AARC Times

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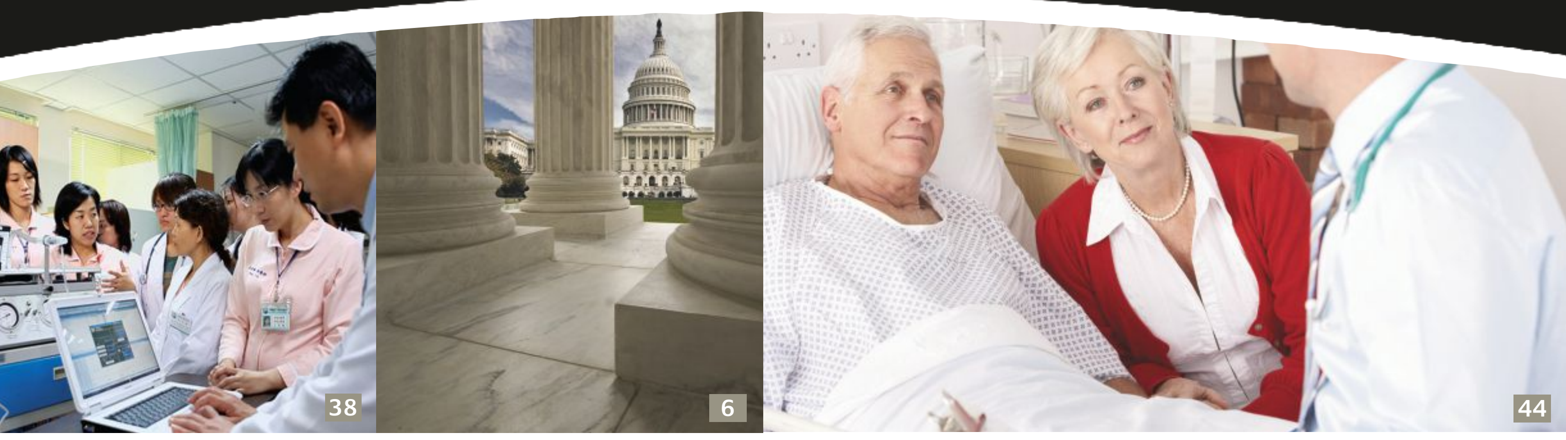

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AARC Strategic Plan

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

- Refine and expand the scope of practice for respiratory therapists in all care settings.
- Advance the knowledge base and educational preparation of respiratory therapists to ensure competent patient care and to foster patient safety initiatives.
- Support research and scientific inquiry to strengthen the scientific foundation and promote best practice for patient care.
- Establish professional standards and outcomes supported by scientific evidence.
- Advocate for federal and state health care policies that enhance patient care, patients' access to care and professional practice.
- Partner with governmental agencies, community organizations, third-party payers, professional societies and the public to promote healthy behaviors and prevent cardiopulmonary disease.
- Broaden consumer and health care providers' knowledge and understanding of the value of respiratory therapists in providing safe, competent and cost-effective care.

The complete version of the Association's Strategic Plan is available to AARC members online at www.aarc.org/members_area/resources/strategic.asp.

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The AARC Program Committee invites everyone – members, nonmembers, and groups – to submit proposals for programs for AARC Congress 2014 in Las Vegas, Nevada, Dec. 9-12, 2014

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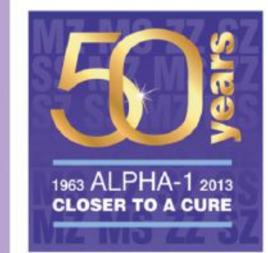


2013 is the 50th anniversary of the discovery of Alpha-1. To find out more and to get involved, visit alpha-1foundation.org /50years.

Research for a Cure

The Medicare Respiratory Therapist Access Act

by Thomas J. Kallstrom, MBA, RRT, FAARC

In July of this year the Medicare Respiratory Therapist Access Act (H.R. 2619) was introduced in Congress. Congressman John Lewis of Georgia introduced the bill in an effort to ensure that expanded access to respiratory therapists beyond the walls of the hospital and into the physician practice becomes a reality. The importance of this bill is that it allows for Registered Respiratory Therapists with a minimum of a bachelor's degree or other advanced degree in a health science field to position our patients to be better self-managers of their chronic lung disease. The respiratory therapist, through disease management, will accomplish this.

This action is very timely as self-management education and training is at the forefront of several important health care initiatives, as seen through the Affordable Care Act (ACA). In fact, the Affordable Care Act is already changing the paradigm of care by introducing innovative payment models that emphasize the importance of primary care physicians, care coordination, bundled payments, and medical homes.

The provision of care and education for patients with chronic disease is dramatically changing. Instituting patient education and self-management during a hospital stay and post-discharge is already a recommendation made by the Medicare Payment Advisory Commission. Further, as part of its strategic framework for optimizing health and quality of life for individuals with multiple chronic conditions, the U.S. Department of Health and Human Services has set a goal to integrate self-management education programs into multiple settings.

about the author...

Thomas J. Kallstrom, MBA, RRT, FAARC, is executive director and chief executive officer of the AARC.

RTs as disease managers

The published evidence continues to demonstrate the value of the RT in disease management. So why is this important for patients and respiratory therapists? For RTs this will allow for a better option of extending services from just the acute care arena to chronic management in the physician practice. It is important to realize that while there are CPT codes for education and training of self-management when furnished by a non-physician health care professional, Medicare does not pay separately for these services in the outpatient setting. Currently, RTs are considered auxiliary personnel in the physician office setting and, thus, cannot provide these services. However, once H.R. 2619 is enacted, these services would be covered by RTs. If CMS follows the precedent set in the diabetes self-management education and training, it is possible that two G codes could be established that set pulmonary self-management education and training apart from the other codes.

Patients with chronic lung disease including cystic fibrosis, pulmonary hypertension, pulmonary fibrosis, COPD, and asthma who are frequent users of the health care system will have a respiratory therapist as a disease manager who can work with them on an individual basis — for instance, teaching them about proper administration of aerosolized medications. It is not always as easy as it may seem to master this technique. As simple as it sounds, for example, we are starting to see varying recommended techniques for differing aerosol delivery devices. Some now require differing inhalation maneuvers despite using

the same device to deliver the medication. This will require an astute and informed clinician to teach patients appropriately. In addition to this, when patients have more than one type of device, adherence may suffer as a result of lower competency of the patient. By utilizing the RT, the patient will be assured of a competent caregiver who can assure that inhaled medication delivery is top notch.

The climate of health care is one that with the emerging large numbers of baby boomers entering their chronic disease years, we will see a considerably large segment of the population with diagnosed or undiagnosed COPD. Couple this with the penalties for excessive hospital readmissions within 30 days, and the respiratory care community is positioned to make a significant contribution.

Working hard... with and for you

We intend to work hard to get our bill, H.R. 2619, passed by Congress. We are partnering with our patients but need you. In order for there to be any level of success, you must reach out to your elected representatives and senators and let them know you support allowing access to respiratory therapy beyond the hospital walls and into the physicians' practice. Some of our loudest proponents are patients who en masse have told us that they want this to happen. We need you to contact your elected representatives in Washington, DC. The only thing missing is you, your friends, family, neighbors, colleagues, etc.

We encourage you to go to www.aarc.org or to www.aarc.org/headlines/13/09/hr2619/ where you will find a step-by-step electronic way to contact Congress. ■

The Year in Review

by Cheryl West, MHA, Miriam O'Day, and Anne Marie Hummel

The AARC's government affairs staff continues to work in partnership with state respiratory societies, patient/consumer associations, and "like-minded" organizations to advance the respiratory therapy legislative and regulatory agenda at both the state and federal levels.

State issues

Medicaid expansion and state health marketplaces: This past year, state governments have had to make a number of decisions on just how much of a role their state would undertake as the implementation date approached for several key provisions of the Affordable Care Act (ACA) (aka Obamacare).

One decision for states was whether or not to opt for the ACA provision that expands eligibility under state Medicaid programs. Under this option, the federal government would cover 100% of the increase for the first three years and 90% of the cost thereafter. States were evenly split, with about half accepting the Medicaid expansion option and half declining to participate.

The other decision for the states had to do with the ACA's mandate that requires individuals to have health insurance beginning Jan. 1, 2014, and no later than March 1, 2014. States had to decide on the level of participation their state would have in establishing regional health marketplaces (by Oct. 1, 2013). The marketplaces are where individuals who need health insurance can compare the policies available in their area, determine if they qualify for subsidies to help cover the costs of the premiums, and select a policy.

Why do we bring up the ACA provisions in the state section of this respiratory therapy (RT) government review column? We believe that provisions of the ACA will indirectly but broadly impact on the RT profession, certainly at the state level. It's a pretty safe statement to say: There will be more individuals with health insurance in some form or another beginning in 2014. For the respiratory therapist, that will mean more individuals seeking services for their lung conditions who might never have received respiratory care until an acute episode resulted in an emergency department visit or hospital admission — and that will mean more demand for respiratory therapists.

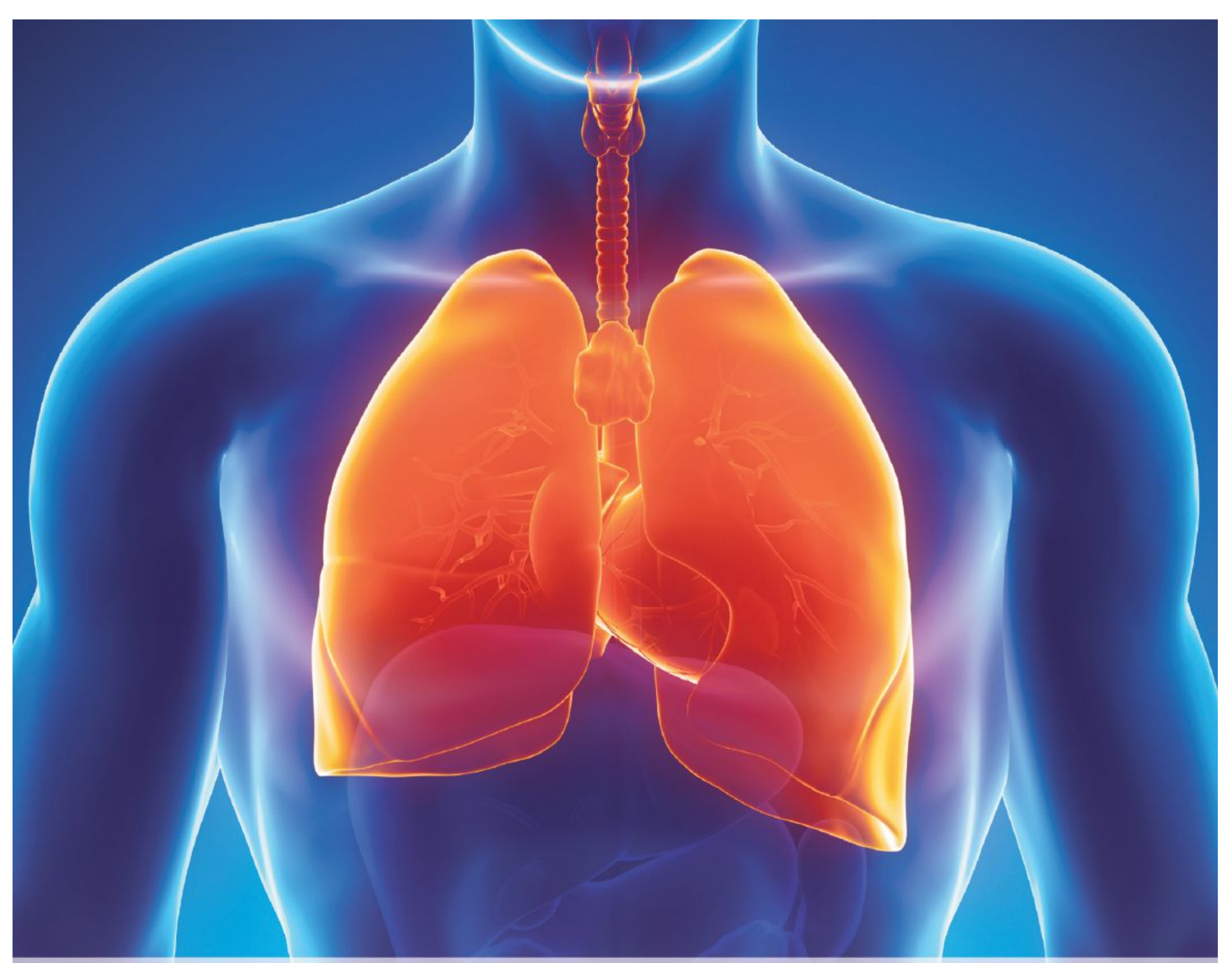
about the author...

Cheryl West, MHA, serves as director of government affairs for the AARC. Miriam O'Day serves as director of legislative affairs for the AARC; and Anne Marie Hummel is the AARC's director of regulatory affairs in Washington, DC.

It is interesting to note that nearly 20 state legislatures have either introduced or passed legislation that expanded the authority and scope of practice for nurse practitioners (NPs) and physician assistants (PAs). One could speculate that this type of legislation that expands the authority of NPs and PAs could be in anticipation of the influx of the newly insured who will gain access to the health care system.

RT licensure laws: While there were numerous state bills that impacted the licensure laws governing the RT profession, none were more serious nor had more potential national repercussions than efforts in Michigan to rescind mandated licensure for the respiratory therapy profession. There are 18 professions, including respiratory therapy, earmarked for de-licensing. The initiative, which began prior to the November national elections in 2012, picked up steam again in late September 2013 when the Michigan legislature introduced a bill, S.B. 514, to repeal the RT licensure laws. The Michigan Society for Respiratory Care has continued its intense engagement on the issue and is prepared for the battle ahead.

Why are state governments making the move to rescind licensure? First, in terms of de-licensing respiratory therapy (at least in Michigan), the administration/



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2013 was a very active year for the AARC government affairs staff as we continued to advocate for the advancement of the respiratory profession through state and federal legislation and regulations.

legislature believes that the professional credentials (in this case the credentials issued by the NBRC), will be a sufficient substitute for RT licensure. These state entities neglect to consider that the NBRC does not perform background checks, nor does it have investigative powers including subpoena authority, nor the ability to sanction a licensee — all key components of licensure (points that the NBRC has made to legislators).

On a larger scale, one could speculate that this delicensing effort may be due partly to the assumption that it is costly to run a licensure board. This argument can be refuted because in nearly all states there are legal requirements that licensed professions be self-funding, e.g., the licensure fees assessed on the professionals must cover the administrative costs of the licensure board since board funding does not come from general tax dollars.

In addition, there are key state government leaders and, perhaps, certain sections of the public who perceive that there is far too much "unnecessary government regulation"; and licensure is an example of that. This might also include the view that state government bureaucracy is too large and that by de-licensing professions, the need for state government employees to run these licensing boards can be reduced, thus saving on salaries and pensions. Perhaps it is the oft-stated belief that more jobs would be available if only professional licensure "barriers" were removed.

Another possible rationale is that licensure sets artificial barriers that prevent less costly personnel from providing services they are "capable" of providing. In other words, why not remove regulatory barriers and legally permit a nurse aide to perform certain clinical services that legally (i.e., via licensure) only a nurse can provide?

As noted above, with the ACA requiring over the course of the first three months of 2014 at least most individuals to have health insurance coverage, states may also be girding themselves for an influx of new individuals into the health care system. That, in turn, will create a demand for health care professionals. Will the state be able to meet the demand?

The best way to keep apprised on developments in your state is to monitor your state society's website and, of course, consider becoming a member of the AARC, which makes you a member of your state society. Respiratory therapy licensure was created by the legislature, and it has to be repealed by the legislature. As citizens of the state, you are voters in the state; and these legislators are elected by you, the voter.

Federal legislative issues

The Medicare Respiratory Therapist Access Act – H.R. 2619. The focus of the AARC's congressional advocacy efforts is to gain support and momentum for H.R. 2619, the Medicare Respiratory Therapist Access Act. This important legislation was introduced this summer by Georgia Representative John Lewis and, with continued efforts from RTs around the country, is gaining co-sponsorships. H.R. 2619 would amend the Medicare Program to add the coverage of pulmonary self-management education and training services when furnished by qualified respiratory therapists in a physician's office for Medicare patients who have been diagnosed with COPD, asthma, pulmonary hypertension, pulmonary fibrosis, and cystic fibrosis. When H.R. 2619 is passed by Congress and the new benefit is implemented, it will not only enhance patient access to respiratory therapists, but it will also provide Medicare pulmonary patients with the tools they need to lead healthier lives through self-management of their disease.

AARC Capitol Hill Lobby Day. Over a dozen years ago, the AARC partnered with its state societies to establish the Political Advocacy Contact Team (PACT). State PACT representatives are politically active RT volunteers appointed by their state societies to act as the coordinators when state or federal political action or response is required.

A key component to moving our federal legislative agenda through the congressional process has been the AARC's annual Capitol Hill Lobby Day. State PACT representatives come to Washington, DC, to meet face to face with their congressional delegations. This important grassroots effort is jointly sponsored by the AARC and our state RT societies.

This past March marked the 14th year for the AARC Capitol Hill Lobby Day, when 119 respiratory therapists from 44 states and the District of Columbia came to DC to advocate for the Medicare Respiratory Therapist

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Access Act — H.R. 2619. We had 15 patient partners hosted by the COPD Foundation, who joined with us in the effort. Several state societies underwrote the costs of having their "own" pulmonary patient accompany them on their Capitol Hill appointments. Additionally, we had nearly 30 respiratory therapy students from around the DC region (and Pennsylvania and New York), attend as well.

It is critical to have your involvement in advocating for the profession. You are also the lynchpin to connecting with pulmonary patients who can express the benefits of proper respiratory care and, therefore, the need for access to respiratory therapists. Please visit the AARC Government Affairs section of the website (http://capwiz.com/aarc/issues/) to take action supporting H.R. 2619. You can have your patients contact Congress as well. The AARC has constructed the site so that anyone can communicate with Congress with the click of a button. We need you!

AARC Virtual Lobby Week. Part of the AARC legislative strategy to raise the profile of the RT profession on Capitol Hill is to encourage respiratory therapists, pulmonary patients, and RT supporters to participate in our online Virtual Lobby Week. This important nationwide activity is where we ask for emails to be sent to members of Congress just prior to the PACT representatives' arrival in DC for our Capitol Hill Lobby Day. This year, Virtual Lobby Day generated nearly 22,000 emails that supported our RT legislative agenda and showed members of Congress that there was support from "back home."

In addition to our Virtual Lobby Week; AARC asked our members to visit with congressional staff and members when they are "back home" in the district. These district visits can be scheduled for most weekends and during the big blocks of time when the members of Congress are in town — such as the August and Holiday recess periods.

Federal regulations and other policies

Affordable Care Act. Many of the provisions under the Affordable Care Act (ACA) continued to be implemented in 2013. Reducing preventable hospital readmissions took center stage, as almost every program and/or new payment model being tested by the Centers for Medicare and Medicaid Services (CMS) is designed to improve hospital performance in this area.

Since the inception of the program, Medicare has tracked three conditions: heart failure, heart attack, and pneumonia. However, respiratory therapists will have an ever-increasing role in this activity come Oct. 1, 2014 (fiscal year 2015), since CMS announced plans to add COPD to the conditions subject to hospital readmissions payment reductions. This is especially important as AARC is collecting "best practices" among our members that can be developed into a shared repository that will position respiratory therapists to add meaningful value in their respective organizations. This repository not only offers assistance to other providers as they seek ways to reduce avoidable readmissions, it highlights how respiratory therapists' leadership can make a difference in improving patient outcomes for COPD patients.

Discharge planning. The interpretive guidelines that state surveyors use when evaluating compliance with the Hospital Conditions of Participation were completely overhauled with respect to the discharge planning process in May 2013. The revisions recognize the importance of improving a patient's transition from an acute care setting to home or the community as a key element in reducing the number of hospital readmissions. The changes also include "advisory boxes" intended to offer successful industry practices that promote better patient outcomes. While the advisories are for information only, they send a strong message to hospitals that there are practices that can work to their advantage in the long term if they are implemented.

The good news for respiratory therapists and their patients is that best practices recognize a well-designed discharge evaluation process as one that involves a multidisciplinary team, including respiratory therapists. Having an RT involved in determining the need for respiratory therapy post-discharge and the patient's ability for self-care are critical elements in improving the health of patients with chronic lung disease. These new policies make the case for the RT to assume a greater role in his or her facility's discharge planning process — so don't wait, be proactive now!

Care coordination. Updates to the physician fee schedule in 2013 placed particular emphasis on primary care coordination and "care transitions" as a way for patients to stay healthier, have better outcomes, and most of all, to stay out of the hospital. *These care coordination services also offer new opportunities for respiratory therapists outside the hospital setting and complement our legislative initiative, H.R. 2619, the Medicare Respiratory Therapist Access Act.*

Transitional Care Management Services — Jan. 1, 2013, saw the advent of transitional care management services. These services offer another way to provide seamless care from hospital to home or community for patients with moderate and complex medical needs during a 30-day period post-hospital discharge. Services that can be provided by licensed clinical staff, such as respiratory

Every year the American Respiratory Care Foundation (ARCF) joins with sponsors from the health industry to award over $30,000 to respiratory therapists and physicians through its education recognition, fellowships, grants and awards programs.

Award Programs

For more information, or to apply for one of these awards, contact the ARCF Executive Office, 9425 N. MacArthur Blvd., Suite 100, Irving, TX 75063-4706, (972) 243-2272, fax (972) 484-2720, email info@arcfoundation.org.

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Grants, Awards, and Fellowships

Community Grants
Community grants are made from funds raised through the annual Ventilator 5K events. These support a wide variety of community events to raise awareness of lung diseases, educate the public and assist patients.

Undergraduate Student Awards
The ARCF has several award programs available to students currently enrolled in accredited respiratory care education programs.

Postgraduate Student Awards
Two award programs are available to respiratory therapists who hold a Baccalaureate degree and seek an advanced degree.

Research Fellowships/Abstract Awards
Fellowships are awarded to researchers having quality abstracts accepted for presentation at the AARC International Respiratory Convention & Exhibition.

Achievement Awards
The ARCF presents these prestigious awards to professionals in recognition of their dedication and commitment to respiratory care.

Literary Awards
All papers submitted in the science journal RESPIRATORY CARE are automatically considered for these awards.

Research Grants
Research funds are available to qualified investigators in the field of respiratory care.

therapists working under physician supervision, include assessment and support of patient adherence to the treatment regimen, oversight of medication management, and education to support self-management, independent living, and activities of daily living.

Complex Chronic Care Management Services — In July 2013, CMS proposed new complex chronic care management services (CCCM) that are intended to become effective at the beginning of calendar year 2015. These services, which are billed once during a 90-day period of care, are intended for patients with two or more chronic conditions lasting at least 12 months or until death, or that put the patient at risk for acute exacerbation, decomposition, or functional decline. When finalized, these services could open doors for respiratory therapists in physician practices since patients who receive CCCM services must have access to a health care professional 24 hours a day, seven days a week.

We will be reading a lot more about these new services in the coming year as CMS continues to refine the benefits and set standards to ensure providers can comply with the requirements in order to bill for services.

Nebulizer cleaning and state surveyor worksheets

Over the past two years, CMS and the Centers for Disease Control and Prevention (CDC) have continued to refine state surveyor worksheets that have been part of a pilot project begun in October 2011 to improve infectious disease requirements under the Hospital Conditions of Participation. A number of respiratory therapists brought to our attention serious patient safety concerns with respect to one element involving nebulizer cleaning. The guidelines referenced "rinsing nebulizers with tap water followed by isopropyl alcohol."

AARC worked closely with CMS and CDC on this issue, offering substantive comments and recommendations for revisions that address current technologies. We were successful in having CMS/CDC put a placeholder for the nebulizer cleaning issue in the last set of worksheets issued to surveyors in November 2012.

In August 2013, we were asked for our final recommendations. We do not expect any reference to "isopropyl alcohol" in the final worksheets. Based on previous communications from CMS, the final worksheets should be issued by the time you read this article.

Competitive bidding

Round 2 of the competitive bidding program for certain items of durable medical equipment got underway midyear despite various efforts by the industry and congressional leaders to delay implementation or to replace it with a market pricing program. The number of metropolitan areas subject to competitive bidding increased from nine to 91 markets. The new payment amounts resulted in a 45% reduction from the Round 1 fee schedule amounts. Payment for oxygen equipment and supplies resulted in a 41% cut, while CPAP devices got hit with a 47% reduction.

Other issues

The AARC joined forces with other key pulmonary organizations and medical societies to address issues with CMS concerning the replacement schedule for tracheostomy (trach) tubes included in local policies for durable medical equipment items and payment updates for pulmonary rehabilitation.

The issue with trach tubes involves a replacement schedule set by Medicare contractors of "one every three months," which is inconsistent with evidence-based studies, Medicare data, U.S. Food and Drug Administration standards, and manufacturers' package inserts — all of which reflect the appropriate replacement to be at a minimum of once every 30 days. Despite meetings with CMS and written comments requesting revisions to the local policies, at the time of this article CMS was standing by its original schedule.

Proposed payment for pulmonary rehabilitation as we move into 2014 remains low at $38.57 compared to the 2013 payment amount of $39.31. Previous efforts to educate hospitals on how to submit appropriate charges through use of the "Pulmonary Rehabilitation Toolkit" have not produced the increase in payment we were hoping to see for next year. Respiratory therapists working in this area should use the AARC resources available on our website (www.aarc.org/resources/pulmonary_rehab_toolkit/pr_toolkit.pdf) and continue working with your respective hospitals to improve the charge data submitted to Medicare in an effort to increase payment in future years.

An active year

2013 was a very active year for the AARC government affairs staff as we continued to advocate for the advancement of the respiratory profession through state and federal legislation and regulations. Implementation of services and programs designed to reduce preventable hospital readmissions as part of the ACA continue to gain ground and offer new opportunities for respiratory therapists outside of the acute care setting. We certainly anticipate that with the rapidly approaching changes coming to the nation's health care system, 2014 will accelerate the AARC's government affairs efforts. ■

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Stereotypes

by Anthony L. DeWitt, JD, RRT, FAARC

A fundamental principle of ethics, and a fundamental rule underlying discrimination law in the United States, is that every person is entitled to be judged (as the late Martin Luther King, Jr., said), on "the content of their character" and not the outward manifestations of their race or national origin.

Everyone understands it is unlawful to refuse to hire someone because they have Chinese ancestry or because their brown skin suggests that their parents or grandparents may have come from Central America. The Civil Rights Act requires that everyone, no matter what they look like or what religion they practice, be treated the same. It is a lofty goal that, as a country, we have still not achieved in spite of years of trying. In spite of advances, women with the same educational background and skills as men still tend to make less money than their male counterparts. And because legislation can change the law but it cannot change people's hearts, discrimination will continue to be a problem for many years to come.

Stereotypes still exist

One of the things that keeps us from reaching the goals of the Civil Rights Act is embracing popular stereotypes about groups of people based on the lowest common denominators of those groups. When people are judged based on a stereotype, it deprives them of the ability to demonstrate the strength of their character.

Using stereotypes in drama and literature has a rich history.[1] It is far easier to create a bad guy (or even a good guy) with stereotypes than it is with long lines of dialog. The Lone Ranger wears a white hat. Pick nearly any movie about terrorists, and you'll find that the terrorist threatening the city's water supply is an Islamist. No one needs to invest much effort into liking or disliking a character if their stereotype fits well within society's already-established biases and prejudices.

The late humorist George Carlin once observed that when someone doesn't speak our language, we often default to speaking slower and louder, as if volume could make up for a stranger's fundamental inability to understand what we're saying. Stereotyping individuals is much the same. Rather than make the investment to determine common ground, we assume that people who look alike all act alike. But we overlook the similarities between people who look like us while expecting others to fit perfectly into the mold we have created in our mind for those we stereotype.

about the author...

Anthony L. DeWitt, JD, RRT, FAARC, is an attorney and a partner in the firm Bartimus, Frickleton, Robertson & Gorny, PC, and resides in Jefferson City, MO. He has also authored two books and numerous legal journal articles. This article is not a substitute for legal advice.

Retaliation?

A recent case makes the point that discrimination based on race, national origin, and the reaction of supervisors to a heavy accent all violate the law.

Anjana A. Dossa was discharged from her civilian position with the Air Force and received a hearing before an administrative judge (AJ) on her claims of wrongful discharge, gender and national-origin discrimination, and retaliation for filing an earlier discrimination charge. The AJ denied her claims. She then took her case to the federal district court.

Dossa was employed in a civilian position as an engineering flight commander. In April 2003, she received a poor performance evaluation. In July, she filed a discrimination charge based on her Indian national ori-

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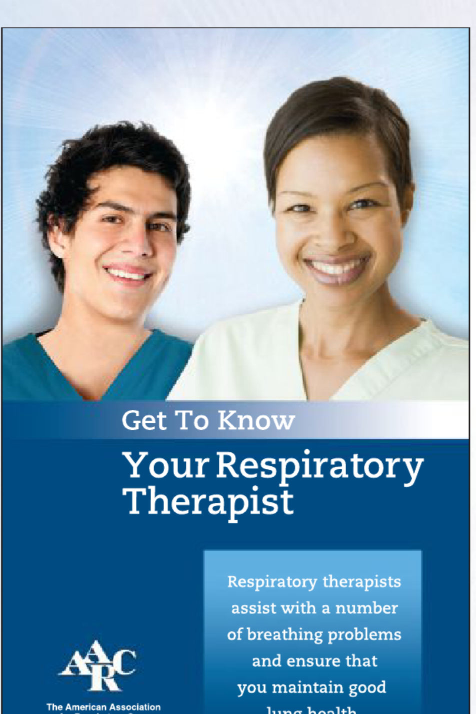

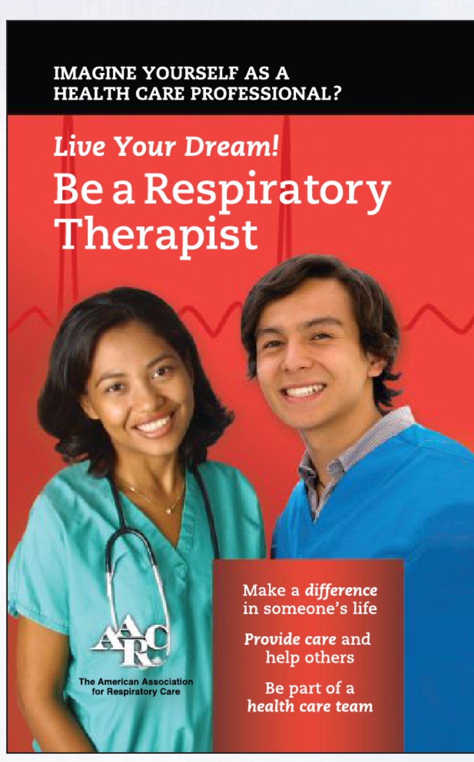

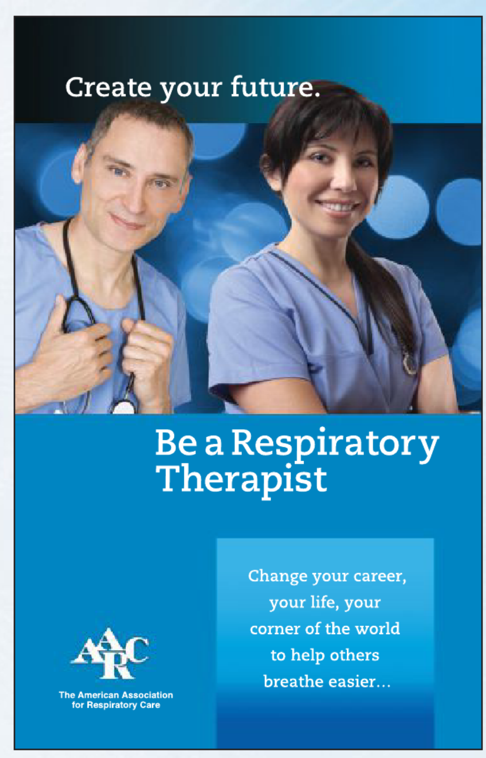

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gin. Due to her purported continuing performance problems, she was placed on a performance improvement plan (PIP). When she failed to meet the requirements of the PIP, she was discharged on June 18, 2004.

Dossa's supervisors testified about her job performance, and her direct supervisor stated that the decision to discharge her was based only on her performance, not on her gender or national origin.[2] Dossa's witness, a member of her former staff, testified about her work pressures. Dossa also testified and described her difficult employment situation during the relevant period, including a lack of support from her superiors; a group of subordinates who were inexperienced, uncooperative, and disrespectful; a heavy work load; inadequate or no overtime pay; inadequate or no leave time; and a belief that her performance was being sabotaged. She asserted that her supervisors made her employment situation difficult due to discrimination based on her gender and national origin.

Dossa testified at length about the reasons she was unable to meet the requirements of the PIP. She claimed the PIP was created to ensure her failure and termination for reasons of gender and national origin. She explained that she spoke with an accent and her subordinates used that as an excuse not to understand her. She related her belief that her subordinates' criticism of her management style was really a cultural difference. She also claimed that a rumor was spread that she treated others like a "bossy, rich Indian" would treat the poor. The District Court dismissed the case, but the Tenth United States Circuit Court of Appeals reinstated it, finding that Dossa had met her burden of producing evidence of discrimination based on national origin.

Differences divide

Sometimes stereotypes based on gender, national origin, or religion can create rifts in a department. Sam is from Dubai. He does not celebrate Christmas as a religious holiday. When the December schedule is published, he is given Christmas off (because he worked both New Year's and Thanksgiving). When several department members tell him that he shouldn't get that holiday because he is the "wrong religion," that can lay the foundation for a charge of discrimination.

Sally is from Canada. The Fourth of July in her native country is just the day after the third. But she should have an equal opportunity to have that holiday off the same as any other worker. To suggest that her national origin leaves her unentitled to celebrate American independence is a discriminatory act. She cannot be treated any differently because she was born in another country.

> When people are judged based on a stereotype, it deprives them of the ability to demonstrate the strength of their character.

Diversity imparts strength

Having a diverse workforce is important. Employees with different cultural experiences can give us a window into how other cultures think. They can help us understand why a patient might be scared of a particular procedure or why they may react to a male therapist differently from a female. Honest dialogue that explores cultural differences without judging and is designed to foster understanding is valuable. Telling an Asian American that they must know "kung fu" based on their physical features poisons the exchange of ideas with unhelpful stereotypes.

While charges of discrimination are among the most difficult of all cases for a lawyer to win, it costs just as much to defend a bad case as it does a good case. Smart managers encourage diversity and avoid stereotyping. ■

FOOTNOTES

1. Arch Obler was a gifted playwright, creating hundreds of suspenseful plays for radio in the 1930s and 1940s. Toward the end of his career in an exercise in self-parody, he wrote a story about a character that literally "jumped off the pages" to come after him along with all his stereotypes. One stereotype that Obler used in his plays depicted police officers with thick Irish accents. When Obler stumbles onto the street in distress and is accosted by a police officer, he introduces himself; and the cop, speaking in a heavy Irish brogue, says "oh yeah, you're the guy who makes all the cops Irish…." Obler's series "Lights Out" can be heard on Radio Classics on Sirius XM, and recordings can be purchased from RadioSpirits.com.

2. In the history of discrimination lawsuits, no supervisor has ever testified that he had an improper motive in discharging an employee.

A Salute to our 2013 Corporate Partners

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Thank You, 2013 AARC *Times* Article Reviewers!

The *AARC Times* staff offers our sincere thanks to the people who reviewed the clinical articles in our publication throughout this year. Your special expertise and dedication to the respiratory care profession were critical to our ability to publish informative articles for the respiratory care professional. Thank you, reviewers!

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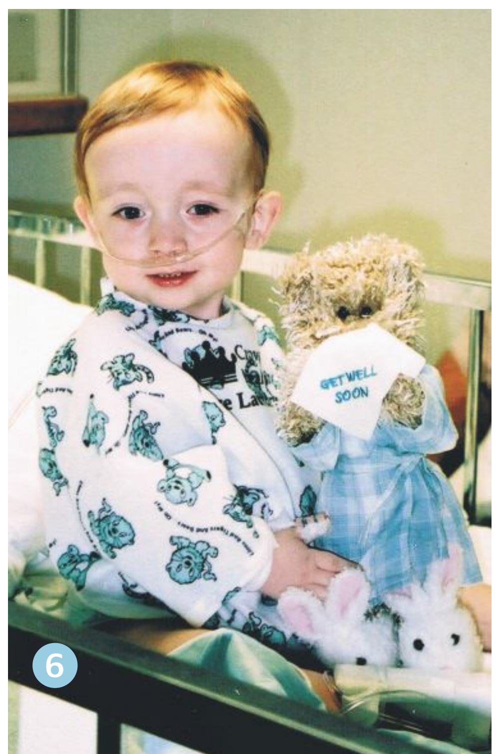

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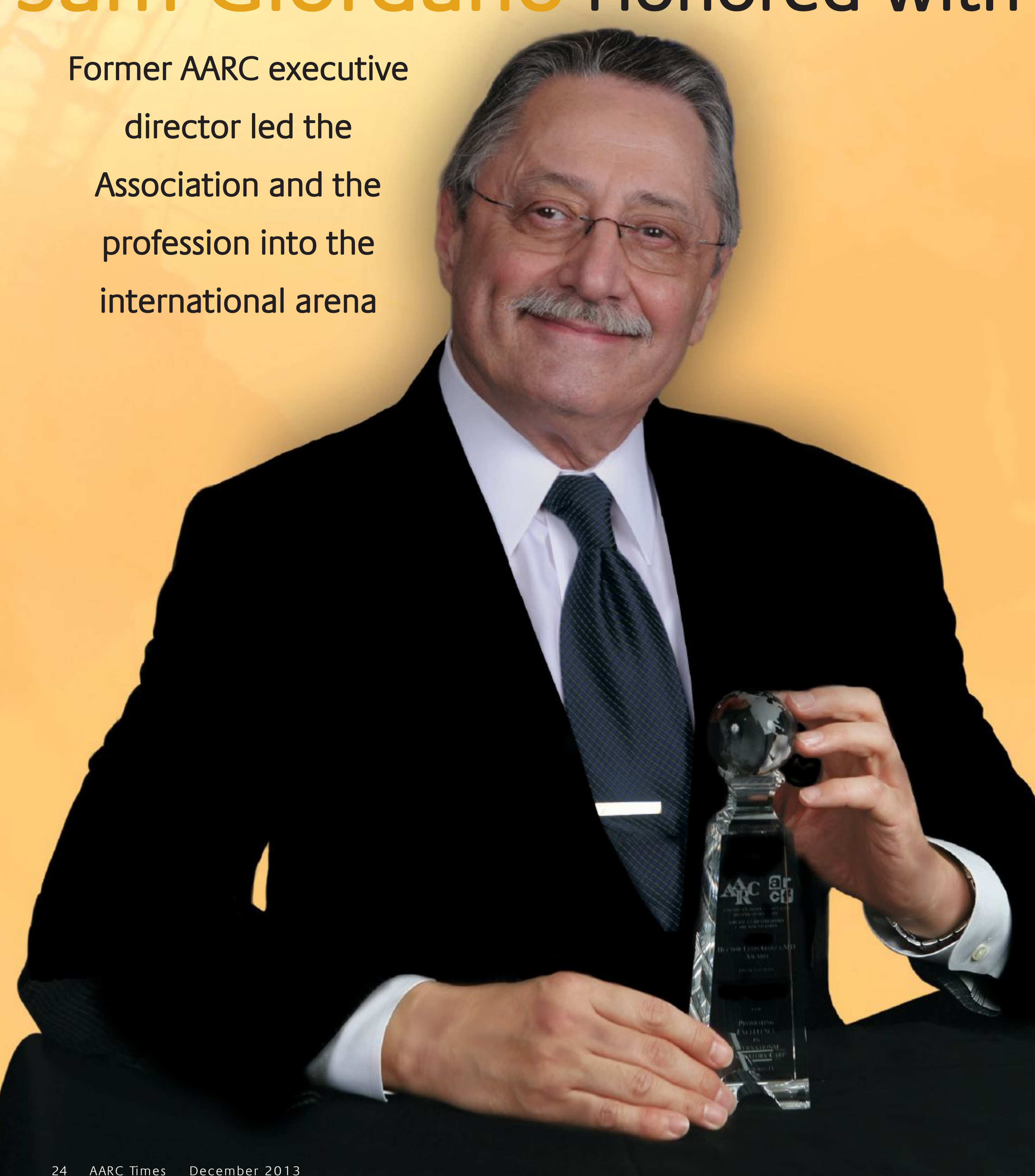
Sam Giordano Honored with

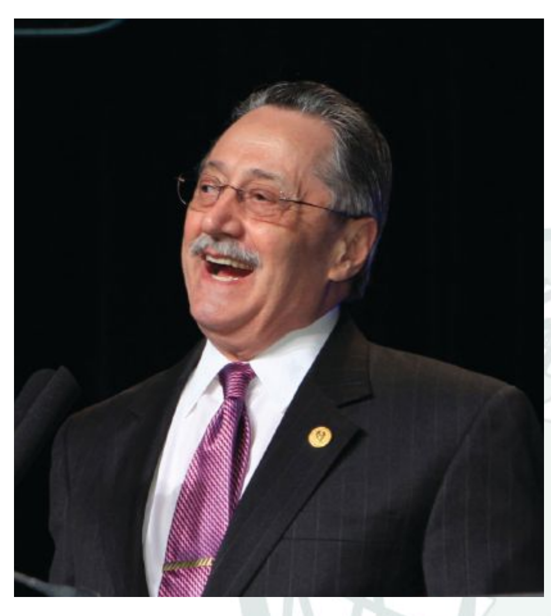
Former AARC executive director led the Association and the profession into the international arena



2012 Héctor León Garza Award

by Debbie Bunch

Today the AARC has connections all over the world, and that translates to an international presence for respiratory therapists, regardless of whether a country has adopted the American model of respiratory care or not. As AARC executive director from 1981–2012, Sam Giordano, MBA, RRT, FAARC, was at the helm when the Association began to build its relationships abroad; and last year he received the Héctor León Garza MD Achievement Award for Excellence in International Respiratory Care to recognize his leadership in the area. He tells us how it all unfolded in this interview.



Back in the 1980s, respiratory therapy was still pretty much a North American phenomenon. What went into your decision to pursue more of an international focus for the profession?

Respiratory therapy as a profession is indeed a North American invention. However, we were invented not by ourselves but by physicians, nurses, hospitals, and others who, decades ago, recognized the need to have persons with special expertise in what we now call respiratory care. That need exists in all countries. The need to take better care of patients with respiratory diseases is an international challenge, so our foray into the international arena was just the natural evolution of our organization and our profession.

How did you come up with the idea for the International Fellowship Program, and what did it take to get that program off the ground?

Development began when Jerome Sullivan, PhD, RRT, FAARC, was president in the late 1980s. We looked at how we evolved as a profession and real-

Found in Translation

Working through its International Council for Respiratory Care, the AARC has translated several of its resources into other languages. Here's what's available to our colleagues from abroad:

- **"The Clinician's Guide to PAP Adherence" (Arabic)**
- **"A Guide to Aerosol Delivery Devices for Respiratory Therapists" (Arabic, Chinese, Italian, Spanish, Turkish)**
- **"Patient Guides on Healthcare-Associated Infections" (Spanish)**

ized that if it were not for physician champions who would talk to their colleagues and essentially be advocates of qualified, properly trained respiratory therapists, we would not exist. So we wanted to pick "shakers and movers" to come to our shores, people who were going to be listened to by their governments. We wanted to go after people who would have the commitment to set up a system so that there could be this respiratory care expertise developed in their country.

The first class of international fellows was selected in 1990 — how did you promote the availability of the fellowships abroad?

We notified all of our international members — the AARC always had a few hundred — and we also notified the various organizations that we had liaisons with, such as the Canadian Society, Mexican Society, and many other groups that now make up the International Council. We also contacted corporations that did business internationally and asked them to spread the news of the program's availability to their counterparts in countries throughout the world.

The program calls for fellows to visit respiratory care facilities in two U.S. cities before attending the AARC Congress. Why did you decide that was the best model to use for the fellows' visits?

In a perfect world, we'd love to have them spend a year in the United States. We realized from the start, however, that was just not going to be practical from a financial standpoint and many others. So we decided to do three-week visits. But we said, let's not do just one city because the way respiratory care is provided has some slight variations regionally. We wanted our international fellows to get a feel for the fact that even though respiratory care is provided to patients very consistently, the service delivery models can vary from one area of the country to the other. This encourages them to find a model that fits in their country. We don't insist that they have respiratory therapists. We do insist that whoever is going to give this care have the same qualifications, training, and education as RRTs in this country. Of course, we also include attendance and participation in AARC's International Respiratory Convention & Exhibition so that international fellows get a sense of our profession, cutting-edge research, collaboration, and the AARC.

If you could point to the top one or two success stories that resulted from the international fellowships, whom would they be and why?

One that comes to mind is the late Toshihiko Koga, MD, FAARC, from Japan. He was one of our earliest fellows. Dr. Koga, who was a Japanese pulmonologist, undertook the fellowship and returned to Japan motivated to utilize the AARC Clinical Practice Guidelines (CPGs). Through his own personal efforts and with our permission (of course), he translated all the CPGs into Japanese so his colleagues, particularly the nurses and would-be respiratory therapists in Japan, could benefit from them.

The other fellow who is a good example is Hector Leon Garza, MD, FAARC, from Mexico. Dr. Garza recognized the need for better trained and educated allied health persons in respiratory care in his country, and he set about being one of the catalysts to organize a credentialing agency similar to what we have here with the National Board for Respiratory Care (NBRC). He was also a prime "mover and shaker" in establishing a formal school system for respiratory care in which schools would have to comply with standards to ensure that the quality of their graduates was what the physicians wanted and the patients needed.

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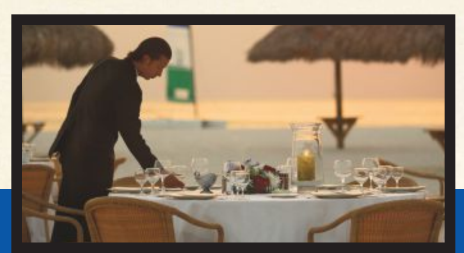


Sam Giordano (left), joins Dr. Jerome Sullivan in a meeting with Dr. Abdullah Al Amro (CEO) and Dr. Saleh Al Tamimi (associate executive director of medical administration) during their visit to King Fahad Medical City in Riyadh, Saudi Arabia in 2010.

In addition to supporting the International Fellowship Program, you worked steadily throughout your years as executive director to promote respiratory care in nations ranging from Saudi Arabia to Italy. How do you think that work is making a difference in international respiratory care today?

Those are two great examples. First of all, the Kingdom of Saudi Arabia is unique. Several decades ago the Kingdom contracted with American companies to set up its hospital systems and respiratory departments. What these contractors did was to export the American model of respiratory care. So the Kingdom of Saudi Arabia does have respiratory therapists like the United States, and their delivery system is very similar to that of the United States. Many of their respiratory therapists have been educated in the United States and have earned NBRC credentials as well. Eventually they organized a credentialing group of their own. That's really when they called on the AARC.

We visited the country to help them set up a credentialing system to ensure people were competent and also to assist them with creating an education system, which is doing very well. They have a baccalaureate degree program there. We were also helpful in dramatizing what can be done for patients with pulmonary conditions such as COPD and asthma. These patients are a special challenge there due to the sandstorms and similar irritants. Our job was to meet with the physician leadership of the Saudi Thoracic Society to make them aware of the benefits of utilizing RTs in a more effective and comprehensive manner.

Italy is a good contrast to Saudi Arabia because there is no legacy of respiratory therapists there. Physiotherapists provide some of the respiratory services, nurses provide some of the others, and physicians supply the rest. So our traditional American scope is really handled by three different professions. We conveyed to them that you do not have to imitate the American model of respiratory therapists. In their case, they created a graduate program for physiotherapists that would give them a master's in respiratory physiotherapy.

Once they were reassured we were not out to supplant them with a new profession but to respect who's there, we were able to work with them to encourage physicians to utilize these specially trained physiotherapists in the roles in which they were trained and qualified to perform. Quite frankly, they've had the same issues I faced in my career back in the 1960s, when I knew I could do something for a patient but the doctors

weren't convinced I could do that. I had to earn that confidence and trust. To the extent we can, we assist our colleagues overseas — not just the Italian group — to earn that trust and give them strategies to gain that trust and respect from the medical community.

> Challenges will certainly continue to stimulate a two-way dialogue between the AARC and many other organizations throughout the world so we can collaborate and adopt best practices.

The Association has also made important connections in international respiratory organizations like the European Respiratory Society (ERS). What do those connections mean for RTs here in this country?

It has always been AARC policy to make liaisons with other organizations that are "simpatico" with regard to our goals. Obviously, the ERS and others have as one of their goals to get effective, optimum treatment to respiratory patients. We have so much in common, including the fact that several of their physicians, like Stefano Nava, MD, are involved on our Journal's editorial board.

These liaisons also give us a nice way to answer the question that never gets asked to us directly in Europe. Which is, if we don't have respiratory therapists and our patient outcomes are about the same, why do we need you? Why does America need you and the rest of the world does not? This is where our international efforts resonate all the way down to the rank and file membership of the AARC. If the majority of the countries around the world don't have respiratory therapists, do we need respiratory therapists?

There are two ways that can go. You can have a movement originating outside the United States that eliminates respiratory therapists from our health care system, or we can be involved in a movement that helps move our model forward by selling it on the basis of the causative results it brings. In order to do that, we have to engage with the "ERSs" of this world. By having these liaisons, we've been able to engage in cooperative efforts, such as sharing lecturers at our meetings. This gives us the ability to compare and contrast different clinical approaches. Central to that whole educational experience is an implicit recognition of the need for persons with expertise in respiratory care that reinforces the value of respiratory therapists but does so without diminishing the value of other professionals.

What do you foresee for international respiratory care going forward? Will there be a day when all nations have RTs as we know them here?

You know, there's a difference between naming something and having something. So, we're going to have a lot of puppies, but we're not going to presume to name them for a country. What we want, though, and what our message has consistently been for decades now, is that patients need a person or persons with this comprehensive skill set. We have that in one package here in the United States in respiratory therapists. How you bring that skill set to the patient's bedside is up to your country, your culture, and how you conduct business in your medical system. We are here as your partner and a resource to ensure patients get what they need; and we welcome you to use our resources to get that done, such as Dr. Koga did with the CPGs.

Will they need to have these people? The answer is yes, particularly with the threat of pandemics facing the entire world. The pandemics of the last 10 years — bird flu, swine flu, etc. — would always stimulate World Health Organization members and other countries to make contact with the AARC and open a liaison. This is especially true in the critical care, ventilator support area. After we had the first bird flu episode, we were contacted by the government of China wanting to bring 50 Chinese physicians to our annual meeting. Unfortunately, they couldn't get their visas, but it was all because of bird flu.

These pandemics are virtually all respiratory diseases. So the idea that we're going to have a disease the same as China, the same as Italy, the same as everywhere else, tends to pull our world closer together — and within that world the respiratory care community is pulled even closer. So I believe the pandemic challenges we're likely to face as we move forward will continue to drive interest in establishing a respiratory care-like profession. They will certainly continue to stimulate a two-way dialogue between the AARC and many other organizations throughout the world so we can collaborate and adopt best practices — in the beginning to address pandemics but then to address other diseases common to our countries, like asthma and COPD. ■

Success in 2013

by John D. Hiser, MEd, RRT, FAARC

Success has a lot of definitions. To some, it is defined as gaining fame or prosperity or achieving a certain level of social status. To others it is the achievement of something desired, planned, or attempted — in other words, the achievement of a goal.

Over the last quarter of a decade, *AARC Times* has published countless articles about success in achieving the goals related to our international mission. In this issue, I wanted to present examples of some of our most recent successes and highlight how our AARC international fellows (IF) have impacted the respiratory care profession in their countries.

Enhance the awareness and understanding of the profession of respiratory care and its vital role on the health care team.

Argentina

Past Fellow Gustavo Olguin, MHA, PT, RRT (IF–2001), working with other members of the newly formed Argentine Society in Cardio Respiratory Kinesiology (SAKICARE), successfully lobbied the Argentine Ministry of Health to adopt rules that mandate a minimum number of physiotherapists specialized in critical respiratory care be present in all intensive care units in Argentina.

Saudi Arabia

Mohammed Al Ahmari, MSc, BSRC, RRT (IF–2005), reported on two major developments in Saudi Arabia that will greatly improve awareness of the profession in that country. After 10 years of lobbying efforts, the Ministry of Civil Service has approved a respiratory therapist position, providing more recognition for the profession as well as producing more jobs and opportunities for respiratory therapists at a national level. Secondly, a fellowship of respiratory care in critical care under the national accrediting body for all health specialties (Saudi Commission for Health Specialties) was recently created. This two-year fellowship is equivalent to a master's degree.

Provide encouragement and assistance to those countries seeking legal recognition of the profession of respiratory care.

United Arab Emirates (UAE)/Philippines

After 25 years of intense lobbying efforts, Noel Tiburcio, PhD, RRT-NPS, RTRP (IF–2009), along with several other UAE and Filipino respiratory therapists celebrated last July when the Philippine Respiratory Therapy Act of 2009 was fully implemented. The first Professional Regulatory Board of Respiratory Therapy (PRBRT) was created by the Professional Regulation Commission (PRC) to regulate the practice of the RT profession in the Philippines through licensure examination. On July 17, 2013, they held an oath-taking ceremony for the first group of Registered Respiratory Therapists in Manila. Several newly credentialed respiratory therapists from the UAE, Saudi Arabia, Qatar, and Singapore came home to attend this memorable event.

The editors thank *AARC Times* Guest Editor John D. Hiser, MEd, RRT, FAARC, for his special contributions to our December international issue.

About the Author
John D. Hiser, MEd, RRT, FAARC, chairs the AARC International Committee and served as the AARC president in 2005. He is the director of the respiratory care program at Tarrant County College Trinity River East Campus Center for Health Care Professions in Fort Worth, TX.

Provide encouragement and assistance to countries seeking to establish the profession of respiratory care as an independent profession.

China

Pei-Feng Xu of Sir Run Run Shaw Hospital in Hangzhou, China, along with Yue-hua Yuan, BS, RT (IF–2009), and Hui-qin Ge (IF–2008), have successfully trained 204 RT students from 14 provinces this year. The program is an AARC International Education Recognition System (IERS) Level II Program designed to help establish the profession in China.

Provide encouragement and assistance to those seeking to provide and establish seminars, programs, and schools in their home country.

Ghana

Following her international fellowship last year, Audrey Forson, MD, ChB, FWACP, (IF–2012), returned to Ghana. With the help of AARC members Paul Eberle, PhD, RRT, and Lisa Trujillo, DHSc, RRT, of Weber State University, along with Karen Schell, DHSc, RRT-NPS, RPFT, were able to convince the provost of the University of Ghana that the college needed to start a new school for the training of respiratory therapists. The curriculum is being finalized, and the program may begin as early as 2014.

Newly licensed RTs celebrate the implementation of licensure at the historic Manila Hotel. (Philippines)

Encourage and promote the exchange of qualified speakers between the AARC and other professional associations around the world.

China

This last July, Manling Liu (IF–2012), hosted AARC International Committee member Natalie Napolitano, MPH, RRT-NPS, FAARC, at Shaanxi Provincial People's Hospital in Xi'an, China. During her time in Xi'an, she visited the neonatal intensive care unit, providing insight into the treatment of neonates. She also presented lectures on the treatment and prevention of bronchopulmonary dysplasia. Pediatricians and nurses from many hospitals across Shaanxi Province attended the lecture.

Manling Lui, as well as Sheng-yu Wang (IF–2011), are instructors in the newly created respiratory care program at Xi'an Medical University, which graduated their first class in 2012. Seven of those graduates are now employed at Xi'an Medical University Hospital.

Norway

Past fellow Heidi Markussen, MHSc, RN (IF–2008) and Siguard Aarrestad, MD, of Bergen, Norway, are speaking at the AARC Congress in Anaheim this year. Their topics are "NIV Competencies: The Norwegian Model" and "Monitoring of Noninvasive Ventilation."

International fellows now number 152 from 63 countries. This year's fellows will come from Brazil, Colombia, Japan, Lebanon, and Morocco.

AARC International Fellows by Continent

- Africa: 7
- Asia: 73
- Australia: 2
- Europe: 45
- South America: 20
- North America: 5

Natalie Napolitano (second from right) and Manling Liu (far left) discuss the treatment of a premature infant at Xi'an Medical University Hospital. (China)

Provide encouragement and assistance to those countries seeking to establish professional associations for respiratory therapists.

Latin America

Past fellows Gustavo Olguin (Argentina), Jose Landeros, PT, CRT (IF 2007–Chile) and Daniel Arellano, PT, CRT (IF 2005–Chile), along with AARC member Ruben Restrepo, MD, RRT, FAARC, were instrumental in starting the Latin American Society for Respiratory Care. Their first Congress was held earlier this year in Santiago, Chile.

Encourage and assist our international colleagues in publishing articles, case studies, or abstracts in Respiratory Care, *AARC Times*, or other professional journals from their country.

China

Recently, an original research article by Jie Li, MSc, RRT-NPS (IF–2005), titled, "Respiratory Care Practices and Requirements for Respiratory Therapists in Beijing Intensive Care Units" was published in Respiratory Care.

Also, Ge Hui-Qing (IF–2008) will be presenting at this year's Open Forum.

United Arab Emirates

Dr. Noel Tiburcio submitted an abstract titled, "The PDCA Cycle: An Optimal Quality Improvement Tool in Respiratory Care — the UAE Experience"; and it has been accepted for this year's Congress Open Forum/Management Section.

Egypt/India/Lithuania/Peru/Saudi Arabia

In the last international issue of *AARC Times*, past fellows Malak Shaheen, MD, FCCP (IF–2011), Devasahayam Christopher, MD, (IF–2005), Valdone Miseviciene, PhD, MD (IF–2007), Guillermo C.C. Nogales, MD (IF–2010), and Adil Al-Otaibi, MSRC, RRT (IF–2010), all had articles published about drug-resistant tuberculosis in their countries.

India/Saudi Arabia/UAE

We also published articles by Arvind Bhome, MD (IF–2002), Dr. Mohammed Al Ahmari, and Dr. Noel Tiburcio about obstructive sleep apnea.

Encourage respiratory care professionals to participate in medical mission projects.

Ghana/Haiti/Dominican Republic

AARC members continue to take medical mission trips around the world. This year medical missions ventured to Ghana, Haiti, and the Dominican Republic. Those activities are highlighted in this issue.

Encourage and assist our international colleagues in providing translations of AARC publications.

Saudi Arabia

Muhammed Al-Ahmari, MSc, BSRC, RRT (IF–2005), is translating the third edition of the "Guide to Aerosol Delivery Devices for Respiratory Therapists" into Arabic.

Encourage professional and educational organizations to gain recognition of seminars, programs, and schools through the ICRC International Education Recognition Systems (IERS).

In the last 12 months, IERS has approved five Level I seminars and nine Level II programs in six different countries. You can read all about IERS in this issue of *AARC Times*.

Encourage student and faculty exchange programs between respiratory care programs around the world.

For the fourth year in a row, students from China Medical University's respiratory care program in Taichung, Taiwan, visited the program at Tarrant County College in Fort Worth, TX, for three weeks of classroom, laboratory, and clinical education. Chia-Chen Chu, MS, SRRT, FAARC (IF–2001) is the technical director for the program in Taiwan.

Encourage the sharing of AARC publications with related foreign publications around the world.

Italy

Selezione ARIR da Respiratory Care e AARC Times, the official publication of the Associazione Riabilitatori Dell'Insufficienza Respiratoria (the Italian Association for Rehabilitation of Respiratory Insufficiency), continues to take advantage of a long-term agreement with the AARC and publishes two articles selected from Respiratory Care or *AARC Times* in each of their issues. Past fellow Pamela Frigerio, PT, ARIR (IF–2000), was instrumental in helping to establish the original agreement.

Encourage international membership in the AARC.

The AARC now has over 650 international members in more than 60 countries around the world.

Provide encouragement and assistance to those seeking to establish governors representing their country to the ICRC.

China

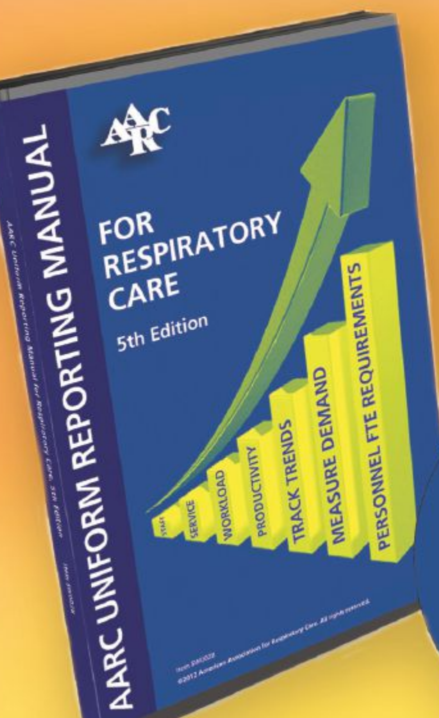
At the most recent meeting of the International Council for Respiratory Care, two new governors for China were approved. They are Xiang Yu Zhang, MD, FCCP, FACCM (IF–1998), from Shanghai and Yuan Yue-hua, RN, RT, (IF–2009) from Hangzhou.

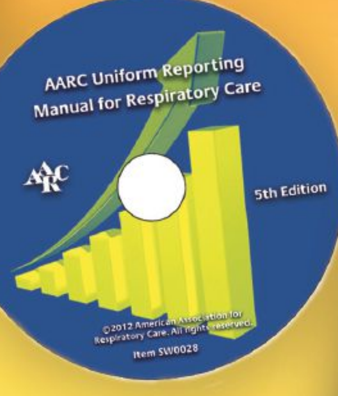
I am proud to announce that with the one exception of adding a new AARC international affiliate, this year we have achieved all of the international goals of the AARC. I congratulate all of our AARC international fellows for their achievements and thank all AARC members who are helping to globalize respiratory care. ■

A recent graduate from the RT program at Xi'an Medical University Hospital in Xi'an, China, treats a patient.

Taiwan exchange students visit AARC Executive Office. Shown are Chang-Hsien Yu; Thomas J. Kallstrom, MBA, RRT, FAARC, AARC executive director and CEO; Shun-Yao Chi; Douglas S. Laher, MBA, RRT, FAARC, associate executive director; SSU-Yu Chen, and Yu-Yu Tu.

Tools to Make Respiratory Management Easier





AARC Uniform Reporting Manual for Respiratory Care, 5th Edition

This updated edition is an invaluable resource to analyze productivity, track trends in the utilization of services, establish FTE requirements, and measure demand and intensity of services. Compares activities based on relative workload intensity, providing an objective means of assessing staffing needs. Extending beyond inpatient services, this URM also provides current standards for clinical activities for additional services frequently directed by RTs and includes: Echo/Non-invasive Cardiology Labs; Blood Gas Labs; Pulmonary Diagnostic Labs; Sleep Disorders Labs; Hyperbaric Medicine; and Pulmonary Rehabilitation Services. Standardized worksheets are included for each productivity system. Copyright 2012 AARC.

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International Education Recognition System (IERS) Responds to Unmet Need

Global RC community commits to quality and consistency

by Jerome M. Sullivan, PhD, RRT, FAARC, and Louis Sinopoli, EdD, RRT, FAARC

Many respiratory care (RC) practitioners in the United States, on first review, might question if they would benefit in any way in their everyday job if RC educational programs outside the United States are recognized and approved as meeting a certain level of quality. On further reflection, it should be noted that outside of the United States, our profession is viewed by other RC practitioners as the "gold standard." Our scope of practice, professional association, education and credentialing systems, accreditation process, and our inclusion as key members of the health care team set the standard to which many of our colleagues in other countries aspire. Our international counterparts want what we have attained, and they speak highly of our important role in U.S. health care. Emulation being the highest form of praise, they also want to provide high-quality RC education experiences that meet recognized standards. The fact that RTs are viewed so favorably outside of the United States makes every one of us as respiratory therapists stronger and more influential in our everyday positions. Indirectly, we benefit greatly as respected professionals from this outreach.

Acting on the desire to implement international quality standards for RC education, the governors representing 26 countries on the International Council for Respiratory Care (ICRC) began almost 10 years ago, in partnership with the AARC, to formulate plans. That groundwork has ultimately resulted in the development of a voluntary system to ensure quality and consistency in RC educational offerings outside of the United States. This system has become known as the International Education Recognition System (IERS). See www.aarc.org/iers/6/index.cfm and www.irccouncil.org/newsite/. Over the last six years, these actions have resulted in over 65 international respiratory care seminars and programs in 14 different countries that have successfully been recognized for adhering to educational quality standards. The educational offerings have met guidelines for quality seminars and programs and have been formally recognized by IERS. In this process, the AARC recognizes quality international respiratory care educational programs that meet or exceed the IERS guidelines developed and approved by the ICRC.

Argentina

Colombia

Egypt

Italy

Japan

Mexico

Vietnam

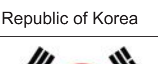
The initial recommendation by the ICRC governors was the motivating force that first documented the need for international standards by which respiratory care educational offerings could be measured for quality and consistency. The resulting standards reflect contemporary education accreditation best practices and are used to determine whether an education experience warrants one of the three levels of recognition granted.

IERS guidelines specify required quality standards for faculty and support personnel, organizational format, and teaching and learning activities. The standards further address the quality of educational goals and objectives, testing or evaluation strategies, post-program surveys, and other outcome data. Guidelines exist for each type and phase of the program, and the requirements increase in complexity and rigor as the educational offering increases in duration from seminar, to repeating program, to school. The three levels of approval for each type of educational experience are included in Table 1.

Education Advisor to the ICRC, Dr. Louis Sinopoli, points out that IERS is an online recognition system that uses the principles of effective evidence-based education to encourage and promote quality RC educational activities all over the world. The recognition is granted at three levels based on length and purpose of the RC educational activity. All applicant levels are coached and encouraged to explain what they intend to teach, how they plan to teach it, and most importantly, how will they know they taught it. By establishing this dialogue with the applicant country from the start, the process is efficient and easy to conduct via the Web and email until recognition is granted.

Professor Chia-Chen Chu teaching lung analog to students

Saudi Arabia



Republic of Korea

China

Taiwan

United Arab Emirates

USA

Turkey

Welcome banners at the Tongji Mechanical Ventilation Forum

American Natalie Napolitano spoke at the forum.

Table 1.

Approval Levels for Types of Educational Experience

Seminar Recognition (Level I)

Granted to educational non-repeating (content) RC seminars of any length. Recognized RC seminars have met or exceeded the guidelines for quality seminars that teach different content each time they are offered.

Program Recognition (Level II)

Granted to RC educational repeating programs, longer than one day in duration, that repeat the same focused skill or competency training each time the program is offered. The program is designed to teach the same content or skill set each time the program is delivered.

School Recognition (Level III)

Granted to educational programs that meet Level III school recognition guidelines. For IERS recognition of RC educational schools, a school is longer than one year in duration and designed to grant a degree in respiratory care at the bachelor's degree level or higher from a recognized university in the host country. RC schools must set local evidence-based outcome measures for (graduate) outcome performance. Graduation from these schools may be approved by the country's credentialing and/or licensure system for RC practice in the hospital, ICUs, and other settings where patients receive respiratory care.

IERS intended for seminars and programs outside of North America

The IERS mandate is to provide quality assurance for RC educational experiences primarily outside of North America; thus, American-sponsored RC programs should not apply for IERS Recognition. IERS is a completely voluntary peer-reviewed process that is not required for licensure or accreditation in the various countries. The AARC's Continuing Respiratory Care Education (CRCE) program accredits continuing education programs for RTs that increase the breadth and depth of RTs' knowledge and reflects the continuing education requirements of RC licensing boards throughout the United States. IERS is differentiated from the AARC's CRCE system as it approves the quality of the overall educational experience, but it does not provide continuing medical education. In the development of IERS standards by the ICRC and its governors, it became apparent that including CRCE approval along with American continuing education units would not be recognized in their home countries for professional development. Each country has its own approved units and process for applying. There are exceptions in countries outside of North America, such as Saudi Arabia and the United Arab Emirates, which have large numbers of AARC members. In these instances, program sponsors and administrators are encouraged to apply for both designations. This was recently the case in the United Arab Emirates, where the Emirates Association for Respiratory Care Practitioners (EARCP) sponsored a large, very successful meeting that was approved for CRCEs and by IERS.

Recent IERS approvals and impact on quality of clinical practice

During the past year, 13 separate educational programs in six different countries have been approved for IERS recognition. In each case, the sponsors and the participants have indicated that the program has met its objectives and will assist in improving the quality of care for respiratory patients in their home country.

In July 2013, the 13th in a series of annual seminars on respiratory care was held in Shonan, Japan. For the last six years, these seminars have been under the direction of governor for Japan to the ICRC, Kazunao Watanabe, MD; and all have carried Level I IERS approval. The quality and outreach of these seminars have had a far-reaching effect on the knowledge level and clinical practice of hundreds of physicians, nurses, physical therapists, and therapists. Another very ambitious project in Japan over the last two and one-half years has been directed at re-educating young Japanese physicians in Level II IERS approved programs on mechanical ventilation theory and practice. These programs, again under the direction of Dr. Watanabe and sponsored by the Japanese Association for Respiratory Care, have been in high demand and well received by the physician community. Over the course of 12 programs, 300 physicians have benefited from these high-quality IERS approved programs.

Dr. Watanabe and his team will be reporting at the AARC's 59th International Respiratory Convention & Exhibition in Anaheim, CA, on the outcome data and qualitative analysis measured over the course of these learning experiences.

Another Level II IERS approved program is underway in Egypt under the direction of Dr. Mahmoud Abbas. This series of programs is also directed at teaching general practice physicians the key concepts in the diagnosis and treatment of COPD through a COPD Educator Course. The first in the series of programs was offered in Cairo, Egypt, in March 2013; and Dr. Abbas feels that it has already had a direct positive impact on respiratory care practice. Continuing a long-standing tradition of quality respiratory care education in Saudi Arabia, the Saudi Society for Respiratory Care has also sponsored a Level II IERS approved Asthma Educator Course May 4–5, 2013, in Jeddah, Saudi Arabia. This was accompanied by an additional Level I IERS approved seminar at the same venue.

The International Education Recognition System
hereby awards this
2013 Certificate of Recognition
The Japan Association for Respiratory Care
The Physicians' Ventilation Workshop Program
November 2-3, 2013
Paramount Bed Co. Training Center, Tokyo, Japan
Has been recognized as a
Level II Program Recognition
by the American Association for Respiratory Care
and the International Council for Respiratory Care
George Gaebler MSEd, RRT, FAARC
AARC President
Jerome Sullivan PhD, RRT, FAARC
ICRC President

Governor for China to ICRC and director of the Sir Run Run Shaw Hospital respiratory therapy department in Hangzhou, Zhejiang, China, Yuan-Ye Hua, RN, RT, has conducted two Level II IERS approved programs in 2013 on "Ventilator Management/Monitoring for Acute Respiratory Failure." Her colleague, Dr. Han, at the Hunan Provincial People's Hospital in Changsha, Hunan, China — for the second consecutive year — has conducted an impressive month-long Level II IERS approved program on "The Respiratory Therapy Critical Care Training Class." These programs have been very well attended and have received very positive post-program survey reviews.

The second governor for China to the ICRC, Dr. Xiangyu Zhang, FCCP, FACCM, a critical care specialist, has again directed his highly successful Level I IERS approved "Tongji Ventilation Forum" at Tongji University in Shanghai, China. The seminar was held July 19–21, 2013, with over 320 participants. It featured a number of notable faculty, including Natalie Napolitano, MPH, RRT-NPS, FAARC, neonatal-pediatric specialist. Napolitano is a member of the AARC International Committee. In addition, Michael McPeck, MS, RRT, FAARC, and James B. Fink, PhD, RRT-NPS, FAARC, from the United States were distinguished faculty members. Of particular note, the past president of the Korean Critical Care Society was a featured speaker, along with a number of domestic experts. Again, post-program surveys indicated a high degree of participant satisfaction that seminar objectives were met.

Respiratory care BS programs also included in IERS approvals

Saudi Arabia and Taiwan each claim a Level III IERS approved bachelor of science RC program. For five consecutive years, the BS Respiratory Care Program at Prince Sultan Military College of Health Science in Al-Khobar, Saudi Arabia, has held full recognition status with IERS. The RC program director at Prince Sultan College is a governor for the Kingdom of Saudi Arabia to the ICRC. He is Mohammed Al Ahmari, PhD, RRT.

A second BS respiratory care program, which also has held IERS Level III approval for the past five years, is located in Tai-Chung City, Taiwan. Chia-Chen Chu, MS, SRRT, FAARC, is the program director and ICRC governor for Taiwan. Chu is also a member of the ICRC executive committee and is president of The Respiratory Therapist Society of the Republic of China.

The International Respiratory Care Community has embraced the international standards for quality respiratory care education established by the ICRC, and it continues to provide quality programming directed at improving quality patient care. This article provides only a small snapshot of these educational experiences. We recognize that many more quality IERS approved programs deserved to be featured. Our appreciation is extended to all our colleagues who have contributed to the IERS project. ■

ABOUT THE AUTHORS

Jerome M. Sullivan, PhD, RRT, FAARC, is the president of the International Council for Respiratory Care. He is also professor emeritus at the University of Toledo, in Toledo, OH.

Louis Sinopoli, EdD, RRT, FAARC, is education advisor to the ICRC Executive Committee. He is also the respiratory care program director at El Camino Community College, in Torrance, CA.

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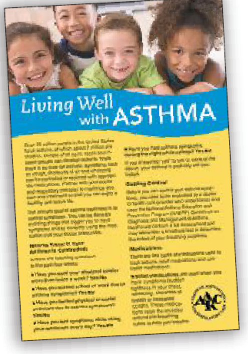

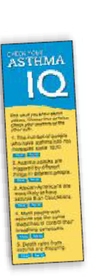

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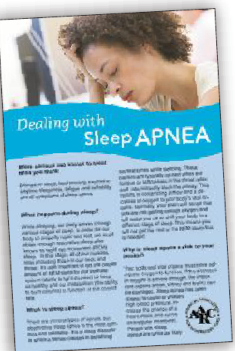
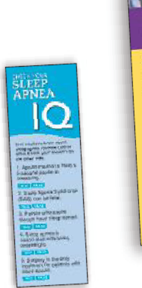
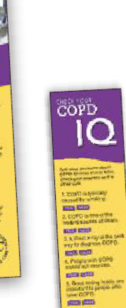




SLEEP APNEA
Tip sheet: BR0010N
Bookmark IQ Card: PE0008



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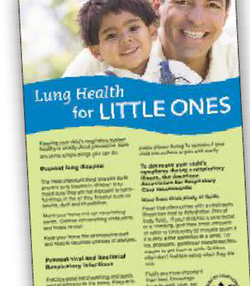

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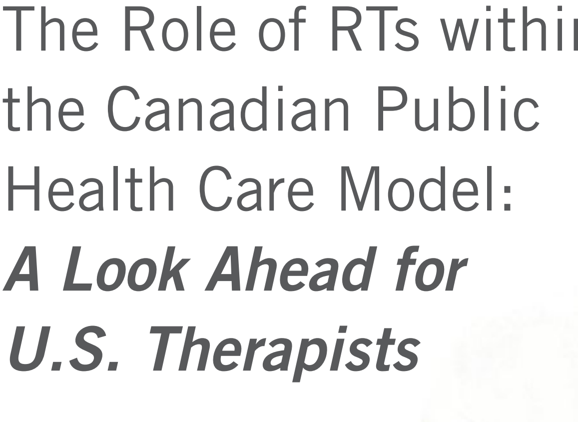

The Role of RTs within the Canadian Public Health Care Model: *A Look Ahead for U.S. Therapists*

by Angela M. Coxe, MBA, RRT, FCSRT

Almost every Canadian respiratory therapist works within the national public health care model. In the Canadian model, each province receives funding from the federal government to deliver health care services based on five key principles: public administration, comprehensiveness, universality, portability, and accessibility. Each province then establishes the standards for health care delivery, and as such, there are variations of health care delivery models across the country.

Because provinces and territories are responsible for the administration and delivery of health care in Canada, the respiratory therapy profession has had to evolve within the regional variations that exist across the country. In fact, despite having "universal health care," health care funding can vary considerably across Canada, and as such, more resource-rich provinces are able to invest more dollars on a per capita basis. Health transfer payments are intended to support the gap in funding for the remaining provinces; however, this does not always ensure a truly universal system.

In addition, due to the large scale of our Canadian health care system, it is difficult to change processes fast enough to meet the growing demands of an ever-changing health care landscape. Often, we are only able to address issues once they have become a problem rather than preventing issues before they become unmanageable. Despite these challenges, there is one critical element common to all Canadian respiratory therapists — the patient is the focus of their care and dedication.

Evolution of RTs and health systems

As the Canadian respiratory therapy profession celebrates its 50th anniversary in 2014, it is impressive to look back at its remarkable progress and evolution. The Canadian public health care model has provided respiratory therapists with opportunities to expand their technical skills, as well as their clinical knowledge, competencies, and scope of practice. RTs have proven to be a flexible health care provider, adapting quickly to the transformation in the health care system, evolving from a purely technical profession to a highly skilled clinical role involved in critical care, anesthesia, neonatal, community, and home care.

Canadian Society for Respiratory Therapists provides U.S. therapists with a glimpse into an evolving, federally controlled health care system.

A point of pride for the Canadian RT is that no individual citizen is denied access to health care based on whether or not they can afford to pay. The challenge we face is that Canadians are finding it increasingly difficult to find a family physician, and they are required to wait for specialty services.

In recent years, public health care systems have shifted to the implementation of integrated health care models with a focus on establishing collaborative care teams where each health care partner is active in making decisions and in the delivery of care. RTs have embraced the concept of inter-professional care and have benefited from working collaboratively, sharing their perspectives and experiences as health care providers and focusing on a common goal: providing a seamless continuum of care. RTs understand that when care is coordinated, it is responsive and efficient and it enhances a patient's experience in the health care system, ultimately making for more successful health care providers.

The opportunities for RTs have expanded with the increasing demands of chronic disease management. As with many other countries, Canada is facing an aging population with a growing prevalence of respiratory disease. With chronic disease being a leading cause of morbidity, governments are increasing funding models for community-based care. Canada's national health care priorities have shifted to improving the health of Canadians through health promotion and disease prevention. This has provided even more opportunities for RTs, and we are seeing an increase of RT involvement in community care and the management of chronic respiratory disease.

Challenges and opportunities

While the national public health care system has provided opportunities to the respiratory therapy profession, there are some areas that have been challenging, including:

- A lack of RT-specific research has resulted in difficulty in establishing national best-practice guidelines and/or evidence-based practice for the profession of respiratory therapy.
- In many regions across Canada, there is an insufficient infrastructure necessary to support collaboration and interprofessional care.
- In some regions, there is a slow response to RT involvement in patient care during the transition from acute care, to rehabilitation, to home care.
- Working within a system that at times is not adequately resourced results in questionable sustainability for the delivery of optimal respiratory care services.

Where will the profession be in five years, in 10 years, in 20 years from now? Our vision for the future is a profession that is:

- Knowledgeable and uses the best evidence to inform clinical decisions
- Qualified and educated to meet the evolving demands of the health care system
- Autonomous and capable of making independent decisions to provide the best possible care and outcomes for the patient
- Actively participating and supporting inter-professional communication and collaboration
- Respected by their peers and the public, and recognized for its leadership in the management and treatment of respiratory disease.

For the past 50 years, RTs have learned to navigate the complexities of Canada's national public health system by being adaptable and responsive to the transformation in the health care system and, most importantly, to the needs of the patient. As governments continue to grapple with funding and sustainable models of care, the RT will remain focused on advocating for patients' access to appropriate health services, safe outcomes, and quality respiratory care.

Ultimately, the Canadian public health system provides an environment for RTs where:

- Care is patient centered, with a focus to provide seamless care across the continuum.
- Quality services are developed that are appropriate for patient needs.
- The system is focused on health promotion and illness prevention.
- The system strives to provide equitable access to quality care.
- Multi-sectoral policies are available to address the social determinants of health.

Maintaining effective health systems

The major areas of concern are the sustainability of the health system based on universal access to quality health services and the need for more accountability by stakeholders (the public, patients, families, providers, and funders) for ensuring the system is effective.

At the end of the day, all health care systems, whether public or private (as in the United States), try to achieve a fair balance between:

- Better care for the patient
- Better general health for its population
- A better overall value and reasonable per capita expenses of health care.

It will require the best minds in government and in health care to come up with effective policies for a health care system that ensures the right providers, at the right time, in the right place, for the right care. RTs in Canada and in the United States must work with other health care providers to provide the leadership required to support a more fully integrated, patient-friendly, sustainable, and accountable health system. ■

About the Author
Angela M. Coxe, MBA, RRT, FCSRT, is president of the Canadian Society for Respiratory Therapists. She serves as the program director for cardiology and site director at the St. Catharines site of the Niagara Health System in Ontario, Canada.

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SOURCE: The Certified Asthma Educator: The U.S. Experience, Pediatric Allergy, Immunology, and Pulmonology, Vol. 24, No. 3, 2011.

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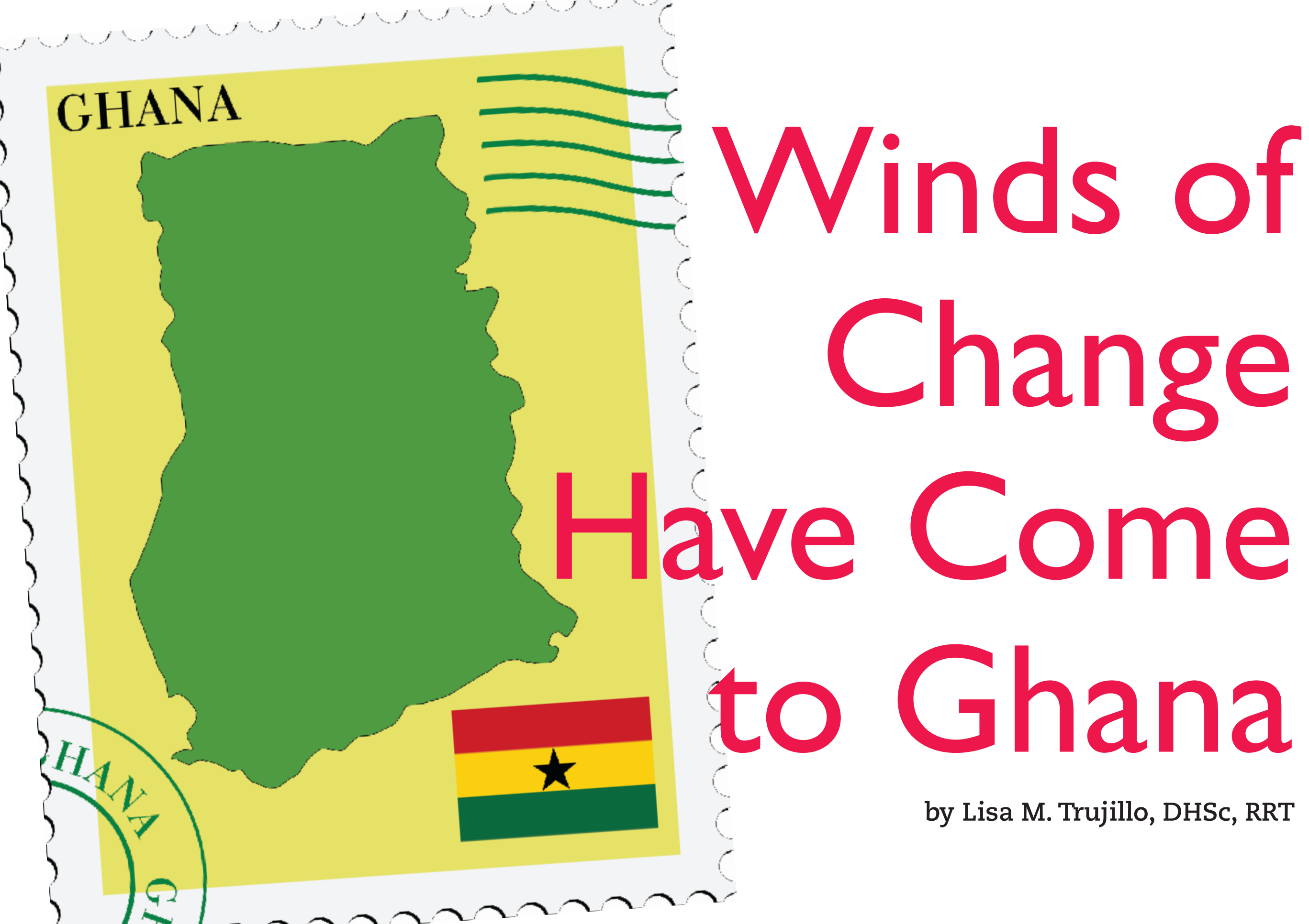

Winds of Change Have Come to Ghana

by Lisa M. Trujillo, DHSc, RRT

"Over 5,300 health facilities exist in Ghana, West Africa, ranging from community-based health planning and services to tertiary hospitals. These facilities serve a population of approximately 25 million. Respiratory therapists are required at all levels of health services to help in the management of acute and chronic cardiopulmonary diseases. However, there are only two known qualified respiratory therapists working at Korle Bu Teaching Hospital in Accra, Ghana. There is, therefore, an urgent need for training of RTs to support health service delivery throughout the country."[1]

Over the past eight years, Weber State University (WSU) respiratory therapy and other allied health students, RTs from across the United States, and a variety of community members have traveled to Ghana to provide medical care, education, and humanitarian aid. In all, over 100 people have made this trip and collectively have taught and cared for thousands of Ghanaians. Although the scope of care and education has been focused on community health, cardiopulmonary resuscitation, and neonatal resuscitation, there has always been an undercurrent of respiratory therapy in what we do. Since respiratory therapy doesn't exist as a recognized profession in Ghana, it has been a personal goal to make contacts and share information about our profession whenever possible.

Each year, mission groups have an opportunity to collaborate with and provide patient care in a variety of facilities, including Korle Bu Teaching Hospital, which is a 2,000-bed facility affiliated with the University of Ghana. Many valuable relationships have been forged at this facility, one of which was with Dr. Audrey Forson, MB, ChB, FWACP, a physician with a special interest in respiratory illnesses. In 2012, the AARC selected Dr. Forson to be an international fellow, providing her the opportunity to travel to the United States. Her travels included visiting

visit several acute care facilities in northern Utah, providing them the opportunity to see RTs at work. They expressed amazement at the high level of critical care expertise and the integral role RTs play in our health care team. This visit solidified their desire to support Dr. Forson's efforts to develop a respiratory therapy program at the University in Ghana.

Moving upward

During a two-month visit to Ghana this summer, WSU's respiratory therapy program chair, Paul Eberle, PhD, RRT, and I consulted with Dr. Forson and university officials regarding the progress that had been made over the past several months. We reviewed and discussed the newly developed curriculum proposal. It was eloquently written and addressed the specific need for the respiratory care profession in Ghana. With the support of the Ministry of Health, Ghana

Kansas and Utah to learn more about the scope and breadth of respiratory care before attending the AARC Congress. Following Dr. Forson's visit, Karen Schell, DHSc, RRT-NPS, RPFT, and I traveled back to Ghana to meet with university and government officials about the development of respiratory care in Ghana. Knowing that the introduction of a new profession would require support from all stakeholders within Ghana, it was important that we were available to assist Dr. Forson as she began this journey for her country.

In the spring of 2013, the dean of the College of Health Sciences, Professor Patrick Ayeh-Kumi; the provost of the School of Allied Health Sciences, Professor Aaron Lawson; and their curriculum specialist, Professor Steven Asante-Poku, traveled to WSU in Utah to observe our respiratory therapy program and learn more about the curriculum and program management. They were also able to

Health Services, and Korle Bu Teaching Hospital, the proposal is now in the approval stages within the University of Ghana. It is anticipated that the first group of baccalaureate respiratory therapy students will begin their studies in the fall semester of 2014.

This milestone has required the diligent efforts of many. Kwami Ahelegbe, a Ghanaian RRT from Minnesota, made the initial connection with Dr. Forson a year prior to her selection as an AARC International Fellow. His interaction with university, hospital, and government officials created valuable and necessary inroads. Michael Mensah, a Ghanaian RRT from Texas, traveled back to his homeland and dedicated a year of volunteer service at Korle Bu Teaching Hospital. His work demonstrated how RTs could make an impact on the care being provided to patients throughout the hospital.

Winds of change

Change takes time; and the introduction of a new profession in a developing nation is no exception. The individuals mentioned in this article have made the dream of developing the respiratory care profession in Ghana come to fruition. Through personal sacrifice and dedication, they have facilitated meeting the right people at the right time under the right circumstances. The winds of change are here and the development of respiratory therapy in Ghana has begun. ■

SOURCE

1. Paraphrased from the University of Ghana School of Allied Health Sciences curriculum proposal for a Bachelor of Science in Respiratory Therapy.

About the Author

Lisa M. Trujillo, DHSc, RRT, is the director of clinical education and the respiratory therapy department at Weber State University in Ogden, UT.

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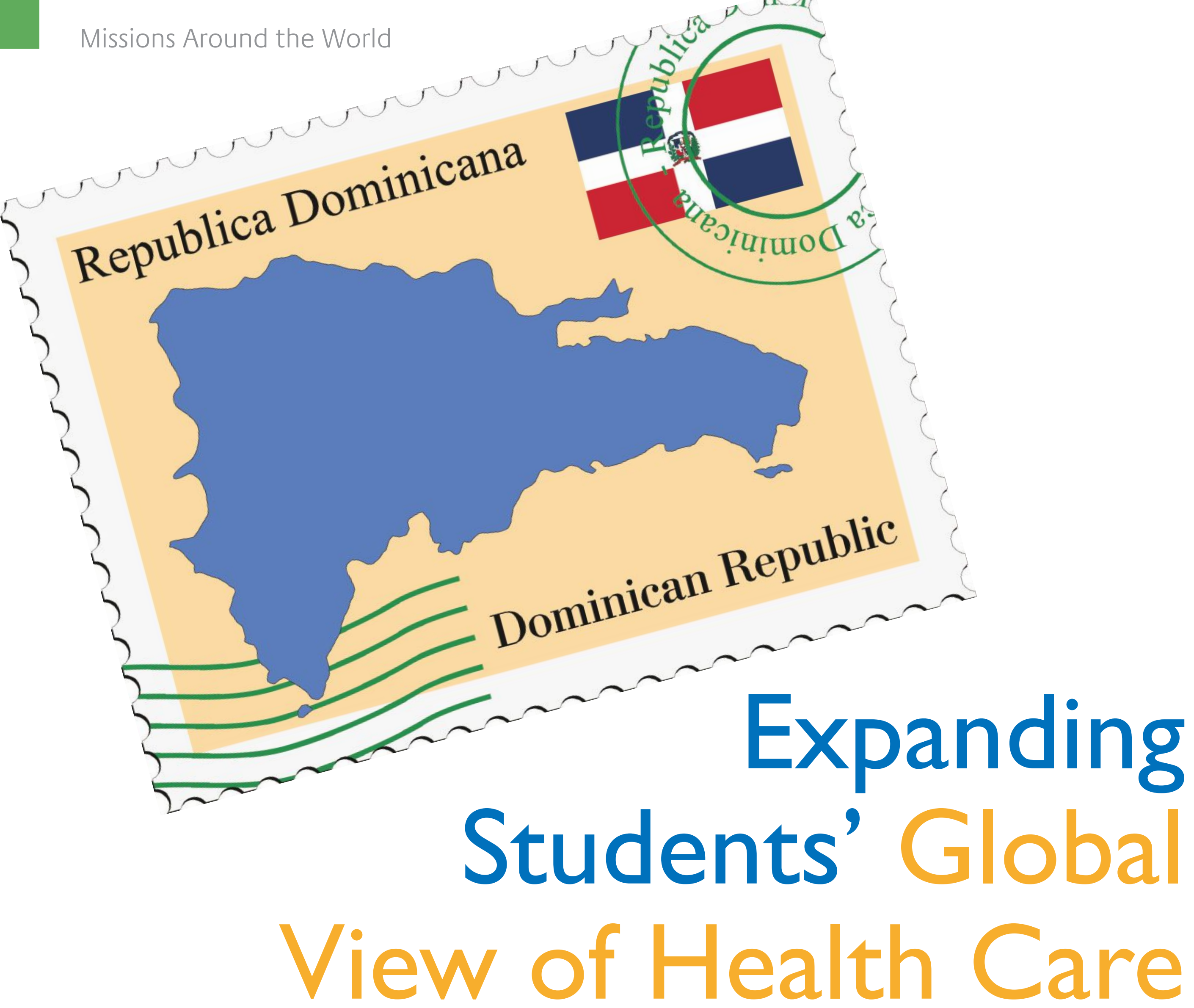

Expanding Students' Global View of Health Care

by Megan Koster, MHS, RRT

As a firm believer that respiratory care has evolved into a unique discipline that is integral to the health care team, I have searched for new opportunities and avenues in which I am able to apply my skills as a Registered Respiratory Therapist. One unique avenue that I believe remains relatively untapped by respiratory therapists is the area of medical mission travel. Over the course of four years, I have been fortunate to participate in several medical missions; but I consider it a mere "drop in the bucket" compared to what it could be. For years, I continued to struggle with how to bridge my love for medical mission travel and respiratory care on a larger scale, providing a truly meaningful impact on underserved populations of the world.

When I became an assistant clinical professor in the respiratory care department at Boise State University, it was soon apparent that my wonderful students would become my prospects to make a profound impact on the respiratory care profession. In May of 2012, a student hoping to be admitted to the respiratory care program approached me about her interest in medical mission work. I had just returned from a medical mission, and she was to travel on her first medical mission with a new organization later that year. She was interested in partnering with the organization by creating a student chapter at Boise State University and wondered if I would be willing to serve as the faculty advisor. Basically, she had me at "hello." After a semester of planning, recruiting, fundraising, and a touch of "red tape" navigation, we became a student organization. Meet TIMMY Global Health: Boise State Chapter!

TIMMY Global Health is a sustainable, non-profit organization that partners American universities with an underserved community abroad in an effort to provide

basic health care to the population. Students are responsible for partnering with licensed medical professionals, procuring medication to be used during the mission, and coordinating the logistics of the medical mission with the in-country contact. Boise State University is proud to be partnered with Banelino, a co-op of banana farmers in Monte Cristi, Dominican Republic.

In January 2013, our inaugural trip was only days away. Two respiratory care students, three pre-medical students, one bilingual education student, and one biomechanics major and I, the faculty advisor, packed our bags, headed to the airport, and flew south, ready to make our mark on the Dominican Republic.

When we touched down in Santiago, we met with a team of medical professionals also traveling with TIMMY. We were fortunate to work with three physicians, three nurse practitioners, a pharmacist, two registered nurses, an ultrasound technician, and a lab technician — all from Indianapolis, IN. Over the ensuing week, we visited five different communities of banana farmers, saw nearly 750 patients, performed 60 ultrasounds, and filled 47,000 prescriptions for people who have minimal access to medical care.

As an instructor, it can be difficult to give up control of a situation. However, at this level and in an environment such as this, learners do not need a lecturer spewing information — they need a facilitator of opportunity. I watched as my students transformed from a somewhat motley crew of individuals into functioning members of an interdisciplinary health care team. One of the Boise State pre-medical students performed his first set of sutures on a patient under the dutiful watch of the mission's head physician. I listened as a student who had never thought about the field of pharmacy speak about how intriguing the field was and how eager he was to learn more. I watched his face grow with excitement as he began to seriously contemplate a change of course. I surveyed with pride as my respiratory care students demonstrated what RTs do best: fill in the gaps. One moment, they ran the triage area, where they measured blood pressures, took temperatures, filled out growth charts, listened to breath sounds, and directed patient flow. The very next moment they were called over to pharmacy to provide education and instruction on a metered dose inhaler (MDI) or dry-powder inhaler. They worked with a physician to fashion an MDI spacer from an empty Tums bottle. They began to evaluate asthma management plans. They never hesitated to complete the next task. I literally watched my students turn into clinicians. Brick by brick, I saw the bridge being built.

One of the most unique attributes of TIMMY Global Health is that because they work with the community year round, they are able to track chronic disease. The organization is currently tracking four chronic diseases in this community: asthma, epilepsy, diabetes, and hypertension. This not only provides a continuum of care but also poses a familiar prospect faced by the American health care system: education and prevention. As the face of health care changes, it will be imperative that respiratory care adapts to those changes. What will the respiratory therapist's job look like in five years? Ten years?

Student Camille Stover helped initiate TIMMY Global Health at Boise State University.

I believe we will again do what we do best: fill in the gaps. That means we will be altering our perspective not just to provide the amazing care we've always provided, but also to look forward, step out of the proverbial "lecturer" role, and become the facilitator of patient education.

Medical missions are an inimitable experience for respiratory therapists and students alike to broaden their horizons about medical care. Working in this environment tailors a distinctive perspective of what it means to provide adequate access and delivery of health care resources, but perhaps most importantly, meets the need for superior health education, promotion, and literacy. These are the bridges that will need to be built for the respiratory care profession to maintain a distinct and highly relevant position at the forefront of a changing world of health care.

As for the more profound impact I've been looking for, I've learned through travel and especially this trip that perhaps instead of focusing on how big my "drop in the bucket" is, I should be looking forward as a facilitator. For every drop of encouragement and opportunity may create a ripple within a student; and within each student, the possibilities are endless waves of forward thinking. ■

About the Author

Megan Koster, MHS, RRT (in center photo), is assistant clinical professor in the Boise State University College Health Sciences Department of Respiratory Care in Boise, ID.

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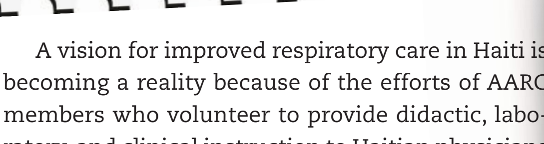
AARC Members Deliver Respiratory Care Training in Milot, Haiti

by Daniel D. Rowley, MSc, RRT-ACCS, FAARC



A vision for improved respiratory care in Haiti is becoming a reality because of the efforts of AARC members who volunteer to provide didactic, laboratory, and clinical instruction to Haitian physicians and nurses.

With learning materials donated from Susan Pilbeam, MS, RRT, FAARC, and respiratory therapy program directors from Central Virginia Community College, Mountain Empire Community College, Rush University, and Tarrant County College, registered respiratory therapists from eight states joined an educational mission to Milot, Haiti. They combined their knowledge and clinical expertise at different times over the course of one year to deliver a progressive respiratory care seminar curriculum at Hôpital Sacré Coeur in Milot. The chief executive officer of Hôpital Sacré Coeur selected 10 health care providers to attend pre-scheduled respiratory care seminar sessions that focused on these content areas:

- Cardiopulmonary anatomy and physiology
- Basic and advanced respiratory assessment
- Basic and advanced respiratory care therapeutics
- Neonatal, pediatric, and advanced life support
- Noninvasive and invasive mechanical ventilation.

As program administrators, Natalie Napolitano, MPH, RRT-NPS, FAARC, and I recognized a need to create a learning environment where students could readily apply what they were learning in the classroom to clinical practice. We scheduled classroom instruction in the morning and then offered laboratory sessions in the afternoon. Students had opportunities to develop team communication and clinical skills as they progressed through problem-based clinical simulations. During invasive and noninvasive mechanical ventilation laboratory sessions, for instance, it was clear that the students were actively engaged in the learning process because the learning environment shifted from passive to collaborative, enthusiastic interaction between the group members.

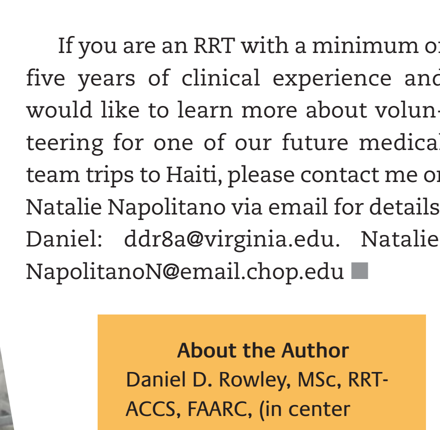
Following a full day of classroom and laboratory sessions, several of the students returned to work at the hospital. It was at this time when the Haitian health care staff was encouraged by U.S. trained respiratory therapy and physician staff to identify patients who might benefit from respiratory care interventions that we had presented during the respiratory care training seminars. During our mechanical ventilation seminar week, respiratory therapy volunteers were consulted by Haitian physicians who inquired about the appropriateness and practicality of applying noninvasive or invasive mechanical ventilation to patients presenting with respiratory distress. We assisted them with the application and management of a noninvasive ventilation interface that resulted in reversal of a patient's respiratory distress. Invasive mechanical ventilation was also applied to a patient with cerebral encephalopathy to protect the airway. They extubated the patient two days later.

The administration and staff at Hôpital Sacré Coeur are thankful to the respiratory therapy volunteers who have participated as instructors for the hospital-based respiratory care training seminars. They have a shared vision and dedication to improving patient care and outcomes. With continued assistance from AARC members serving as respiratory therapy volunteers, such as the ones listed in the accompanying sidebar, a shared vision will become a reality.

Students learned in a laboratory session on noninvasive ventilation.

AARC Members Serving as RT Volunteers in Milot, Haiti

- Jim Black, BS, RRT (New York)
- Ed Coombs, MA, RRT-NPS, ACCS (New York)
- Tabatha Dragonberry, BSRT, RRT-NPS, AE-C (Washington, DC)
- Bernato Lafleur, RRT (Massachusetts)
- Abby Motz, MSc, RRT-NPS (Ohio)
- Wes Mullins, MBA, RRT-NPS (Virginia)
- Natalie Napolitano, MPH, RRT-NPS, FAARC (Pennsylvania)
- Mike Purcell, MSc, RRT-NPS, RPFT (Texas)
- Daniel Rowley, MSc, RRT-NPS, FAARC (Virginia)
- Karen Schell, DHSc, RRT-NPS, RPFT (Kansas)
- Brandy Seger, MSc, RRT-NPS (Ohio)
- Richard Stairhime, MSc, RRT (Virginia)



If you are an RRT with a minimum of five years of clinical experience and would like to learn more about volunteering for one of our future medical team trips to Haiti, please contact me or Natalie Napolitano via email for details. Daniel: ddr8a@virginia.edu. Natalie: NapolitanoN@email.chop.edu ■

About the Author
Daniel D. Rowley, MSc, RRT-ACCS, FAARC, (in center wearing cap) is respiratory therapy supervisor in the Pulmonary Diagnostics and Respiratory Therapy Services Department at the University of Virginia Medical Center in Charlottesville, VA.

Class of respiratory care seminar students with Daniel Rowley, Richard Stairhime, Abby Motz, and Haitian staff interpreters. Far right: 2012 AARC International Fellow, Job Joseph, MD.

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Medical Missions: Opportunities for a Global Impact as an RT

by Dora Cardillo, BS, RRT-NPS, CPFT

Imagine flying alone into a developing country to join a team you've never met, to do your daily job as a respiratory therapist during your vacation time, to work with outdated equipment and a language barrier. All the rewards and challenges of being an RT are multiplied exponentially on medical missions.

So why go? Quite simply, I know the patients have life-threatening illnesses with no local resources to help them; and I can be part of their healing. I love critical care, and the Good Lord has given me opportunities I never dreamed of, such as cardiac surgery trips to Ukraine, Ecuador, and Peru with International Children's Heart Foundation (ICHF) and Cardiostart International, both outstanding programs.

Imagine having three infant cardiac surgery patients on ventilators and having the hospital suddenly run out of oxygen. Ventilator alarms going off and saturations dropping, the local resident tells you in Ukrainian, "We feex," and points to the clock to indicate this should happen in about 25 minutes. He then goes back to reading his book. On one mission, the 1970s German ventilator at the hospital suddenly started spewing water from the air hose

inlet. Someone forgot to empty the huge water trap for the hospital's compressor. The toddler on that ventilator was bagged by her own personal RT for hours until she woke up from surgery.

I wheezed on my first trip at the idea of using a Russian ventilator because I couldn't understand the alarm messages. By my second trip, I had used vents in Russian, German, Swedish, and even English. No sweat. Some mission situations may sound similar to our normal RT jobs, like being so busy that a bathroom break takes strategic planning.

Cardiac patients in developing countries are often sicker than you would expect because they have lived so long with their disease. I've seen school-aged children with saturations in the 60s and clubbed digits the size of grapes. Often, the adults present with three heart valves destroyed by rheumatic fever. Many times we dealt with pulmonary hypertension without nitric oxide; and regardless of the degree of hypoxemia, home oxygen is not an option in poor countries.

Here is the take-home message on medical missions: Everyone can contribute to impact people's lives abroad. Things you can do include:

- Save opened but unused disposables and organize a staff effort at your hospital to join you on this.
- Gather discards from your distribution department.
- Collect equipment from your biomed department and other donations to ship supplies to mission warehouses stateside.
- Sponsor a child's heart surgery through ICHF for $2,500.
- Or volunteer to go on a mission yourself.

The team members brainstorm constantly because the bottom line is we use any resources available and try not to focus on what's lacking. Despite the obstacles, most patients have impressive outcomes comparable to major medical centers in the United States.

Poverty is always difficult to see. Many families in Ecuador would sleep on the sidewalk outside the hospital waiting to have their children assessed by the team. I would take extra food from the hospital lunchroom to leave in the waiting room for people who had nothing

Russian Hamilton ventilator

to eat. In the end, being able to help a little is better than not helping at all, but it's still heartbreaking to witness.

The rewards are as extraordinary as the challenges. One Ukrainian hospital wouldn't allow parents in the pediatric ICU, so they waited anxiously in the post-op ward. I had the privilege of carrying three-year-old Maria out of ICU the day after her cardiac surgery. This beautiful girl with Down Syndrome snuggled her face into my neck and promptly melted my heart. Her mother was overjoyed at finally seeing her daughter and how well she looked. She expressed her gratitude by pointing to her heart and motioning toward me as she said "thank you" repeatedly in Ukrainian. Thank you from her heart.

I always take a portable photo printer with me. I gave one young mother a picture of her son; and she danced in circles, hugging the picture to her chest. It probably was her first picture of her one-year-old child. Can you imagine? These were very rich moments from this mom to those moms.

One stoic gentleman who had a huge tumor removed from his atrium in Peru told me that he wanted to visit us when the mission group returned. This was no small feat; he lived in a remote mountain village with significant poverty, but he wanted to bring us a gift from his village and to show us that he would follow our instructions diligently and be healthy when we saw him again. Best-case scenario: the patient does his part and we do ours.

Imagine being part of an incredible healing process for someone with a life-threatening diagnosis in a poor country, hoping for a miracle. It's an amazing opportunity. ■

About the Author

Dora Cardillo, BS, RRT-NPS, CPFT, is a staff therapist at St. Vincent Healthcare in Billings, MT. She is active in clinical care, flight, education, ACLS, and pulmonary diagnostics. She is also an adjunct faculty member at the University of Montana respiratory care program.

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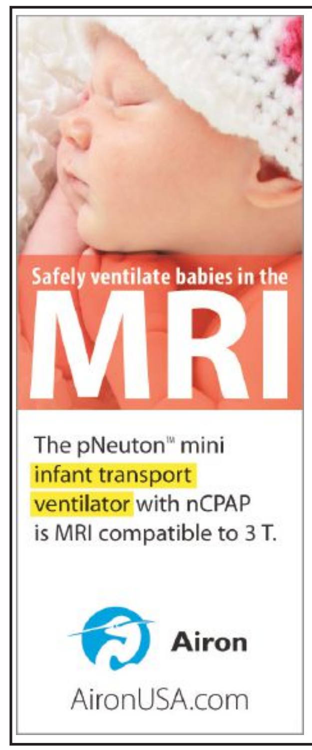

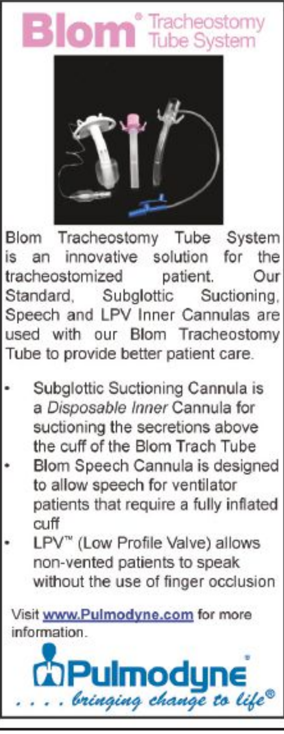

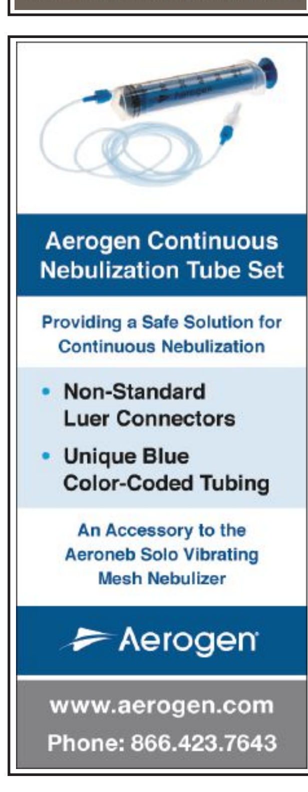

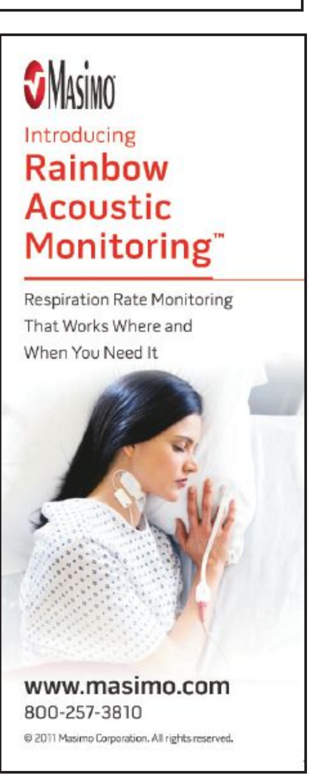

Press releases and photos on new products are welcome. Send to Marsha Cathcart, *AARC Times* editor, at cathcart @aarc.org.

Nasal Mask

The Eson™ nasal mask from Fisher & Paykel Healthcare Corporation features three simple components — the RollFit™ Seal, ErgoFit Headgear, and Easy Frame — that work in harmony to deliver comfort, seal, and ease of use for the patient. As the name suggests, the RollFit seal rolls back and forth on the bridge of the nose, minimizing pressure on the nasal bridge without the need for complicated T-piece adjustments. www.fphcare.com

CO_2 Detection Device

The new and improved StatCheckII™ from Vortran Medical offers clinical advantages such as the ability to be pre-attached and ready for instant use, thus improving compliance. It may also be left attached to continuously monitor any risk of tube migration during resuscitation and is quick and simple to deploy. To activate, simply turn the cap clockwise to tighten, and then remove it. www.vortran.com

Cuffless Neonatal-Pediatric Trach Tubes

Covidien's new Shiley™ cuffless neonatal and pediatric tracheotomy tubes offer an expanded range of tube sizes down to a 2.5 mm inner diameter to accommodate the smallest patients — an option that hasn't previously existed in the Shiley portfolio. A soft, clear flange facilitates easier examination of the underlying skin for infection and eases trach-tube holder insertion. The tubes are manufactured with a medical grade PVC with a citric-based, non-phthalate plasticizer to meet the latest patient safety standards. www.covidien.com/rms

New Suctioning Accessory

NJR Medical Inc.'s No-Bite V™ is revolutionizing suctioning around the world by avoiding the nasal pathway altogether. Invented by a registered nurse after he was bit by an AIDS- and hepatitis C-positive patient during suctioning, the No-Bite V™ is a multipurpose insertion accessory for oral and nasal medical devices that helps to improve safety, comfort, and efficiency. The device was featured in a recent edition of "Health Briefs with Terry Bradshaw." www.njrmedical.com

Portable, Battery-operated Vest

As the first-ever portable, battery-operated high-frequency chest wall oscillation vest, the AffloVest from International Biophysics Corporation allows users to move about freely during treatments. Weighing approximately 10 pounds, AffloVest is also the lightest and most quiet device of its kind on the market today, and it provides adjustable levels of treatment intensity along with settings that allow for treatment on both the front and back of the vest. AffloVest is available in a full range of sizes to serve both children and adults. www.AffloVest.com

Nasal Mask

Sleepnet Corporation's Innova Nasal Mask is the latest addition to the DeVilbiss Heathcare interface line. The mask's AIR°gel™ cushion with Advanced Cushion Technology™, coupled with the Active Headgear Connector™ feature, provides optimal fit, maximum comfort, and freedom to move without breaking the seal. The mask also incorporates the unique Touchless Spacebar™ design, which eliminates any contact with the patient's forehead. www.DeVilbissHealthcare.com

Make Your Voice Heard in Washington at www.AARC.org/Advocacy

RC Currents

IN THE NEWS

AARC Election Results

Voting in AARC Elections 2014 ended on Oct. 1, and President George Gaebler, MSEd, RRT, FAARC, has announced the results. The results of this year's officers and directors election is:

- President-Elect: Frank Salvatore, MBA, RRT, FAARC
- Directors-at-Large: Bill Lamb, BS, RRT, CPFT, FAARC; Karen Schell, MHSc, RRT-NPS, RPFT, RPSGT, AE-C, CTTS; and Cynthia White, MS, RRT-NPS, FAARC.

Four AARC Specialty Sections held elections, and the chair-elects are: Adult Acute Care: Keith Lamb, RRT-ACCS; Diagnostics: Katrina Hynes, BAS, RRT, CPFT; Education: Ellen Becker, PhD, RRT-NPS, RPFT, AE-C, FAARC; and Management: Cheryl Hoerr, MBA/HCM, RRT, CPFT, FAARC. ■

Steven Nelson Named ISSA Senior Member

Steven B. Nelson, MS, RRT, FAARC, an associate executive director for the AARC, was named a Senior Member by the Information Systems Security Association (ISSA). ISSA is the community of choice for international cybersecurity professionals dedicated to advancing individual growth, managing technology risk, and protecting critical information and infrastructure.

Steven Nelson

Senior Member honors established cybersecurity professionals with 10 or more years of experience for their contributions to the security community and commitment to the mission of the association.

"We are pleased that Steve brought his years of experience to the AARC. He used his background as a security architect, along with his knowledge of the unique needs of the respiratory therapy profession, to create a path to secure our online services," says Thomas J. Kallstrom, MBA, RRT, FAARC, executive director and CEO of the AARC. "He has significantly improved the security of the information that is vital to our Association." ■

Resources for Using the Strategic National Stockpile Ventilator Assets

The AARC has partnered with the Centers for Disease Control and Prevention's Strategic National Stockpile (SNS) to provide necessary resources for the respiratory therapist to prepare for mechanically ventilating a large population during a public health emergency. Information is provided for the three ventilators in the SNS: the LP10 (Covidien), the LTV1200 (CareFusion), and the Uni-vent Eagle 754 (Impact Instrumentation). In addition to ventilator-specific information from the manufacturers, we have provided educational information for RTs and for the cross-training of respiratory therapy extenders for medical emergencies.

View resource videos at www.aarc.org/resources/sns_vent_training/. ■

"New Members" Column Now Online

The "New Members" column can now be accessed at www.AARC.org/new_members. Current AARC members are encouraged to check this site on the first of each month to view the names of individuals who have been approved as "Active Members" of the Association. Any current member may object to a new membership by filing a written objection with the AARC Executive Office at info@aarc.org within 30 days. ■

Ensure Your Clinical Preceptor Program Meets Today's Standards

This new AARC course has everything you need as a respiratory care manager or department educator to provide standardized training for your hospital's preceptor staff. Deliver the training one-on-one, in a group setting, or both. You'll have 365 days of access to:

- Four online modules addressing adult learning, understanding the learning context, the challenging trainee, and handling feedback
- Four online instructional videos with additional scenario videos containing multiple examples of effective and ineffective preceptor behaviors
- Two online videos demonstrating student performance for standardizing preceptor evaluation
- Downloadable workbooks and handouts for preceptors
- Downloadable course management documents for respiratory manager/department educator.

Authored by faculty from The Ohio State University, this course correlates with the CoARC standards for inter-rater reliability. Successful completion of the course (video and workbook) and testing earns two CRCE® credits. For more information, log on to www.aarc.org/education/clinical_pep/. ■

Respiratory Care Education Annual Call for Papers

The AARC will publish Volume 23 of the "Respiratory Care Education Annual" in the fall of 2014. This refereed journal is committed to providing a forum for research and theory in respiratory care education and is listed in the "Cumulative Index to Nursing and Allied Health Literature."

The AARC Education Section invites educators to submit papers for consideration. Preference will be given to papers that emphasize original research, applied research, or evaluation of an educational method. Other topics that may be considered include interpretive reviews of literature, educational case studies, and point-of-view essays. Submissions will be reviewed based on originality, significance and contribution, soundness of scholarship (design, instrumentation, data analysis), generalizability to the education community, and overall quality of the paper. Papers should be approximately 6–10 pages in length and **must** follow the guidelines in the "Uniform Requirements for Manuscripts Submitted to Biomedical Journals," 5th edition (1997). These may be found at www.rcjournal.com/guidelines_for_authors/preparing_the_manuscript.cfm. Abstracts should not exceed 250 words. For more information, contact Dennis Wissing, PhD, RRT, FAARC, editor, at dwissi@lsuhsc.edu or (318) 573-9788. Electronic copies of completed manuscripts should be sent to Shawna Strickland at edu@aarc.org. Deadline is Feb. 15, 2014. ■

Respiratory Care Education Annual

The American Association for Respiratory Care

Volume 22 — Fall 2013

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100% NPS!

Leonile Kitnurse, MBA, RRT-NPS, with seven-year-old patient.

As of this fall, there were 11,762 respiratory therapists across the nation who had earned the Neonatal-Pediatric Specialist (NPS) credential from the NBRC. If you consider there are about 5,700 hospitals nationwide, that averages to about two NPS-credentialed RTs at every facility. Of course, not all hospitals treat children, and children's hospitals likely have more than their fair share — but it's likely that few have met the standard reached earlier this year by Children's Medical Center in Dallas, TX. All 180 RTs on staff are now proudly displaying the "NPS" behind their names.

"Our leadership team decided to pursue this accomplishment, with a goal of elevating our practice to better serve our specialty population," says Kristen Hood, RRT-NPS, clinical educator for the department. When the effort kicked off in mid-2012, about 70 staff members already held the credential; and many of them played an integral role in helping the remaining staff members prepare for the exam.

"Several of our previously NPS-credentialed staff organized study groups to assist their colleagues in preparing for the exam, and 'colleague to colleague' discussions about exam content occurred on nearly every shift," says Hood. Staff also shared the results of practice exams and, after sitting for the test, would go over specific questions and research the correct answers so their peers would be prepared when their turn came to head to the exam center. "Each week, to inspire the therapists, our leadership team announced those who passed the exam the previous week," notes the educator. "Some weeks we had as many as five therapists pass."

"An unexpected outcome is the camaraderie that grew out of this pursuit," says Hood. "Not only is our staff more adept at dealing with neonatal and pediatric patients, but they relate to each other and communicate better." She hopes the success her hospital has had with the NPS credential will inspire other respiratory therapy departments to go after a 100% specialty credentialing goal of their own. "The goal is great, but the journey is beautiful!" says the AARC member. ■

All 180 respiratory therapists on staff at Children's Medical Center have earned their NPS credentials. Shown here are the day staff members.

Call for Open Forum Abstracts for AARC Congress 2014

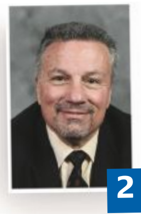
The AARC invites you to submit abstracts for the Open Forum at AARC Congress 2014. Considered by many to be the premier event at the AARC Congress, the Open Forum is your opportunity to gain recognition for your research in cardiorespiratory care by submitting an abstract for presentation at the Congress and having it published in Respiratory Care. New in 2014: three different ways you can present your poster at AARC. For more details, see http://rc.rcjournal.com/site/open_forum/2014_call_for_abstracts.xhtml/. The deadline to submit abstracts for the Open Forum is June 1. ■

Honoring Military RTs

If you are an AARC member currently serving your country in the military, *AARC Times* would like to publish a story and photo about your service or deployment. Please contact *AARC Times* Editor Marsha Cathcart (cathcart@aarc.org) to provide information for an "RC Currents" story. The AARC honors those who serve, and we would like to share your story with your respiratory care colleagues here and abroad ■

▶ Transitions

Frank Salvatore, Jr., MBA, RRT, FAARC, has received the John and Louise Julius Award for Outstanding Practitioner from the Connecticut Society for Respiratory Care. Salvatore is director of respiratory services, the sleep disorders center, and the wound care center at Orange Regional Medical Center in Middletown, NY. He was recently elected AARC president-elect. (Photo 1)



Michael T. Amato, MBA, has been named as CEO of InspiRx Pharma, a New Jersey-based company. Previously, he has been president of a startup drug and device company located in Durham, NC. Amato has been involved in the respiratory industry for almost 40 years. He has served on the Board of Trustees for the American Respiratory Care Foundation for over 20 years and is its current chairman. (Photo 2)

Harold Oglesby, RRT, has received the 2013 St. Joseph's/Candler Lientz Award from St. Joseph Hospital in Savannah, GA. The award is given annually to reflect the humanitarian efforts of former Candler Hospital board chair and community activist the late James R. Lientz. Oglesby was honored for his work with at-risk students and the 100 Black Men of Savannah organization, along with the inspirational leadership he provides to his staff as manager of the RC department.

Donna Smith, BA, CRT, was honored with the Industry Excellence Award from the Wisconsin Association of Medical Equipment Services for her work on the organization's respiratory committee. Smith serves as director of respiratory care at Home Care Medical, Inc. in New Berlin, WI.

Henry Oh, PhD, RRT, has received the Master Teacher of Honor Award from Kappa Delta Pi, the International Honor Society in Education. Dr. Oh is associate professor and director of the RT program at San Juan College in Farmington, MN, and chair of the New Mexico Respiratory Care Licensure Board. He is also an executive board member of the National Lambda Beta Honor Society for Respiratory Care.

You can submit news about AARC members by going to www.AARC.org/transitions. ■

Patient Advocate Terrie Hall Passes Away

Cancer patient Terrie Hall, who was featured in several Centers for Disease Control and Prevention public service announcements about the dangers of smoking, finally succumbed to her disease last fall. Hall was known for her touching and honest portrayals of life after a smoking-related cancer diagnosis. In one ad (www.youtube.com/watch?v=5zWB4dLYChM) she was seen putting on a wig, putting in dentures, and then covering her artificial voice box with a scarf so she could begin her day. ■

Lung Screening in the Wake of Superstorm Sandy

John Hill discusses respiratory symptoms with a member of the community who attended one of the Deborah Heart and Lung Center screenings.

Superstorm Sandy left a wide swath of destruction when it hit the East Coast in October of 2012; and the Deborah® Heart and Lung Center in Pemberton Township, NJ, recognized from the outset that residents, first responders, contractors, and emergency cleanup crews may have been exposed to a number of toxic substances that could cause or worsen respiratory problems.

"The Deborah Hospital Foundation did some research on disaster-related health issues and decided it would be beneficial to be proactive and put together an outreach screening program to identify those who might have been affected by Sandy," says RT Department Director John Hill, RRT-NPS. The foundation applied for a grant from the Robin Hood Foundation to help fund the effort and was pleased to receive $625,000 to put the program together. As the manager in charge of pulmonary function testing and the auscultation of the lungs, Hill was integrally involved in the planning and implementation process.

"In the beginning, we had to figure out everything from scratch, since this was a new program," says Hill. After settling on a name — the group came up with "RESP" to stand for the "Respiratory Evaluations for Sandy Program" — he and his colleagues decided the best way to get to the people who needed the screening was to partner with other organizations in the area that were already working with storm victims. "These include the Long Term Recovery Groups of Ocean and Monmouth Counties, churches, municipal governments, nonprofit groups like the Salvation Army, and local food pantries," continues the AARC member. Those groups helped the RESP leaders find locations within the community to host the screenings and to take appointments over the phone to minimize wait times on the day of the event.

As of early fall, RESP had screened about 500 people at several events, and the group was hoping to have screened 1,000 by the end of November. Hill says seven of his RTs have stepped forward to work at the screenings and have appreciated the chance it has given them to give back to their community. "Many of the therapists live in the areas that were damaged, and they feel a deep sense of commitment to helping our neighbors and being part of a health and well-being project that can really make a difference," he says.

In addition to the lung function screenings, the group is offering blood pressure and pulse oximetry checks to help uncover any cardiac problems that may have stemmed from the stress people have been under since the storm. Among the first group of 345 who were screened, 14% were referred for further care; but that jumped to 30% for the next group of 140, an increase Hill attributes to their living closer to the most severely damaged areas.

The group is collecting ongoing data on the people it screens to report back to the Robin Hood Foundation as well as other organizations, including the New Jersey State Department of Health, that are attempting to ascertain the health implications of the storm. Hill says it will be some time before any final conclusions can be drawn. "At this point, we are not speculating at all that these referrals are purely Sandy-related, as there could be prior histories of asthma, smoking, or COPD, for example," he says. "We are trying to be very careful not to jump to any conclusions about what we are finding out."

Still, he believes the program is helping to identify problems that may have been caused by Sandy, and the people who have taken part in the screenings have been overwhelmingly appreciative of the testing. "Those who have been given a clean bill of health are given a sense of relief and peace of mind," he says. "I've heard several say, 'It's just a post-nasal drip, or just a cough — I'm so glad it's nothing worse.'"

Individuals who have gotten less-positive reports are also grateful to know their symptoms may be an indication of something that can be treated. "Those whom we've encouraged to seek follow-up testing are very thankful that, whatever the issue may be, the problem was detected early." ■

Smoking Lingers on the Family Tree

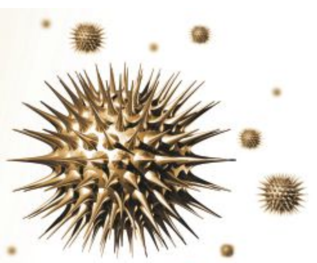
A new study out of the Los Angeles Biomedical Research Institute at Harbor-UCLA Medical Center suggests cigarette smoking may leave a long and deadly legacy in families where women smoke during pregnancy. Working in a mouse model, they found grandchildren, and even great-grandchildren, of mice exposed to nicotine while pregnant were at higher risk of developing asthma, even though they were never exposed to nicotine themselves.

The research compared outcomes for mice with grandmothers or great-grandmothers that received a dose of nicotine injected under their skin daily starting when they were six days pregnant until 21 days after they gave birth. These mice were compared with those whose ancestors received a daily placebo injection over the same time period.

The investigators aren't sure how smoking increases asthma risk down the generations but speculate it may influence which genes are turned on or off in offspring, including genes in their sperm and eggs. These genes can be passed down from generation to generation, upping asthma risk for future generations. The study was published online ahead of print by the *American Journal of Physiology-Lung Cellular and Molecular Physiology* in September. ■

▶ Strange But True…

Artificial lung: Using respiratory anatomy found in nature as their model, University of California, Irvine investigators have come up with a new way to filter carbon dioxide from the smokestacks of electrical power plants. The unit consists of an array of tubes made from porous membranes fitted side-by-side, much like blood vessels in a natural lung.



Hurtful bacteria: The immune system isn't the only thing responsible for causing pain in the body, report Boston researchers in *Nature*. They found bacteria have a direct effect on nerves that sense pain, making it possible for them to trigger the pain sensation before immune cells even arrive on the scene.

CO for preeclampsia? Canadian researchers may have figured out why women who smoke during pregnancy have about a 33% lower risk of developing preeclampsia, and it's all about their increased exposure to carbon monoxide. In a mouse study, animals exposed to inhaled CO while pregnant exhibited increased vessel diameter, a significant increase in the number of radial artery branches, and significantly higher maternal blood flow. (*American Journal of Physiology*) ■

Simple Pre-Surgery Tobacco-Cessation Program Works

Studies show patients recover from surgery more easily if they quit smoking before undergoing the procedure. But how to best encourage these patients to quit has yet to be determined.

New research from Canadian investigators is helping to shed some light on the issue. They found a simple four-part intervention led to considerably higher quit rates when compared to no intervention: 14% versus 4%. The intervention consisted of:

- A brief (under five minutes) counseling session
- Brochures on smoking cessation
- Referral to a quit-smoking hotline
- A six-week supply of nicotine patches provided at no cost to the patient.

Patients who quit smoking before surgery were released from the recovery room sooner than those who didn't. Among those who took part in the intervention, smoking cessation was more likely to be sustained as well. Thirty days after surgery, 29% of patients assigned to the quit-smoking program reported they were still refraining from smoking versus 11% of initial quitters in the placebo group. The study appeared in the September edition of *Anesthesia & Analgesia*. ■

Bikers Ride Hard, Breathe Easy

Riders mount up for the 100-mile course.

Respiratory therapy students at Cincinnati State Technical and Community College in Ohio looked past the typical bake sale for their fundraising event this year and instead decided to rev up their engines for the first-ever Ride2Breathe motorcycle event.

"In the spring of 2013, one of our students, Brandon Evans, conceptualized the idea of a motorcycle ride as a fundraiser for the Respiratory Care Club and to raise awareness for COPD," explains Julie Klensch, BS, RRT, an instructor with the program. "When he presented it to the club for the first time, most everyone was excited to be a part of it and began helping." The planning process itself proved to be a real education for her RC students.

A long-time motorcycle enthusiast himself, Evans began by finding a local Quaker Steak & Lube restaurant that was willing to serve as the starting point for the event and then developed a website and Facebook page to advertise it to the community. The AARC member also designed the nearly 100-mile route, and police departments along the way were notified that the riders would be coming through their territory.

Since the club wanted to use the school logo in conjunction with the event, students also had to acquire permission from the college; and a contract between the school and the restaurant was developed and signed. From there, club members tackled everything from advertising to recruitment of riders. The former involved coming up with the name for the event, along with a slogan (Ride Hard, Breathe Easy), while the latter involved networking with local motorcycle groups through weekly "Bike Nights" and other activities. A poster was created to advertise the event to local respiratory care departments, and donations were collected to cover the cost of raffle baskets and to help offset

Riders could purchase raffle tickets based on the length of their cycles — AARC member Jaclyn Price helps one of the riders measure a bike to see how many tickets it would bring in.

AARC member Kyle Barrow (left) and Janie Wahnbaeck sell "Ride Hard, Breathe Easy" t-shirts.

the cost of the event. A band was recruited to play in the afternoon, and t-shirts were printed.

While a key goal of the fundraiser was to help students offset the cost of attending AARC Congress 2013 in Anaheim, COPD awareness remained at the forefront throughout the planning process. "A group of six students developed an educational poster on COPD evidence to display during the event," says Klensch. "The Midland, OH, American Lung Association offered to send a representative with whatever educational materials we needed for the day, and the students chose to partner with the COPD Foundation as well." AARC COPD Coordinator Jason Moury, BS, RRT, provided them with DRIVE4COPD screeners, educational materials, and giveaways. "We couldn't have asked for better support from these two organizations," says the educator.

Klensch says the students were naturally nervous as they gathered in the restaurant parking lot at 7 a.m. on Sept. 7, but soon relaxed as their riders started showing up and the fun got underway. "As the fog lifted and the weather began warming up, Quaker Steak looked as if a party was going on," says the AARC member. "We raised $1,575 through registrations, raffle tickets, and split-the-pot ticket sales, t-shirt sales, and Quaker Steak proceeds. After all expenses were paid and a $68 donation was given to the COPD Foundation, the club netted a profit of $633."

Perhaps most importantly, a number of people were screened for COPD, and everyone learned more about this chronic lung condition. "COPD awareness is important to these students, enough to sacrifice an extraordinary amount of time, trying to make a difference," says their instructor. "They have a passion for lung disease awareness, and we couldn't be prouder." ■

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 lifesaving event outside the hospital setting or experienced something that took your breath away. Whatever the story, we are interested in seeing it.

If you have a story to tell, please contact *AARC Times* Editor Marsha Cathcart at cathcart@aarc.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! ■

Classifieds

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United States

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Biomedical Electronics Services & Technologies (B.E.S.T), servicing the greater Chicagoland area and surrounding states for over 40 years, is expanding its service areas to new markets. B.E.S.T represents numerous medical and biomedical manufacturers, offers state-certified medical gas testing/certification, and repairs/rents/sells durable medical equipment. B.E.S.T is looking for an experienced, self-motivated sales force for both part-time and full-time positions throughout the United States. Previous sales experience a plus but will consider applicants with a good work record and enthusiasm. If interested, please send a resume to info@ebestonline.com or call Linn at (888) 495-1300 x102.

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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 respiratory 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 December 17. Blind ads available. **For Recruitment Advertising Information, Contact Classified Advertisement** Andrea Conté • 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 www.aarc.org/marketplace/media_kit/recruitment_2013.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

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Anaheim, CA
AARC Congress 2013
Contact: AARC, (972) 243-2272, www.aarc.org/education/meetings

December 5–6
Springfield, MO
MSRC's 9th Annual Fall Specialty Conference
Contact: Christopher Cox, (417) 659-6590

May 1–3
Scottsdale, AZ
AARC's and the American Sleep & Breathing Academy's Sleep & Wellness 2014: A Conference for Professionals
Contact: www.americansleepandbreathingacademy.com

Submissions for the next available issue are due Dec. 19.

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

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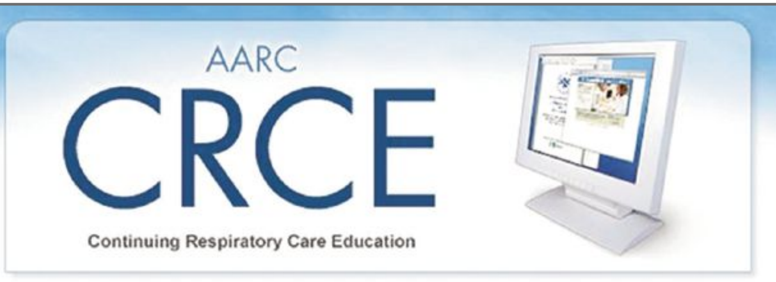

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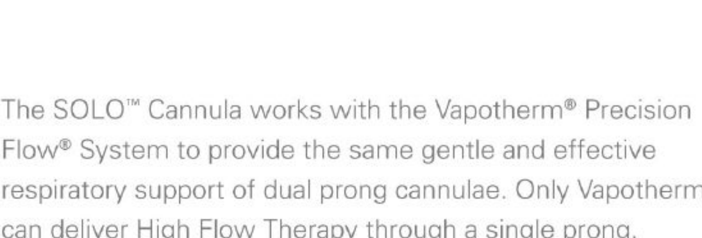

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