> Outpatient Facility     |   |

### Check the Highest Degree Earned

- |                              |                               |                               |                              |                              |                               |                              |                              |                              |                              |                              |
|------------------------------|-------------------------------|-------------------------------|------------------------------|------------------------------|-------------------------------|------------------------------|------------------------------|------------------------------|------------------------------|------------------------------|
| <input type="checkbox"/> PhD | <input type="checkbox"/> EdD  | <input type="checkbox"/> MEd  | <input type="checkbox"/> MBA | <input type="checkbox"/> MS  | <input type="checkbox"/> MHA  | <input type="checkbox"/> MHS | <input type="checkbox"/> MPA | <input type="checkbox"/> MPH | <input type="checkbox"/> MEd | <input type="checkbox"/> MSN |
| <input type="checkbox"/> MA  | <input type="checkbox"/> BSRT | <input type="checkbox"/> BSRC | <input type="checkbox"/> BS  | <input type="checkbox"/> BHS | <input type="checkbox"/> BSEd | <input type="checkbox"/> BSN | <input type="checkbox"/> BA  | <input type="checkbox"/> AAS | <input type="checkbox"/> AS  | <input type="checkbox"/> AA  |

**Job Status**    Full Time    Part Time    Years in Respiratory Care \_\_\_\_\_

**Credentials**    MD    DO    RRT-NPS    RRT-SDS    RRT    RPFT    CRT-NPS    CRT-SDS    CRT

CPFT    RN    RPSGT    AEC    CTTs    EMT-P    LPN    LVN

**Honorary Credentials**    FAARC    FACHE    FAACVPR    FCCM    FCCP

**Date of Birth** \_\_\_\_\_ **Sex** \_\_\_\_\_

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

# AARC

# AN EXCELLENT INVESTMENT

Membership has many personal and professional benefits. The potential savings from these benefits go well beyond the cost of AARC membership, only a quarter a day!

### PLEASE SIGN

I hereby apply for membership in the American Association for Respiratory Care. If approved for membership in the AARC, I will abide by its bylaws and professional code of ethics. I authorize investigation of all statements contained herein and understand that misrepresentations or omissions of facts called for is cause for rejection or expulsion.

A yearly subscription to RESPIRATORY CARE journal and AARC Times magazine includes an allocation of \$11.50 from my dues for each of these publications, if applicable.

NOTE: Contributions or gifts to the AARC are not tax deductible as charitable contributions for income tax purposes. However, they may be tax deductible as ordinary and necessary business expenses subject to restrictions imposed as a result of Association lobbying activities. The AARC estimates that the nondeductible portion of your dues — the portion which is allocable to lobbying — is 19%.

Signature \_\_\_\_\_ Date \_\_\_\_\_

You may apply or renew instantly on-line by going to <https://secure.aarc.org/membership/>

### Membership Fees (U.S. dollars only)

Payment must accompany your application to the AARC. Fees are for 12 months. These fees contain the \$12.50 new members processing fee.

Renewing members (except students) can deduct \$12.50.

### Choose One Level of Membership

**AARC REGULAR MEMBERSHIP** (Receive both AARC Times magazine and RESPIRATORY CARE journal)

Active \$102.50    Associate (Industrial or Physician) \$102.50    Associate (Foreign) \$117.50    Special \$102.50    Student \$50.00

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Or

**AARC CHOICE MEMBERSHIP** (Choose one publication)   I want    AARC Times magazine **or**    RESPIRATORY CARE journal

Active \$91.00    Associate (Industrial or Physician) \$91.00    Associate (Foreign) \$106.00    Special \$91.00

Or

**AARC PLUS MEMBERSHIP** (All publications and other special benefits)

Active \$137.50    Associate (Industrial or Physician) \$137.50    Associate (Foreign) \$177.50    Special \$137.50

(Includes one **free** specialty section – please mark your choice below.)

Or

**Web-only MEMBERSHIP** (Open only to international members)

Foreign \$92.50

**\*Voluntary PAC Contribution**   \$ \_\_\_\_\_

**\*\*Voluntary ARCF Contribution**   \$ \_\_\_\_\_

\* AARCPAC is a separate aggregated fund. Voluntary political contributions by individuals should be written on personal checks. Contributions from corporations are illegal and cannot be accepted. The AARC will not favor or disadvantage anyone based upon the amounts of or refusal to make AARCPAC contributions. Contributions to a political action committee are not deductible for federal income tax purposes.  
\*\* American Respiratory Care Foundation (ARCF) is a not-for-profit organization formed for the purpose of supporting research, education, and charitable activities in respiratory care. Contributions to the ARCF are tax deductible.

### Specialty Sections (Open to all members) E-mail address is required.

Membership in AARC Specialty Sections connects you to others who practice in your area of respiratory care through an electronic mailing list, monthly E-Newsletters, quarterly Section E-Bulletins, and an information-rich Specialty Section website. Programs created by specialty section members are integral to the AARC Summer Forum and AARC International Respiratory Congress.

- Adult Acute Care Section \$15.00    Education Section \$20.00    Neonatal-Pediatric Section \$15.00    Diagnostics Section \$15.00
- Management Section \$20.00    Transport Section \$15.00    Long-Term Care Section \$15.00    Home Care Section \$15.00
- Continuing Care Rehabilitation Section \$15.00    Sleep Section \$15.00

### Payment Information

Enclosed is a check for the membership fee I selected **plus** any specialty section fees **plus** any contributions to AARCPAC or ARCF for the total amount of \$ \_\_\_\_\_. Please make checks payable to the AARC.

Please charge my dues to:    MasterCard    Visa    American Express

Card Number \_\_\_\_\_ Card Expires \_\_\_\_\_ / \_\_\_\_\_ Signature \_\_\_\_\_

**Send this application and fees to:**

**American Association for Respiratory Care**

9425 N. MacArthur Blvd., Suite 100, Irving, TX 75063-4706 (if using a credit card)

or P.O. Box 650097, Dallas, TX 75265-0097 (if sending a check)

Fax: 972-484-2720 • Phone: 972-243-2272

**Did you remember to give us your email address on page 1?**

## THANKS FOR BEING PART OF THE TEAM



V

Bird, Jeanne, Charlottesville, Va\*  
 Brown, Pamela, Yorktown, Va\*  
 Clark, Michael, Chesapeake, Va\*  
 Coons, Philip, Barhamsville, Va\*  
 Cowboy, Ronald, Ashburn, Va\*  
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A Salute to our 2011 Corporate Partners

Since 1947, the AARC has been leading the effort to advance the respiratory care profession and promote quality respiratory health care. Working with our 50 state organizations, we have successfully advocated for the profession at the federal, state and local level.

The link between the respiratory profession and manufacturers is clear. If respiratory practice expands, so too does the economy for our industry partners.

As health care budgets shrink and patient care becomes increasingly complex, our mutual challenges become greater. The synergy of the corporate partner concept is an effective way to address those needs utilizing our combined skills and resources.





# Classifieds

ADVERTISING SECTION

## For Sale/For Rent

### RC Week Specials

Oakes' Books now on your hospital computers and/or your personal I-Pad, tablet, laptop, or smartphone. Free tour @ [www.RespiratoryUpdate.com](http://www.RespiratoryUpdate.com) or 8 Oakes' books for \$99. See [www.RespiratoryBooks.com](http://www.RespiratoryBooks.com) or call (207) 262-0123.

### AARC Times Classified Advertising Information & Requirements:

#### Classified Word Advertisements

AARC Members: \$50 for 50 words or less; each additional word, \$1. Free Internet placement. Non-members: \$60 for 50 words or less; each additional word, \$1.20. Listings are categorized by state. Following the state listings are United States/International, For Sale/For Rent, Miscellaneous, and Situations Wanted. All copy should be typed double-spaced. All ads will be set in 8-point type. To calculate the cost per advertisement, a "word" is considered to be one or more letters, numbers, or special characters with a space before and after.

Ads are featured on the AARC website for one month after publication. Ad may only be placed on the website with an insertion order for placement in an AARC publication. Ad is noncancelable after placement on the website. NOTE: AARC Times reserves the right to refuse any advertisement not directly relevant to res-

piratory care. AARC Times does not endorse any advertiser, its positions, practices, services, or products.

We reserve the right to make editorial changes for reasons of clarity and consistency. Every effort is taken to avoid mistakes, but AARC Times cannot be responsible for clerical or printing errors.

**Deadline for Ad Placement/Cancellation** Deadline for ad placement and written cancellations for the next available issue is August 24. Blind ads available. **For Recruitment Advertising Information, Contact Classified Advertising** Anna Blydenstein • Alhambra Plaza • 725 N. Highway A1A, Suite C-106 • Jupiter, FL 33477 • (561) 745-6793 • Fax (561) 745-6795 • AARCAD@aol.com

#### Recruitment Display Advertisements

For Recruitment Display Ad Rates, go to [http://www.aarc.org/marketplace/media\\_kit/recruitment.pdf](http://www.aarc.org/marketplace/media_kit/recruitment.pdf), or contact Tim Goldsbury and Associates, Alhambra Plaza, 725 N. Highway A1A, Suite C-106, Jupiter, FL 33477, (561) 745-6793, Fax (561) 745-6795

**DIRECTOR, RESPIRATORY CARE SERVICE**

Montefiore Medical Center, the University Hospital for the Albert Einstein College of Medicine in New York City, is a major healthcare provider serving a community area of more than two million people. As one of the nation's largest and most prestigious medical centers, we provide our employees a productive workplace, rewarding benefits and ongoing opportunities to grow as leaders.

In this crucial role you will oversee the operations of our Respiratory Care Service ensuring high-quality care is consistently provided to our patients. Responsibilities include managing staff; developing clinical and administrative policies and procedures for all phases of operations; preparing and monitoring operating and capital budgets; and overseeing the development of patient care plans. In addition, you will direct the quality improvement program for our Respiratory Care Service.

To qualify you must be a graduate of a respiratory care therapist program with a bachelor's degree (master's preferred) and at least 3 years' experience at a director level. You also must be NBRC-registered and have a current NYS license.

As part of our team you will receive excellent compensation and outstanding benefits. For immediate consideration, send your resume (including salary requirements) to: **Angie Mercado, Montefiore Medical Center, Recruitment & Staffing, 111 East 210th Street, Bronx, NY 10467; fax: 718-920-2242; email: [amercado@montefiore.org](mailto:amercado@montefiore.org) or online at [www.montefiore.org/careers](http://www.montefiore.org/careers).**

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**NEW!** **AARC Professor's Rounds 2011**

**Non-Invasive Ventilation of Neonatal-Pediatric Patients: Do We Really Want to Intubate?**

**Rob DiBlasi, RRT-NPS FAARC**  
**Ira M. Cheifetz, MD FAARC FCCM**  
**Tom Kallstrom, MBA RRT FAARC**

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**Professor's Rounds**

**Find out more at [www.AARC.org/go/pr2](http://www.AARC.org/go/pr2)**

## Partnering with Your Patients To Reduce Hospital Infections

(continued from page 24)

these efforts that care, quality, and reduced costs will become a reality. As RTs, we should educate ourselves about the “Speak Up” campaign through The Joint Commission and encourage patients to do the same. If doing so prevents just one health care associated infection, it would all be worth it. ■

### REFERENCES

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## The Challenge of Effectively Training COPD Patients

(continued from page 28)

manage their own care. The effectiveness of that training largely rests on an understanding of the specific patient and the application of the principles of adult education. By recognizing the various patient learning styles and adapting the training approach, favorable outcomes can be achieved. The goal is to effectively transfer knowledge to the patient in a way that helps them develop the skills they need to manage their disease and enhance the quality of their life. ■

### REFERENCES

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**NEW!**

## AARC Professor's Rounds 2011

### Tracheostomy: Current Practice

Alexander C. White, MD MS  
Dean Hess, PhD RRT FAARC

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# Calendar of Events

## AARC & State Society Programs

**August 3–5**  
Biloxi, MS  
40th Tri-State Respiratory Care Conference  
Contact Doug McIntyre at (985) 764-6754 or [www.tsrcc.net](http://www.tsrcc.net)

**August 3–7**  
Savannah, GA  
Georgia Society for Respiratory Care's Summer Clinical Symposium  
Kathryn Morgan at (404) 299-4641 or [www.gasrc.org](http://www.gasrc.org)

**August 15–16**  
Columbus, OH  
33rd Annual State Meeting of the Ohio Society for Respiratory Care  
Contact [beth.cooper@cchmc.org](mailto:beth.cooper@cchmc.org) or [www.OSRC.org](http://www.OSRC.org)

**August 16–18**  
Prescott, AZ  
ASRC's 45th Annual AzSRC Conference  
Contact [www.azsrc.org](http://www.azsrc.org) or Amy.Bardin@yahoo.com, (623) 205-4930

**August 22–23**  
Las Vegas, NV  
2011 NSRC Conference at The Orleans  
Contact Connie Small or Bonnie Weaver at

(707) 807-9311 or [www.nsrc.us](http://www.nsrc.us)

**September 6–9**  
Myrtle Beach, SC  
SCSRC's 40th Annual Conference  
Contact Randy Lydick at [randylydick@yahoo.com](mailto:randylydick@yahoo.com) or [www.scsrc.org](http://www.scsrc.org)

**September 20–21**  
Honolulu, HI  
38th Annual Hawaii State Respiratory Care Conference  
Contact [www.hawaiiircps.org](http://www.hawaiiircps.org) or [hsrcconferenceattendee@yahoo.com](mailto:hsrcconferenceattendee@yahoo.com)

**September 22–23**  
Verona, NY  
31st Annual Symposium of the NYSSRC  
Contact Chuck Svoboda, (315) 792-5476 or [www.nyssrc.com](http://www.nyssrc.com)

**September 27–28**  
Sioux Falls, SD  
South Dakota Society for Respiratory Care's Annual Meeting and Conference  
Contact Lora Bornhoft at (605) 328-2436 or [www.sdsrc.org](http://www.sdsrc.org)

**September 27–30**  
Wilmington, NC  
North Carolina Society's Annual Symposium  
Contact Bill Kiger at (336) 971-9931 or [www.ncsrc.org](http://www.ncsrc.org)

**September 28–30**  
Hot Springs National Park, AR  
40th Annual ASRC State Meeting  
Contact John Lindsey at [John.Lindsey@Mercy.net](mailto:John.Lindsey@Mercy.net) or [www.arksrc.org](http://www.arksrc.org)

**September 29–30**  
Pittsburgh, PA  
Pennsylvania Society's 2011 Western Regional Conference  
Contact Tom Lamphere at (215) 687-2904 or [www.psrc.net](http://www.psrc.net)

**September 29–30**  
Casper, WY  
Wyoming Society for Respiratory Care's 2011 State Conference  
Contact Stacey Metzger at (307) 577-2546 or [www.wysrc.org](http://www.wysrc.org)

**October 13–14**  
Indianapolis, IN  
Indiana Society for Respiratory Care's 37th Annual Fall Seminar  
Contact Ross Havens at [rhavens@in-isrc.org](mailto:rhavens@in-isrc.org) or [www.in-isrc.org](http://www.in-isrc.org)

**October 14**  
Harrisburg, PA  
Pennsylvania Society's 2011 Conference in the Capital  
Contact Tom Lamphere at (215) 687-2904 or [www.psrc.net](http://www.psrc.net)

**October 23–29**  
Respiratory Care Week  
Contact AARC, (972) 243-2272, [www.aarc.org](http://www.aarc.org)

**October 26**  
Lung Health Day  
Contact AARC, (972) 243-2272, [www.aarc.org](http://www.aarc.org)

**October 27**  
Newark, DE  
18th Annual Trends in Respiratory Care Conference  
Contact John Emberger at (302) 733-3565 or [www.delawarelung.org](http://www.delawarelung.org)

**November 5–8**  
Tampa, FL  
AARC International Respiratory Congress  
Contact AARC, (972) 243-2272, [www.aarc.org/education/meetings](http://www.aarc.org/education/meetings)

## Other Meetings

**October 17**  
King of Prussia, PA  
Neonatal Care Today Conference sponsored by Dräger  
Ed Coombs at [edwin.coombs@draeger.com](mailto:edwin.coombs@draeger.com)

Submissions for the next available issue are due Aug. 24.

For information on submitting calendar events, contact: Beth Binkley, AARC Times 9425 N. MacArthur Blvd, Suite 100, Irving, TX 75063-4706 (972) 243-2272, Fax (972) 484-2720 E-mail [binkley@aarc.org](mailto:binkley@aarc.org)

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➔ **If your photo is taken with a standard film camera,** we will need a color print and negative shipped to us at **PHOTO CONTEST**, AARC, 9425 N. MacArthur Blvd., Suite 100, Irving, TX 75063-4706.

➔ **Most digital cameras give you a choice of settings for image resolution.** Photos taken at lower resolution settings take up less room on your memory card but may not be useable for print productions. Set your camera for the highest resolution photo and save it as JPEG or TIFF.

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