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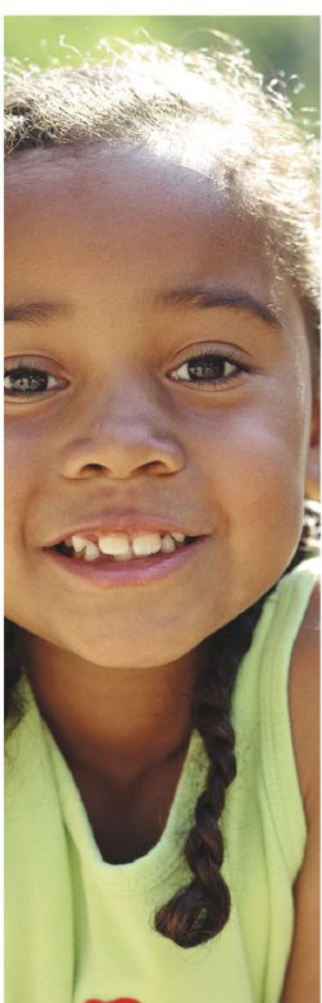

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AARC Strategic Plan

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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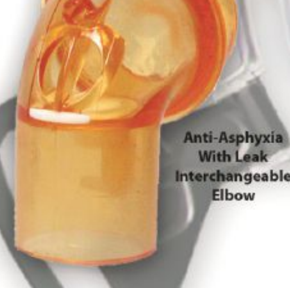

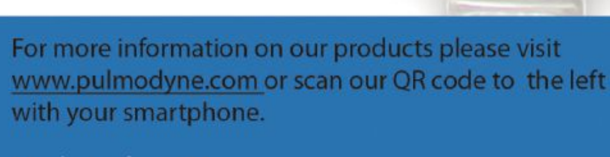

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INDICATION

SURFAXIN® (lucinactant) Intratracheal Suspension is approved by the FDA for the prevention of respiratory distress syndrome (RDS) in premature infants at high risk for RDS.

IMPORTANT SAFETY INFORMATION

SURFAXIN (lucinactant) Intratracheal Suspension is intended for intratracheal use only. The administration of exogenous surfactants, including SURFAXIN, can rapidly affect oxygenation and lung compliance. SURFAXIN should be administered only by clinicians trained and experienced with intubation, ventilator management, and general care of premature infants in a highly supervised clinical setting. Infants receiving SURFAXIN should receive frequent clinical assessments so that oxygen and ventilatory support can be modified to respond to changes in respiratory status.

Most common adverse reactions associated with the use of SURFAXIN are endotracheal tube reflux, pallor, endotracheal tube obstruction, and need for dose interruption. During SURFAXIN administration, if bradycardia, oxygen desaturation, endotracheal tube reflux, or airway obstruction occurs, administration should be interrupted and the infant's clinical condition assessed and stabilized. Overall the incidence of administration-related adverse events did not appear to be associated with an increased incidence of serious complications or mortality relative to the comparator surfactants.

SURFAXIN is not indicated for use in acute respiratory distress syndrome (ARDS).

For more information about SURFAXIN, please visit **www.SURFAXIN.com** and see accompanying brief summary on the next page.

MK-100A

BRIEF SUMMARY OF PRESCRIBING INFORMATION

Please see package insert for full prescribing information.

INDICATIONS AND USAGE

SURFAXIN® is indicated for the prevention of respiratory distress syndrome (RDS) in premature infants at high risk for RDS.

CONTRAINDICATIONS

None.

WARNINGS AND PRECAUTIONS

Acute Changes in Lung Compliance

Administration of exogenous surfactants, including SURFAXIN, can rapidly affect lung compliance and oxygenation. SURFAXIN should be administered only by clinicians trained and experienced in the resuscitation, intubation, stabilization, and ventilatory management of premature infants in a clinical setting with the capacity to care for critically ill neonates. Infants receiving SURFAXIN should receive frequent clinical assessments so that oxygen and ventilatory support can be modified to respond to changes in respiratory status.

Administration-Related Adverse Reactions

Frequently occurring adverse reactions related to the administration of SURFAXIN include bradycardia, oxygen desaturation, reflux of drug into the endotracheal tube (ETT), and airway/ETT obstruction.

Increased Serious Adverse Reactions in Adults with Acute Respiratory Distress Syndrome (ARDS)

Adults with ARDS who received lucinactant via segmental bronchoscopic lavage had an increased incidence of death, multi-organ failure, sepsis, anoxic encephalopathy, renal failure, hypoxia, pneumothorax, hypotension, and pulmonary embolism. SURFAXIN is not indicated for use in ARDS.

Clinical Trials Experience

The efficacy and safety of SURFAXIN for the prevention of RDS in premature infants was demonstrated in a single randomized, double-blind, multicenter, active-controlled, multi-dose study involving 1294 premature infants (Study 1). Infants weighed between 600 g and 1250 g at birth and were 32 weeks or less in gestational age. Infants were randomized to received 1 of 3 surfactants, SURFAXIN (N = 524), colfosceril palmitate (N = 506), or beractant (N = 258). Co-primary endpoints were the incidence of RDS (defined as having a chest x-ray consistent with RDS and an $FiO_2 \geq 0.30$) at 24 hours and RDS-related mortality at 14 days. The primary comparison of interest was between SURFAXIN and colfosceril palmitate with the intent of demonstrating superiority. Beractant served as an additional active comparator. Compared to colfosceril palmitate, SURFAXIN demonstrated a statistically significant improvement in both RDS at 24 hours and RDS-related mortality through Day 14. A second multicenter, double-blind, active-controlled study involving 252 premature infants was also conducted to support the safety of SURFAXIN (Study 2). Infants weighed between 600 g and 1250 g and were less than 29 weeks in gestational age. Infants received 1 of 2 surfactants, SURFAXIN (N = 119) or poractant alfa (N = 124).

The safety data described below reflect exposure to SURFAXIN administered intratracheally to infants at a dose of 5.8 mL per kg (up to 4 doses) in either 4 aliquots (Study 1) or 2 aliquots (Study 2) in 643 premature infants.

Comparator surfactants colfosceril palmitate and beractant were administered at the recommended doses (5.0 and 4.0 mL per kg, respectively) while the first dose of poractant alfa administered (2.2 mL per kg) was less than the recommended dose of 2.5 mL per kg. Any subsequent doses of poractant alfa were at the recommended 1.25 mL per kg dose.

Overall, the incidence of administration-related adverse reactions was higher in infants who received SURFAXIN compared to other surfactants (Table 1) and resulted in a greater proportion of infants treated with SURFAXIN who experienced administration-related oxygen desaturation and bradycardia. For Study 1, oxygen desaturation was reported in 17%, 9%, and 13% and bradycardia for 5%, 2%, and 3% of infants treated with SURFAXIN, colfosceril palmitate, and beractant, respectively. For Study 2, oxygen desaturation was reported in 8% and 2% and bradycardia in 3% and 2% of infants treated with SURFAXIN and poractant alfa, respectively. These adverse reactions did not appear to be associated with an increased incidence of serious complications or mortality relative to the comparator surfactants (Table 2).

Table 1. Administration-Related Adverse Reactions in SURFAXIN Controlled Clinical Studies[a]

	Study 1[b]			Study 2[c]	
	SURFAXIN (N = 524)	**Colfosceril palmitate (N = 506)**	**Beractant (N = 258)**	**SURFAXIN (N = 119)**	**Poractant alfa (N = 124)**
Total Doses Administered	994	1038	444	174	160
	Total Number of Events (Events per 100 Doses)				
ETT Reflux	183 (18)	161 (16)	67 (15)	47 (27)	31 (19)
Pallor	88 (9)	46 (4)	38 (9)	18 (10)	7 (4)
Dose Interruption	87 (9)	46 (4)	30 (7)	7 (4)	2 (1)
ETT Obstruction	55 (6)	21 (2)	19 (4)	27 (16)	1 (1)

[a] Table includes only infants who received study treatment.
[b] Study 1 doses were administered in 4 aliquots.
[c] Study 2 doses were administered in 2 aliquots.

Table 2. Common Serious Complications Associated with Prematurity and RDS in SURFAXIN Controlled Clinical Studies Through 36-Weeks Post-Conceptual Age (PCA)

	Study 1			Study 2	
	SURFAXIN (N = 527) %	**Colfosceril palmitate (N = 509) %**	**Beractant (N = 258) %**	**SURFAXIN (N = 119) %**	**Poractant alfa (N = 124) %**
Apnea	52	52	46	66	75
Intraventricular hemorrhage, all grades	52	57	54	39	38
-Grade 3/4	19	18	21	13	8
Periventricular leukomalacia	10	10	12	4	9
Acquired sepsis	44	44	44	45	52
Patent ductus arteriosus	37	35	37	43	44
Retinopathy of prematurity, all grades	27	26	25	32	31
-Grade 3/4	6	7	6	5	9
Necrotizing enterocolitis, all grades	17	17	19	13	15
-Grade 2/3	6	8	14	8	8
Pulmonary air leak through Day 7, all types	15	17	14	9	7
-Pulmonary interstitial emphysema	9	10	10	3	5
-Pneumothorax	3	4	2	4	1
Pulmonary hemorrhage	10	12	14	6	9

All-cause mortality through 36-weeks PCA was similar regardless of which exogenous surfactant was administered.

Adverse reactions reported in the controlled clinical studies through 36-weeks PCA occurring in at least 10% of infants were anemia, jaundice, metabolic acidosis, oxygen desaturation, hyperglycemia, pneumonia, hyponatremia, hypotension, respiratory acidosis, and bradycardia. These reactions occurred at rates similar to the comparator surfactants.

No assessments for immunogenicity to SURFAXIN were performed in these clinical studies.

Follow-up Evaluations

Twelve-month corrected-age follow-up of 1546 infants enrolled in the 2 controlled clinical studies demonstrated no significant differences in mortality or gross neurologic findings between infants treated with SURFAXIN and those treated with the comparator surfactants (colfosceril palmitate, beractant, or poractant alfa).

OVERDOSAGE

There have been no reports of overdose following the administration of SURFAXIN.

HOW SUPPLIED/STORAGE AND HANDLING

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To report SUSPECTED ADVERSE REACTIONS, contact Discovery Laboratories, Inc. at 1-877-SURFAXN (877-787-3296) or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

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Ensuring Hemodynamic Harmony in ARDS Patients

by Carl R. Hinkson, MS, RRT-ACCS, FAARC

The management of circulation is a fundamental skill in all critical care settings to ensure adequate tissue perfusion, especially of the brain and heart. The inclusion of positive pressure ventilation can greatly increase the complexity of managing blood pressure. Acute respiratory distress syndrome (ARDS) can further complicate the clinical picture of circulation management because of the alterations in lung pathophysiology.[1]

Since being described in 1967, there have been relatively few advances for ARDS patients. The most significant discovery in reducing the mortality of ARDS came in 2000 with the targeting of tidal volumes to 6–8 mL/kg of predicted body weight.[2] In ARDS (as with all critical illness), the goal of oxygenation and ventilation is to deliver an adequate amount of oxygen to the tissues to prevent cell damage. An adequate blood pressure is essential for achieving perfusion. This article will discuss concepts of blood pressure management and how respiratory therapists' management of mechanical ventilation influences circulation.

Two major components

Blood pressure consists of two major components: cardiac output and systemic vascular resistance (see Figure 1). Cardiac output is the amount of blood the heart circulates in one minute, measured in liters. It is comprised of heart rate and stroke volume. Heart rate is the number of contractions the heart makes per minute, while stroke volume is a measure of the volume ejected from the heart every beat. Preload, afterload, and contractility are the determinants of stroke volume; a change in any of these factors will impact cardiac output and, thus, blood pressure. Most protocolized approaches address the preload prior to afterload or contractility.[3]

For example, a trauma patient with significant blood loss will experience a low preload state due to inadequate amounts of blood returning to the heart. This low preload will lead to an inadequate blood pressure because a patient's fluid status makes the largest contribution to preload. Other factors that affect preload would include anything that affects the intravascular volume status (such as dehydration) or fluid shifts (such as third spacing). Angiotensin II is a hormone that promotes vasoconstriction, which results in increased afterload. Oxygen delivery and sympathetic stimulation are the greatest contributors to cardiac contractility.

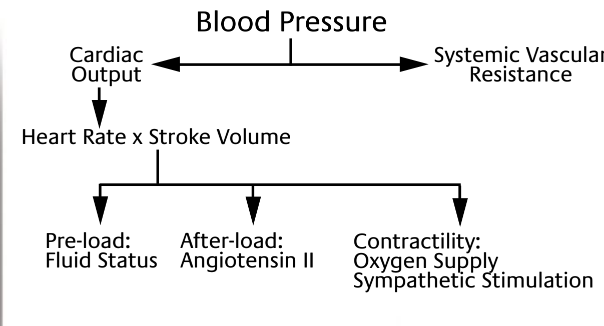
about the author...

Carl R. Hinkson, MS, RRT-ACCS, FAARC, is assistant manager of respiratory care at Harborview Medical Center in Seattle, WA.

Fluid management

Preload is associated with managing fluid balance and is necessary to maintain adequate perfusion. There are two main approaches to fluid management in ARDS patients: liberal and conservative fluid management. With liberal fluid management, patients are generously given fluid and colloids to augment preload, with higher central venous pressure (CVP) or pulmonary capillary wedge pressure (PCWP) goals.[1] An increase in fluid causes cardiac muscle fibers to stretch further, resulting in a greater ejection of blood volume, a phenomenon known as the Frank-Starling mechanism.[4] The increase in stroke volume increases cardiac output and is believed to improve end organ perfusion. On the other hand, conservative fluid management limits fluid intake while maintaining adequate preload by targeting lower CVP or PCWP goals. The rationale with conservative fluid management is that there will be a reduction in lung edema and subsequently a shorter duration of mechanical ventilation.

Figure 1. Blood Pressure Control Schematic



To determine which fluid management method had better outcomes in ARDS patients, the Fluid and Catheter Treatment (FACT) trial was conducted.[5] The FACT trial is the largest trial to date to look at preload management of intubated patients with ARDS. Patients were randomized to either a conservative or liberal fluid management arm, each with different CVP or PCWP goals. The study determined that there was no difference in 60-day mortality. However, patients in the conservative fluid management group had more ventilator-free days and fewer ICU days. In light of these results, the current recommendation is to follow a conservative fluid management strategy. However, in a follow-up study that looked at long-term outcomes in ARDS survivors, the conservative fluid management strategy was identified as a potential risk factor for long-term cognitive and executive function impairment, although it is unclear how conservative fluid management could have caused cognitive impairment.[6]

The choice of fluid to increase preload includes normal saline or colloids such as albumin. Since ARDS alters the permeability of the alveolar membranes, the increase in seepage of plasma components such as albumin (from increased membrane permeability) has given rise to the consideration that colloids should be given in ARDS patients.[1] Several studies have examined the administration of albumin in ARDS patients. Although one study showed an improvement in P/F ratio, another study demonstrated that there were no differences in outcomes.[1]

Vasopressor management

Once a management method for preload has been chosen, the patient response must be monitored. There are several methods to assess adequate preload. Historically, fluid therapy was guided by either pulmonary artery catheter (PAC) or central venous catheter (CVC). A trial conducted concurrently with the FACT trial found that there were no differences in outcomes when therapy was guided by either PAC or CVC.[7] Because of this trial, the use of PACs has significantly decreased.[8]

Other methods for assessing fluid responsiveness have been suggested. One is pulse pressure variation (PPV).[9] PPV entails examining the arterial pressure waveform and observing for variations in systolic and diastolic measurements that coincide with ventilator breath delivery. Research has been inconclusive as to whether or not PPV is a good clinical tool for determining if a patient's blood pressure will be responsive to administration of volume replacement, or "fluid challenge." Factors that can limit the usefulness of PPV include lower tidal volumes and lower levels of positive end-expiratory pressure (PEEP).

Some clinicians have suggested a strategy termed "permissive hypotension" for the management of trauma patients.[10,11] Patients who have experienced significant hemorrhage and received a large infusion of volume potentially could dislodge clots that have formed. These clots could then travel to another location and impact the lungs or brain.

When adequate intravascular volume is achieved by reaching pre-determined clinical goals such as a CVP or adequate urine output but the patient is still in a state of shock (hypo-perfusion), the focus should shift toward vasopressor support to improve afterload. There exists a dearth of research on vasopressor support specific to patients with ARDS on mechanical ventilation. However, septic shock is a condition that often occurs in the same setting as ARDS. The guidance offered in the "Surviving Sepsis Campaign" is applicable to patients with ARDS.[3] Vasopressor support is recommended when mean arterial pressure (MAP) falls below 65 mmHg. However, the goal for MAP may be adjusted given a patient's individual clinical scenario.

The choice of vasopressor should be made in the context of the patient's condition. Often either norepinephrine or dopamine is used as a front-line medication. Vasopressin, epinephrine, or phenylephrine may be used as alternative agents or added to norepinephrine if the expected response is not noted. If an assessment reveals poor cardiac contractility, then inotropic therapy may be initiated. An inotrope such as dobutamine could increase cardiac output, thus increasing blood pressure.[11]

Be aware

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Common Terms in Blood Pressure Control[4,12]

Term	Definition
Preload	Tension on the cardiac muscle before contraction.
Afterload	Load against which the cardiac muscle exerts contractile force.
Contractility	Ability of the heart muscle to squeeze.
Systemic Vascular Resistance	Average resistance to blood flow through the entire systemic circulation.
Cardiac Output	Amount of blood pumped by the heart in one minute; calculated by multiplying heart rate x stroke volume.
Mean Arterial Pressure	The average driving force in the arterial system throughout the cardiac cycle; calculated by systolic + 2(diastolic) / 3.
Pulse Pressure	Difference between systolic and diastolic pressures.
Central Venous Pressure	Allows for measurement of right atrial pressure.
Pulmonary Capillary Wedge Pressure	Pressure measured when a small balloon is wedged in a pulmonary artery; this value approximates preload on the left ventricle.

sure should be carefully managed as PEEP, tidal volume, or plateau pressures are manipulated. For example, an increase in PEEP could have a deleterious effect because the increase in intra-thoracic pressure can decrease preload or volume returning to the heart. By being aware of how blood pressure is being managed and communicating with the rest of the multi-disciplinary team, we can help others to understand the interplay the ventilator can have on patients with acute respiratory distress syndrome. ■

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A Rare Opportunity for Our Profession

by Thomas J. Kallstrom, MBA, RRT, FAARC

At the 59th International Respiratory Convention & Exhibition in Anaheim, CA, on November 16, Keynote Speaker Stephen F. Jencks, MD, MPH, presented an overview of the changes and challenges of Medicare reimbursement as they relate to future penalties for readmissions. His address can be viewed by AARC members on our website (www.aarc.org).

Dr. Jencks left the convention attendees with a parting comment that the Affordable Care Act (ACA) offers a rare opportunity for the respiratory care profession and that if we do not embrace this opportunity we risk being left out in the cold. It could not be stated more succinctly. However, I will go a step further and say that the future of our profession hinges on respiratory therapists addressing the needs of patients in light of the ACA. If we do not proactively position the respiratory therapist in hospital-based disease management programs that manage patients with chronic pulmonary disease now — specifically COPD patients — we risk not being recognized as a team leader or even a team player.

Preventing readmissions

With Medicare dollars being wasted, it is important that better ways of care and preparation of the patient take place so that preventable readmissions do not occur. The costs of readmissions to the hospital for chronic disease are staggering. In 2009, Dr. Jencks was the primary author of a frequently quoted landmark paper that unveiled the enormity of the problem.[1] His work suggested that preventable hospitalizations account for approximately $12 billion annually paid by Medicare. One of the conclusions of the paper was that re-hospitalizations of patients is a frequent, costly, and sometimes life-threatening event associated with gaps in follow-up care and that the rate of re-hospitalization can be reduced with the implementation of more reliable systems. Although the re-hospitalization rate is often presented as a measure of the performance of hospitals, it may also be a useful indicator of the performance of the health care system.

Looking closer at COPD readmissions, the Medicare Payment Advisory Commission (MedPac) Report published in 2007 found that the readmission rate for COPD within 30 days was 10.7%, behind heart failure (12.5%) and ahead of pneumonia (9.5%). Currently there are in place readmission penalties for heart failure and pneumonia.[2] These diagnoses are notable because all three fall into the purview of the respiratory care profession.

As you are probably aware, in eight months (October 2014) COPD patients who are readmitted to the hospital within 30 days will cause the hospital to be subjected to Medicare-directed penalties. This is a significant punitive action that will place hospitals in a position of correcting the problem or be subject to losing millions of dollars. Forward-thinking hospital administrators must have a serious conversation with respiratory care department managers/directors who can develop and implement disease management programs for patients with chronic lung disease in the hospital that continue post discharge. This is evidenced by recent data on COPD readmissions.

The Centers for Medicare and Medicaid Services conducted a dry run of COPD readmission rates so hospitals would have an idea of their performance prior to the payment reduction policy kicking in. According to the September 2013 "Medicare Hospital

about the author...

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

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> Through the year, the AARC will present updates on the ACA as well as share with members the successes of other programs.

Quality Chartbook: Performance Report on Outcome Measures," mortality and readmission rates for COPD patients vary widely by hospitals.

Interestingly, there are some disparities noted in COPD readmissions when looked at nationally, which are surprising.[3] Seven of the top performing cities that have seen a notable reduction of readmissions are Los Angeles, Indianapolis, Salt Lake City, Fort Worth, San Antonio, Charlotte, and Grand Rapids. In contrast to this were other large cities that were poorer performers. They included Washington DC, Chicago, Baltimore, Boston, St. Louis, Cincinnati, Pittsburgh, and Las Vegas. These outcomes emphasize the need for a proactive role by respiratory therapists and (as noted by CMS) suggest opportunities exist for hospitals to improve the quality of care provided to COPD patients.

How do you get started?

I would challenge all practicing RTs to first understand why this is important in your own institution. Do some research in your hospital. Learn what the readmission rates are. You will need to work with your medical director and hospital administration of your hospital in an attempt to get their support. You must become an expert in developing and implementing your own self-management programs for COPD patients. To do this, it may be helpful to learn from the successes of others in the respiratory care community with self-management programs. Additionally, there is a presentation given as a webcast in August 2013 called "COPD Best Practices" that can be accessed at www.aarc.org/education/webcast_central/past_programs.cfm/.

The best practices webcast was presented by respiratory therapy departments in California, North Dakota, Georgia, and Kansas that had already designed and implemented their own programs. In these presentations they discuss their journey from inception to rollout of their programs. In all programs, outcomes readmissions showed a statistically significant reduction.

The AARC also offers another way to connect with others who are interested in a program called COPD Readmission Best Practices available through the AARConnect listserv that offers more in-depth discussion with respiratory therapists who wish to learn more or share their program with others.

There is also a disease management webcast that was recorded in December 2013 that explains exactly what disease management is and the important role of the RT. There are several examples of published disease management programs that describe how RT-directed self-management programs can make significant improvement in quality of life, decreased cost of care, and lower readmissions to the hospital. This can be accessed at www.aarc.org/education/webcast_central/past_programs.cfm/.

Through the year, the AARC will present updates on the ACA as well as share with members the successes of other programs. The choice is yours. Either embrace this new opportunity — which possibly will not be seen again — or follow the parade. ■

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Social Media, the Patient, and the Respiratory Therapist

by Brian Cayko, MBA, RRT

When I think about pulmonary disease management, the first thing that comes to mind is access to care. I like to think of "access to care" as removing the barriers that prevent patients from acquiring care rather than what actually takes place during the scheduling process. These barriers typically include finances, transportation, motivation, and support, among other things.

In today's highly technological world, however, we cannot ignore the role that social media can play in our patients' access to us as respiratory therapists. In a world where my first grader talks to his great-grandmother via a video chat on their tablets, it goes without saying that we need to examine how technology — specifically social media — can be used to increase our ability to not only reach out to our patients but for our patients to reach out to us. Let us not fail to also consider the pitfalls associated with these new platforms.

Social media sites as a resource

Social media is defined as "websites and other online means of communication that are used by large groups of people to share information and to develop social and professional contacts."[1] In my daily life this means "resource." Whether that is networking in order to share information or just checking up on a friend's status, the truth is most of us gather information via social media. So why not utilize this technology to connect with and educate our patients as well?

Common social media platforms include Facebook, Twitter, LinkedIn, and YouTube, just to name a few. By definition, websites can also be included; but the reality is that any entity that has its own website also has its own page on most of the aforementioned platforms. Therefore, this discussion will be limited to the "pages" type of social media.

Facebook

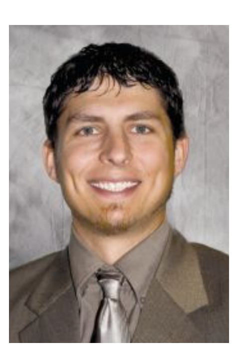
A great place to start for the pulmonary patient and therapist alike is Facebook. A recent survey found 67% of online Americans use Facebook;[2] Twitter only garners 18%.[3] Conducting a search for "COPD" results in an exhaustive list of pages and groups devoted to lung disease.

Whether you're a patient or a practitioner, I would recommend checking out the COPD Foundation's page.[4] That's the same group that sponsors the DRIVE4COPD campaign responsible for quickly and efficiently screening patients. A quick scroll down their timeline highlights linked resources for patients and therapists. You'll also find fun stories and pictures of screening events and patient experiences. Worthy of note is the link to their website, which contains vast patient resources.

COPD International has a page that is more directly focused to patients and has a strong interactive following.[5] This page also serves as a great portal to many other COPD-related pages that will benefit patients. COPD International provides some informative posts explaining common disease misconceptions, pulmonary function testing, and medication usage. However, it truly shines in that it has the feel of an interactive support group for our patients. Each post has several comments from patients, who share their experiences and offer encouragement to other subscribers.

Follow up these pages with a search using the term "pulmonary," and you will locate numerous pages for fi-

about the author...



Brian Cayko, MBA, RRT, is the director of clinical education in the respiratory care program at Great Falls College, Montana State University, in Great Falls, MT.

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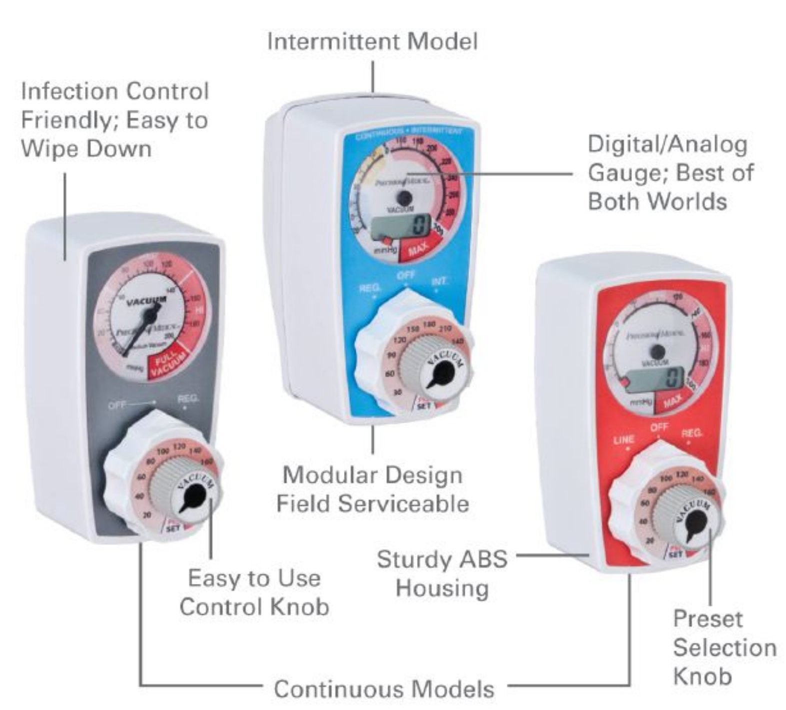

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Join the Discussion

The social media sites covered by Brian Cayko, MBA, RRT, can serve as great resources for our patients. However, when it comes to professional networking for respiratory therapists, there's no better place to turn than to the AARC's own AARConnect. Developed especially for members, the site offers everything from dedicated discussion lists (members can even create their own) to libraries full of useful documents and other information you can put to work in your hospitals and other organizations.

If you haven't explored the site yet, then visit **http://connect.aarc.org** to set up your personal profile and get started networking with your peers in the AARC. ■

brosis, embolism, hypertension, rehabilitation, sleep, respiratory medicine, pediatrics, and the list goes on. The fact of the matter is that if you are looking for more information or support on a respiratory-related matter, you will likely find a Facebook page and/or group to fit your need.

Twitter

As we switch the focus over from Facebook to Twitter, it is important that we understand that there are fundamental differences between these two social media giants. First, though, let's discuss what is similar. Both platforms provide "status updates" that allow their followers to be alerted to current and recent activity. A nice Twitter feature similar to the "share" function in Facebook is the ability to "retweet" or share an update you received with all of your followers. (I affectionately refer to my followers as my "tweeple.")

The last feature I will mention is a type of search method that utilizes a "hashtag." You can easily see what is popular (trending) right at the moment in the "Twitterverse" by placing your search term in the provided field. Your result will bring up any "tweets" that fit your term. Users frequently place the pound or number sign (#) in front of specific words in order to "tag" their update to that search term. Hashtagging has recently become a social phenomenon, so much so that Facebook has adopted the feature as well.

Without getting too deep, that is about where the similarities end. Twitter limits its updates to 140 characters. This effectively keeps the type of posts and content shared to brief announcements, activity reports, and links leading to more comprehensive content. This abbreviated style actually suits many busy professionals and patients better than the sometimes more lengthy posts on Facebook. It reduces the amount of scrolling through pages of non-vital social "fluff," allowing subscribers to interact with the content only if they find it appealing. It is more of an "alert" system from which you receive the updates you have subscribed to.

Most beneficial to the working therapist would probably be @aarc_tweets, @respcare, and your state society's account, if it has one. For example, Montana's is @msrcmt. These accounts are fantastic for keeping current with your profession and the latest in research and educational offerings.

For the patient, the COPD Foundation can be found at @copdfoundation, which provides news and events related to chronic obstructive pulmonary disease (COPD) and their efforts to improve the quality of life for those affected by the disease.[6] Many local physicians, rehab clinics, and support groups also utilize Twitter to quickly send updates to their patients to keep them current on changes in schedules and upcoming events happening in their hometowns.

LinkedIn

LinkedIn is a great platform for bolstering your professional network and sharing resources among those "connections." It will likely benefit the respiratory therapist more so than the patient. However, I do recommend that patients look up their physicians and other health care providers on LinkedIn to get a professional overview of the practitioner they are seeing. A word of caution: These pages are not held accountable for the accuracy of their content. Most profiles on LinkedIn are set up by the individuals themselves; and while the platform works well to provide peer-review endorsements, it is not an online review of the provider.

YouTube

Finally, YouTube can be used by patients and RTs alike. It can provide a

seemingly unending depth of educational material in a visually friendly format that most patients would enjoy. As an educator, I have viewed hundreds of videos and often utilize the really good ones in the classroom. Of course, you have to be careful because these also are not held to any standard of accuracy; therefore, an unknowing patient could easily come across a video that makes unsupported claims. The credentialed therapist should be able to critically review the content and make an educated decision as to whether or not to use it for educational purposes.

Buyer beware!

Given the technological climate we now live and work in, it is no longer surprising to connect with every generation using some kind of social media. The platforms mentioned in this article serve as vehicles for educational resources, patient support, and social and professional networking. Each one has advantages that will benefit patients and therapists, but caution must be employed. After all, despite popular belief, they can put things on the Internet that aren't true. ■

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CoARC Accreditation and Its Value to You

by Tom Smalling, PhD, RRT, FAARC

EDITOR'S NOTE: This month we welcome a new column to *AARC Times*, written by The Commission on Accreditation for Respiratory Care (CoARC) to inform everyone about CoARC's ongoing mission and its role in the respiratory care profession. *AARC Times* will publish these columns from time to time, just as we do with "NBRC Insight."

What is accreditation?

Accreditation is a voluntary, nongovernmental peer-review process that operates in accordance with nationally recognized standards established for the practice of accreditation in the United States. Accreditation is both a process and a status that provides assurance to prospective students, their families, and the general public that an institution (or a program) meets minimum requirements (i.e., accreditation standards) and that there are reasonable grounds to believe the institution (or program) will continue to meet those standards in the future. Accreditation provides consumer protection, advances and enhances the profession, and protects against compromise of educational quality.

about the author...

Tom Smalling, PhD, RRT, FAARC, is the executive director of the Commission on Accreditation for Respiratory Care in Bedford, TX.

What role does CoARC have with regard to accreditation?

The Commission on Accreditation for Respiratory Care (CoARC) is the sole nationally recognized authority for the accreditation of entry into respiratory care professional practice degree programs in respiratory care at the associate's, baccalaureate, and master's degree level. The CoARC also accredits respiratory care degree programs offering certificates in polysomnography. CoARC's mission is to serve the public by promoting high-quality respiratory care education through accreditation services.

What is the purpose of accreditation?

Accreditation is assurance that a respiratory care program meets the quality standards established by the profession. Speci- fically, accreditation by the CoARC is intended to:

1. Hold respiratory care programs accountable to their communities of interest by ensuring that such programs have resources, goals, and outcomes that are appropriate to prepare individuals to fulfill their expected roles;
2. Assess the extent to which a respiratory care program is successful in complying with accreditation standards and policies;
3. Inform students, employers, and the public of the purposes and values of programmatic accreditation;
4. Foster continuing improvement and self-review in respiratory care programs;
5. Promote, develop, and support charitable, scientific, literary, and educational activities that advance high-quality respiratory care education.

How is accreditation obtained?

The accreditation process is initiated only at the request of an institution that meets the criteria for sponsorship as identified in the "Accreditation Standards for the Profession of Respiratory Care" (the Standards). The CoARC conducts a comprehensive review of the program relative to these Standards. Accreditation decisions are

based on the CoARC's review of information contained in the accreditation application and self-study report, the report of site visit evaluation teams, the annual report, and any additional requested reports or documents submitted. Programs that have successfully undergone the review process are granted accreditation status by CoARC, which provides public recognition of achievement. The CoARC Board of Commissioners has final decision-making authority for all accreditation actions.

Why are standards necessary in accreditation?

Since 1962, the Standards have been the minimum requirements to which an accredited respiratory care program is held accountable. The Standards are used for the development, evaluation, and self-analysis of respiratory care programs and provide the basis on which the CoARC confers or denies accreditation. They provide the explicit framework for which accredited programs are expected to demonstrate competency in achieving their programmatic goals within the context of their institutional missions.

The Standards ensure that all programs prepare students at a competency level consistent with the national credentialing examination for Registered Respiratory Therapists. This level of preparation better equips graduates to begin practice with the professional competencies needed to work effectively in partnership with other health care providers. The Standards place a greater emphasis on the desired foundation and practice, the manner in which programs must assess student achievement of competencies, and the importance of the development of the student as a health care professional. Further, the Standards focus on the development of core and professional knowledge, skills, attitudes, and values, as well as sound and reasoned judgment and the highest level of ethical behavior.

The CoARC is currently revising the 2010 "Accreditation Standards for the Profession of Respiratory Care." This comprehensive review and revision process occurs every five years as an integral part of the CoARC's ongoing mission to serve the public by promoting high-quality respiratory care education through accreditation services. The first draft of the proposed 2015 "Accreditation Standards for the Profession of Respiratory Care" has been completed and published. The CoARC Board continues to solicit comments or suggested edits/additions/deletions from its communities of interest regarding proposed drafts of the 2015 Standards. For more information, please visit CoARC's website: www.coarc.com.

Where to find more information about accreditation

All accrediting organizations provide information to the public about the institutions and programs they accredit, when they are reviewed, and the general results of the most recent accreditation review. In addition to the CoARC website previously mentioned, information about the accreditation process can be accessed through the Council for Higher Education Accreditation (www.chea.org) and the Association of Specialized and Professional Accreditors (www.aspa-usa.org).

Inquiries regarding this article can be addressed to CoARC Executive Director Tom Smalling, PhD, RRT, FAARC, tom@coarc.com, 1248 Harwood Rd., Bedford, TX 76021-4244. ■

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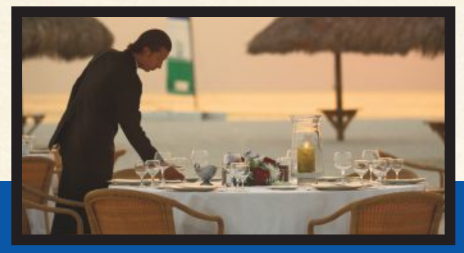

Patient-centered Resources on the CMS Consumer Site

by Cheryl West, MHA

Occasionally we use this column to highlight various government programs or information sites that can provide important information and help that you as respiratory therapists might pass on to your pulmonary patients, clients, or even yourself. Sometimes the sheer breadth of information or resources available on the Internet can become overwhelming, and the accuracy of the information can be questioned. In particular, when researching what state or federal health services are available for your patients, it is advisable to first review official government websites — noted by the ".gov" suffix.

This column will focus on the patient-centered resources the Centers for Medicare and Medicaid Services (CMS) — aka the Medicare Program — has available to Medicare beneficiaries. While the information is from the Medicare website, it most certainly isn't just useful to Medicare beneficiaries. Anyone needing a hospital, nursing home, rehabilitation facility, home health agency, or a physician will find quite valuable what Medicare has tucked away on its consumer site.

about the author...

Cheryl West, MHA, serves as director of government affairs for the AARC.

MyMedicare.gov

CMS actually has two websites. One is for providers, professionals, and policy makers — and that's www.cms.gov. The other CMS website is set up to help make the complex Medicare system — with its Part A (hospitals and skilled nursing facilities), Part B (physician and outpatient, HME, etc.), Part C (managed care option), and Part D (prescription drugs) — benefits more comprehensible. That website is located at www.mymedicare.gov. While the main page of this site makes a very large effort to get you to sign up and sign in, you can skirt around that to find information you or the pulmonary patient could find very useful and enlightening.

As most of you know, the health care system (mostly pushed by changes in the vast federal Medicare program) has been turning slowly on its axis to focus on the quality of the care that is being provided rather than the quantity of care provided. Using quality standards and measures that have been developed, vetted, and are now accepted as reliable, CMS is using these measures to track just how well providers are doing. Medicare first focused on hospitals; and by initially meeting certain CMS standards, hospitals were rewarded with slightly higher Medicare reimbursements. Now that's transitioning from a CMS reimbursement reward to a CMS financial penalty if standards are not met.

The "compare" websites

With quality measures being reported by hospitals to CMS, the agency did not keep this information to itself. It launched the first of the "compare" websites at www.medicare.gov/hospitalcompare/search.aspx. By simply entering the zip code for the search area you are interested in, all the hospitals in that zip code pop up, and you can select facilities to compare how each hospital fares in meeting the measures set by CMS. Those measures range from how many Medicare patients were treated per diagnosis (including a category for "lung disease"), to how the hospital was rated based on patient satisfaction surveys, to information on readmission rates, complications, and deaths.

A person may have less maneuvering room to pick a hospital to go to for a number of reasons, including that their personal physician may not have admitting privileges at a hospital that is the person's preference. However, patients do have more choice in selecting their own doctor: and CMS now has a compare site for physicians: www.medicare.gov/physiciancompare/.

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The Physician Compare site does not currently report on meeting specific quality standards but does note a physician specialty, type of practice, and medical school and residency information. CMS is beginning to phase in quality measures for physicians, and it's a safe bet that in the near future the Physician Compare site will report on those as well.

Individuals may have less choice selecting other types of facilities they may require for their health needs that are reportable on other Medicare Compare sites. Nevertheless, information from these sites can be quite useful when a patient or family or caregiver considers a particular facility. So consider these compare sites as well:

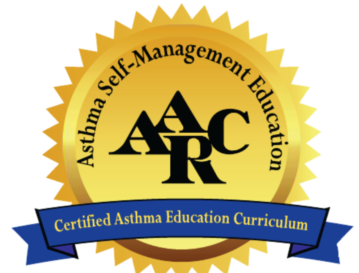
- Home health agency: **www.medicare.gov/homehealthcompare/**
- Dialysis center: **www.medicare.gov/dialysisfacilitycompare/**
- Nursing homes (including rehabilitation facilities): **www.medicare.gov/nursinghomecompare/.**

Quality measures are different for each type of provider. For example, Nursing Home Compare asks about staffing, something Hospital Compare does not. On the other hand, Hospital Compare gets more disease specific with information (for example, on effective pneumonia care).

As noted earlier in this column, while all this comparison information is on the Medicare website, it clearly can be applied and be very useful for non-Medicare patients wanting to make informed choices on where to get their care if they have the option to do so.

Standards and Measures

Finally, if you are really interested in knowing the genesis of where these standards and measures came from that are now being used in the various Medicare Compare sites, check out the National Quality Forum (NQF) at **www.qualityforum.org/Home.aspx**, which is a not-for-profit private sector standard-setting organization whose efforts center on the evaluation and endorsement of standardized performance measurement. The standards endorsed by the NQF are not the only entity Medicare uses in selecting its required reporting measures, nor does Medicare use all the measures endorsed by the NQF. However, if you want to have a good feel for what standards might be used in the future, the NQF measures will certainly give you a sense of that future. ■



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- Basis for possible reimbursement from third party payors

For more information go to: www.aarc.org/asme/

Engineering for Success and Compliance

by Anthony L. DeWitt, JD, RRT, FAARC

Lawyers are often faulted for suing for product defects in situations where no rational person would have been injured. The man who attempted to pick up the lawn mower to use it as a hedge trimmer is perhaps the most extreme example of this. However, lawyers also get involved in products liability litigation when people are injured through no fault of their own. For example, I was involved in a case early in my career where design defects in an early model of a PCA (patient-controlled analgesia) pump caused a 52-year-old woman to die from a massive overdose of Demerol® (Sanofi Aventis US, Bridgewater, NJ). The lawsuit identified and forced the correction of a deadly design defect (the designers did not account for human error in the installation of the drug cartridge).

Human error — whether it comes about from misuse of the product or failure to be compliant with the treatment regimen — is the hardest thing for engineers to design around.

Designing for compliance

Recently I interviewed Peter Farrell, PhD, DSc, AM, who works for a major CPAP manufacturer, regarding the design of medical devices. I chose this company because I was familiar with their continuous positive airway pressure (CPAP) masks and devices. My wife uses their product, and I have a different one that does not perform as well her device does. I was interested from the lawyer's perspective in what the company's philosophy was regarding human factors engineering.

Sleep medicine has revolutionized the treatment of chronic diseases like arteriosclerotic heart disease (ASHD), diabetes, and hypertension. CPAP provided by therapists in the home is actively treating lots more than a simple breathing disorder. By restoring the quality of a person's sleep, patients lose weight, experience drops in blood sugar, and see their high blood pressure return to normal or near-normal. However, some CPAP machines are loud, uncomfortable, and take a lot of getting used to. Thus, the benefits of therapy only flow to patients who are compliant.

Smart companies know this and design with compliance in mind. Dr. Farrell notes that "without compliance, everyone loses: patients, insurers, and manufacturers." Dr. Farrell's company manufactures CPAP for the treatment of obstructive sleep apnea. Insurers have grown weary of paying for machines that patients use two or three nights and then stop using. Dr. Farrell says "the traditional measure of compliance is four hours per night for at least five days. We believe that this is the absolute minimum, and we like to see at least five hours per night seven days per week."

In order to obtain that level of compliance, Dr. Farrell and his design team have spent years making their equipment smaller, lighter, and quieter. Almost all of the companies that produce these devices have been working on improving the designs along these lines, and these are all laudable goals. Perhaps the most important improvement, however, has come in the software used to interface the patient to the equipment.

How a device senses and responds to changes in a patient's ventilation during sleep is arguably the most important part of CPAP therapy, both in terms of maximizing the benefit of the treatment and in terms of achieving patient compliance. While quieter motors and

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.

— 2014 —

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

A SALUTE to Our CORPORATE PARTNERS

The combined efforts between the respiratory care profession and manufacturers in seeking ways to improve the quality and outcomes of our patients make us natural partners in today's healthcare continuum.

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

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Paying attention to what works and what doesn't work, understanding why, and adjusting equipment as needed is one big reason why respiratory therapists are vital in home care.

better masks also help improve performance, it is the ability to conform the unit to the patient — and for the patient to feel comfortable using it — that sets apart those units that are well designed from those that are not. Dr. Farrell explained that his company's design has focused on algorithms that improve patient comfort. "Ours are now extremely comfortable to breathe on." Dr. Farrell's company has seen where the future is headed in terms of insurance reimbursement. Those who cannot show a commitment to quality are going to be cut out of the loop.

Keys to reimbursement

Under the Patient Protection and Affordable Care Act, every entity that provides health care, whether in the home or in the hospital, is charged with continuous quality improvement. The only real way to monitor the effectiveness of a CPAP program in the home environment is to track compliance. All machines now have memory sticks or cards that allow physicians, home care companies, and ultimately, insurers to monitor patient compliance. Eventually, companies will begin to rigorously compare the differences in design and compliance between vendors. It should be obvious that insurers will gravitate to the providers that can show the best patient compliance with their CPAP regimens.

Unfortunately, many durable medical equipment (DME) providers make the choice of what equipment to use in the home on the basis of cost alone; but this is "pennywise and pound foolish." If a patient does not stay compliant on CPAP, eventually insurance will quit paying for the services, supplies, and equipment just as Dr. Farrell suggests. Equipment durability, design, and cost are all important, but the effect on patient compliance should be the main thing that DME providers look at when deciding what equipment to use in the home. Insurers are data collectors, and they analyze the data they collect. Preferred providers are going to be those that ensure patients stay compliant because compliance with obstructive sleep apnea treatment improves so many other medical conditions.

Tracking compliance by model and vendor is also a hedge against product liability litigation. In that rare instance where a product fails, in most cases both the DME provider and the manufacturer are sued. The manufacturer is sued for product liability; the provider is sued for negligence. A smart DME provider wants to be able to show a jury that it paid very close attention to the quality of care it was delivering and that it was ensuring compliance to the extent possible.

The same teaching applies in the hospital and to the purchase of products like pulse oximeters and mechanical ventilators. Generally speaking, no one ever came to court and said "I wish we'd done less documentation and less quality assurance." However, there are lots of cases out there where a company or hospital has been slapped with a big damage award because it was perceived as having put profits ahead of patients.

The respiratory therapist's vital role

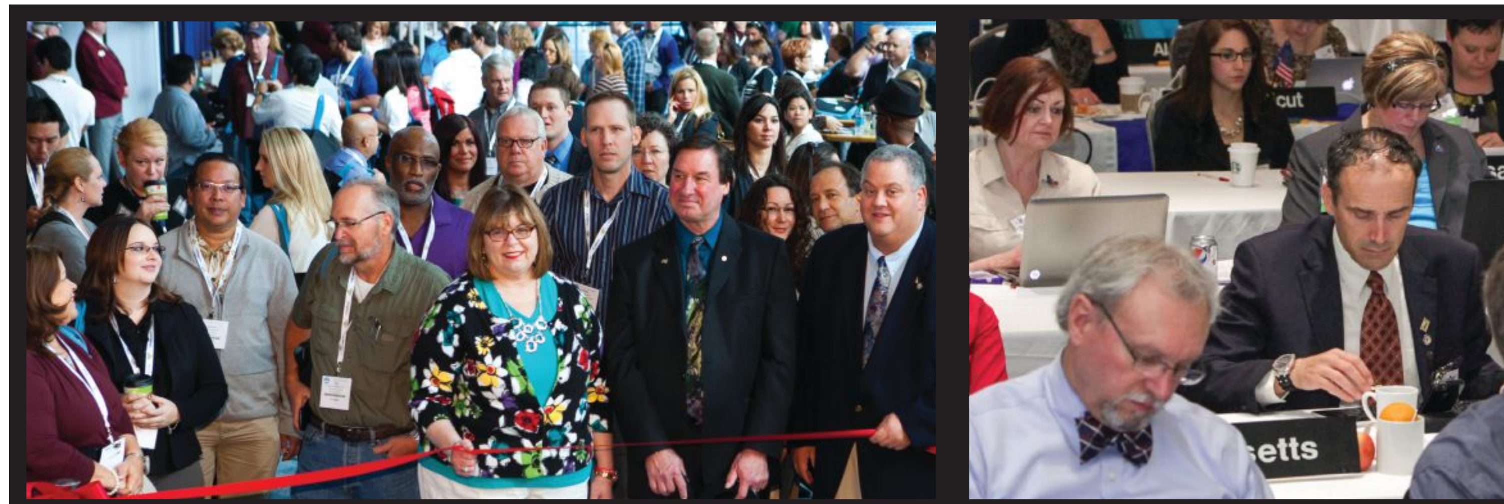
Therapists have an important role to play here. Those in home care should not be bashful about testing different units and making clinical judgments about efficacy. However, they should also be paying attention to compliance as it pertains to the makes and models of the equipment they're using. Paying attention to what works and what doesn't work, understanding why, and adjusting equipment as needed is one big reason why respiratory therapists are vital in home care. ■

AARC Congress 2013:

More of Everything That Matters!

Today provisions of the health care reform law are going forward on a daily basis. For respiratory therapists, perhaps none is more important than being ready for the inclusion of COPD in the Hospital Readmissions Reduction Program beginning on Oct. 1, 2014. As respiratory therapists gathered for AARC Congress 2013 in Anaheim, CA, last November, they knew they had less than one year before penalties kick in; and they came to the meeting fully expecting to hear more about the professional role they can and should play in the process.

Photos by Lennie Sirmopoulos, Convention Photography, Tustin, CA



Ribbon-cutting ceremony opened the Exhibit Hall

They weren't disappointed. The Congress was filled with need-to-know information about COPD readmissions and other factors of health care reform with the potential to impact the respiratory care profession and the patients it serves. From our keynote address by Stephen F. Jencks, MD, MPH, the nation's foremost authority on readmissions, to sessions addressing practical ways for therapists to become more involved in delivering the patient education and aerosol delivery device instruction essential to keeping patients out of the revolving door, AARC Congress 2013 delivered.

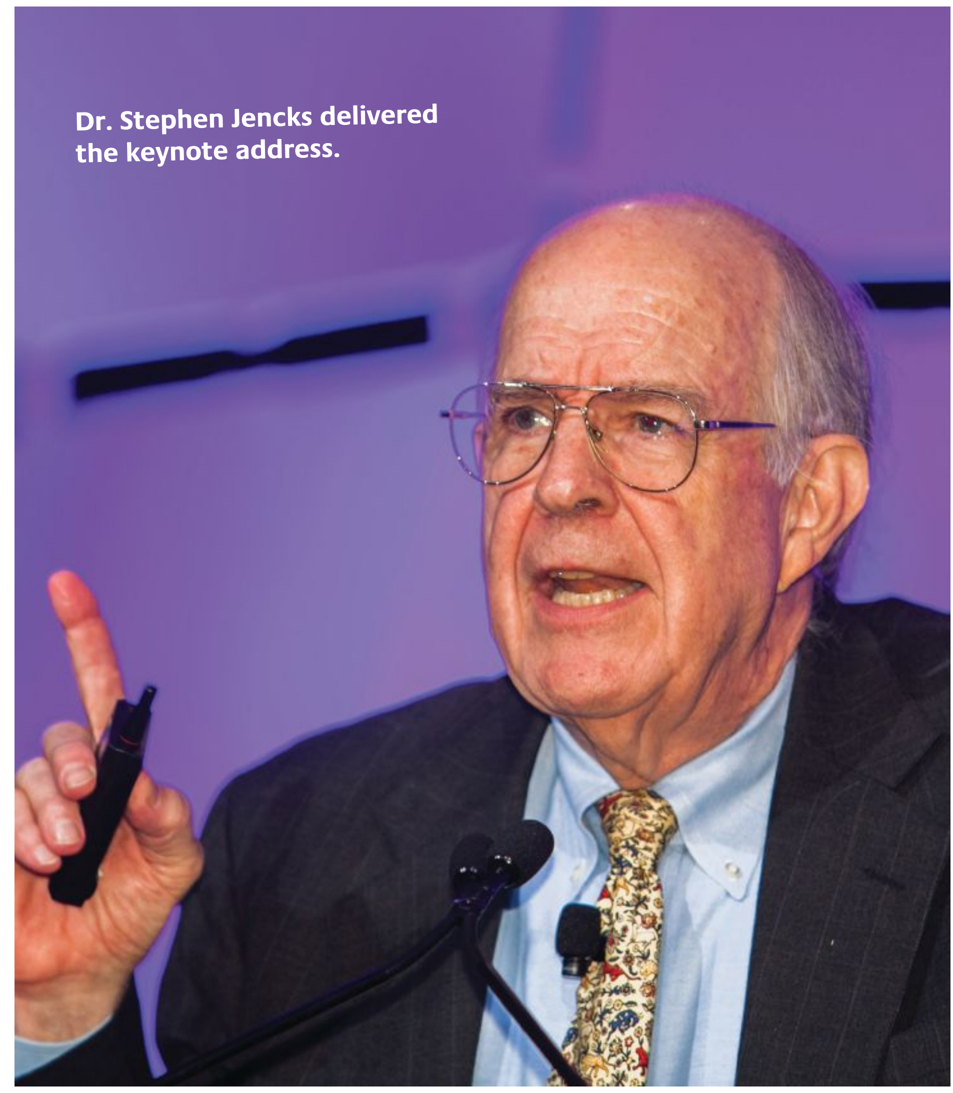
Dr. Forrest Bird attended the Night at the Museum event.

"2014 promises to be a pivotal year

for our profession, and we planned our 2013 Congress with that in mind," says AARC Associate Executive Director Douglas S. Laher, MBA, RRT, FAARC. "Our No. 1 goal was to ensure that when hospitals put their COPD readmissions reduction plans into operation, respiratory therapists would not only have the knowledge they need to take a seat at the table, but also to step up and lead the way when it comes to providing the chronic disease management that will be required to get the job done."

With hundreds of educational sessions scheduled for the first time in mostly 30-minute blocks to allow more attendees to attend more lectures — plus more than 280 original research papers presented in 19 Open Forums — AARC Congress 2013 covered all the bases when it came to other important aspects of respiratory care as well. And as it does every year, the annual meeting also served as the place to honor top performers in respiratory care, network with colleagues from around the world, see the newest technology, and enjoy the camaraderie of friends old and new at social events.

On the following pages you'll find an extensive recap of the 59th AARC International Respiratory Convention & Exhibition. So continue reading to learn how AARC Congress 2013 offered more of everything that matters to you and your patients, then begin making plans to attend AARC Congress 2014 at the beautiful Mandalay Bay Resort in Las Vegas Monday–Thursday, Dec. 9–12, 2014. ■



Dr. Stephen Jencks delivered the keynote address.

Readmissions Expert Dr. Stephen Jencks Delivers Keynote Address

On the first day of the Congress, Stephen F. Jencks, MD, MPH, shared his groundbreaking research on readmissions and encouraged respiratory therapists to step up and be a part of the team contributing to excellent patient care across the continuum during his keynote address. "You can leave this meeting equipped to lower readmissions for your patients," he said.

A consultant in health care safety and quality, a senior fellow at the Institute for Healthcare Improvement, and a former assistant surgeon general of the United States, Dr. Jencks is considered the nation's top authority on preventable hospital readmissions. His study on readmissions, published in *The New England Journal of Medicine* in 2009, validated the readmission projections used by the Centers for Medicare and Medicaid Services during the construction of the Hospital Readmissions Reduction Program and penalties for excessive readmissions for certain diagnoses — including COPD beginning Oct. 1, 2014.

"The game is changing — something is really happening," Dr. Jencks noted. "We are already seeing readmission rate decreases. We are also seeing reduced admission rates for all patients. There are new kinds of collaboration across the continuum."

Dr. Jencks spoke about the role respiratory therapists can play in the new health care system. "You need to be part of the team," he said. "Don't give up the base of clinical expertise you have because it is needed." Noting that teamwork between hospitals and communities is vital, he urged RTs to use a discharge checklist and, importantly, to collaborate with those in the community who will be taking care of their patients once they are discharged. "Examine what you're doing and what you think you're doing," he emphasized. "Talk with patients readmitted." He emphasized the new rules are giving RTs the opportunity to do for their patients what they set out to do when they first began in the profession.

Dr. Jencks closed the keynote by encouraging RTs to "Preserve a hope and belief that you can achieve a bunch of things. There's a lot of stuff on your agenda — go out and learn!" The opening keynote address was supported by a grant from Boehringer Ingelheim. ■

EDITOR'S NOTE:
Don't miss an article titled, "The Medicare Penalty for COPD Readmissions," written by Dr. Stephen Jencks for *AARC Times*, which will appear in an upcoming issue.

The Best of the Best: *Honors, Awards, and More*

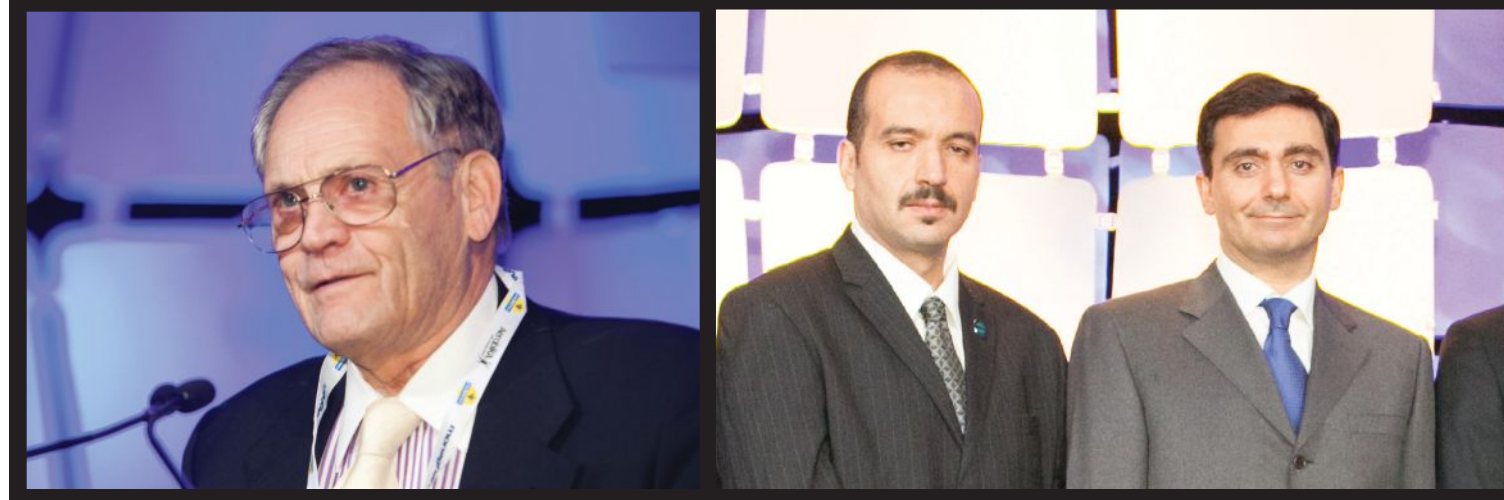
The AARC Congress is always the place to recognize those who go above and beyond for the respiratory care profession.

Rewarding Excellence in Respiratory Care

The following top performers in the AARC, the National Board for Respiratory Care (NBRC), and the Commission on Accreditation for Respiratory Care (CoARC) received awards during the annual Awards Ceremony held at the Congress.

(continued on page 34)

Photos by Lennie Sirmopoulos, Convention Photography, Tustin, CA



Forrest M. Bird Lifetime Scientific Achievement awardee Dr. Michael T. Newhouse

International Fellows

Hector Leon Garza Achievement Award to Dr. David J. Pierson

(continued from page 32)

- Jimmy A. Young Medal: Kerry George, MEd, RRT, FAARC
- NBRC/AMP William W. Burgin Jr., MD, Education Recognition Award: Tracy Bedar
- William F. Miller, MD, Postgraduate Education Recognition Award: Jared B. Rice, BSRT, RRT-NPS, RPFT
- NBRC/AMP Gareth B. Gish, MS, RRT, Memorial Postgraduate Education Recognition Award: Charity Clark, BS, RRT
- Morton B. Duggan, Jr., Memorial Education Recognition Award: Stewart W. Morrison
- Jimmy A. Young Memorial Education Recognition Award: Kanokon Raksriaksorn
- Charles W. Serby COPD Research Fellowship: Krystal Craddock, RRT-NPS
- Monaghan/Trudell Fellowship for Aerosol Technique Development: John W. Newhart, RRT
- Philips Respironics Fellowship in Non-Invasive Respiratory Care: Miri Suh
- Philips Respironics Fellowship in Mechanical Ventilation: Gerald Moody, RRT-NPS, AE-C
- CareFusion Fellowship for Neonatal and Pediatric Therapists: Robert Gillete, MD
- Forrest M. Bird Lifetime Scientific Achievement Award: Michael T. Newhouse, MD MSc, FRCP(C)
- Dr. Charles H. Hudson Award for Cardiopulmonary Public Health: COPD Foundation, John Walsh
- Thomas L. Petty, MD, Invacare Award for Excellence in Home Respiratory Care: Patricia Blakely, RRT, FAARC (Millard Blakely accepting)
- Mike West, MBA, RRT, Patient Education Achievement Award: William F. Galvin, MSEd, RRT, FAARC
- Ikaria Best Paper Award by Best First Author: Cynthia C. White, MSc, RRT-NPS, FAARC

Jimmy A. Young medalist Kerry George

The COPD Foundation (John Walsh accepting) received the Dr. Charles Hudson Award.

William F. Galvin received the Mike West Patient Education Achievement Award.

- Dr. Allen DeVilbiss Best Paper Award: Mark S. Siobal, BS, RRT, FAARC
- Albert H. Andrews Jr., MD, Memorial Award: David C. Levin, MD, FCCP
- Dr. Ralph L. Kendall Outstanding Site Visitor Award: Monica Schibig, MA, RRT-NPS, CPFT
- Héctor León Garza, MD, Achievement Award for Excellence in International Respiratory Care: David J. Pierson, MD, FAARC
- International Fellows: Ana Cristina Okada, PT; Lysbeth Roldán, RT; Daisuke Tsukahara, RN, MSN; Mohamad El-Khatib, PhD, MD, FAARC; Mohammed Herrag, MD, PhD
- Zenith Awards: Masimo Corporation, Covidien, Aerogen, Draeger Medical Inc., Philips Respironics, Teleflex Medical
- Honorary Membership: Kathy Blackmon
- Life Membership: Linda I. Van Scoder, EdD, RRT, FAARC
- AARC Fellows: Edwin L. Coombs, Jr., MA, RRT-NPS, FAARC; John W. Lindsey, Jr., MEd, RRT-NPS, FAARC; Kathy A. Short, RRT, RN, FAARC; Garry Dukes, BS, RRT, FAARC; Edward Conway, BBA, RRT, FAARC; Mel Welch, MPH, RRT-NPS, FAARC; Robert J. Harwood, MSA, RRT-NPS, FAARC; Edward A. Scully, MA, RRT, FAARC; Terry L. Forrette, MHS, RRT, FAARC; Barry M. Westling, MS, RRT-NPS, FAARC

These outstanding members were recognized in a separate awards ceremony during the AARC Annual Business Meeting.

- Outstanding Affiliate Contributor: Sheila Guidry, CRT, Louisiana
- Delegate of the Year: Daniel D. Rowley, MSc, RRT-ACCS, FAARC
- Summit Award: Florida Society for Respiratory Care

Ikaria Best Paper Award by Best First Author went to Cynthia C. White.

Albert H. Andrews awardee Dr. David C. Levin

Specialty Practitioners of the Year:

Adult Acute Care, Tom Gillin, RRT; Continuing Care/Rehabilitation, Connie Paladenech, RRT; Diagnostics, Balamurugan Panneerselvam, BS, RST, RPSGT; Education, Lynda Goodfellow, EdD, RRT, FAARC; Long-Term Care, Kendra Milliron, CRT; Management, Dana Evans, MHA, RRT-NPS; Neonatal-Pediatrics, Wade Rich, BS, RRT, CCRC; Surface & Air Transport, Alex Brendel, MBA, RRT-NPS

Specialty Practitioners of the Year

Prizes, Prizes, and More Prizes

AARC members took home some great prizes from Anaheim for participating in a variety of Association-related efforts in 2013.

Membership Drive: This year-long, friendly competition between the state societies to see which would end up with the biggest percentage change in members and which could draw in the largest number of members came to a close right before the meeting, with Nevada coming out on top in the percent change category. New Mexico came in second, and Mississippi came in third. Pennsylvania came in first in the actual number change category, with Florida a close second and California taking third.

Ventilator 5K: The respiratory care program at Weber State University in Ogden, UT, won a brand new ventilator donated by Breathe Technologies Inc. for their award-winning participation in the ARCF's annual fundraising event.

DRIVE4COPD: VIP tickets for two to the Daytona 500 in February of 2014 went to Sherry Compton, MBA, RRT, AE-C, in a drawing conducted among all AARC members who participated in a DRIVE event this year. Lawson Millner, RRT-ACCS, and Terry Gilmore, MA, RRT-NPS, were selected to receive free registration to the AARC's COPD Educator Course.

Find more photos and stories by logging on to www.aarc.org

Ventilator 5K winner Weber State University

Thomas L. Petty, MD, Invacare Award for Excellence in Home Respiratory Care went to Patricia Blakely, Millard Blakely accepting.

Honorary Membership awardee Kathy Blackmon

Top Companies Receive Zenith Awards

AARC members made their voices heard, and six respiratory care companies walked away with Zenith Awards during the Awards Ceremony:

- Masimo Corporation
- Covidien
- Aerogen
- Draeger Medical Inc.
- Philips Respironics
- Teleflex Medical

Each Zenith winner was selected by AARC members based on the quality of their products, accessibility of their sales staff, responsiveness, service record, truth in advertising, and support of the respiratory care profession.

Outstanding Affiliate Contributor is Sheila Guidry.

Delegate of the Year: Daniel D. Rowley

The Florida Society for Respiratory Care won the Summit Award. Mikki Thompson was among those accepting.

2014 Officials Take Office

The Association installed its 2014 officials during the Annual Business Meeting. Frank Salvatore, MBA, RRT, FAARC, was installed as president-elect, and Bill Lamb, BS, RRT, FAARC; Karen Schell, DHSc, RRT-NPS, RPFT; and Cynthia White, MS, RRT-NPS, FAARC, as directors-at-large. Incoming section chairs with Board of Directors seats included Natalie Napolitano, MPH, RRT-NPS, FAARC (Neonatal-Pediatrics) and Kimberly Wiles, BS, RRT, CPFT (Home Care).

Four Specialty Sections also held elections in 2013, and these individuals were elected: Adult Acute Care, Keith Lamb, RRT-ACCS; Diagnostics, Katrina Hynes, BAS, RRT, CPFT; Education, Ellen Becker, PhD, RRT-NPS, FAARC; and Management, Cheryl Hoerr, MBA/HCM, RRT, FAARC.

New House of Delegates officers are: speaker, Debra Skees, MBA, RRT, CPFT; speaker-elect, John Wilgis, MBA, RRT; secretary, Kari Woodruff, BS, RRT-NPS; and treasurer, Keith Siegel, BS, RRT, CPFT. John Steinmetz, MBA, RRT, is now the past speaker.

Life Membership: Dr. Linda I. Van Scoder

Fellows of the AARC

AARC Announces the 2014 Corporate Partners

The Association was pleased to welcome these 12 companies to its 2014 Corporate Partners program:

- CareFusion
- Masimo Corporation
- Covidien
- Monaghan Medical Corporation
- Philips Respironics
- Draeger Medical Inc.
- Maquet Inc.
- Teleflex Medical
- Boehringer Ingelheim Pharmaceuticals Inc.
- Forest Laboratories, Inc.
- Ikaria
- Sunovion Pharmaceuticals, Inc.

All of these companies comprise best-in-class organizations interested in supporting the goals and work of the AARC. The program provides respiratory care providers with information, insights, and innovative approaches to improve performance and advance the health of their patients. ■

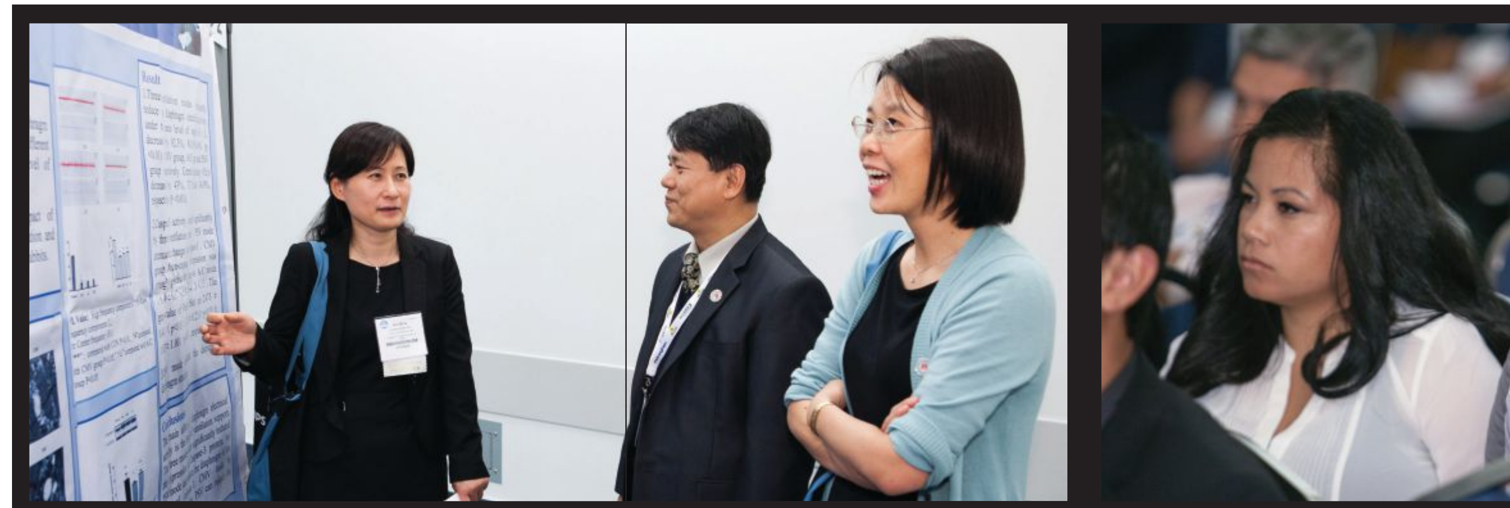
Dr. Allen DeVilbiss Best Paper Award went to Mark S. Siobal.

Cutting-edge Information Rules the Day

Everywhere they turned at AARC Congress 2013, attendees found state-of-the-art information they could take home and put to work in their facilities.

(Continued on page 42)

Photos by Lennie Sirmopoulos, Convention Photography, Tustin, CA



AARC President George Gaebler

President Gaebler Outlines 2014 AARC Plans

AARC President George Gaebler, MSEd, RRT, FAARC, took the podium at the Annual Business Meeting to bring the Association members up to date on plans for the final year of his presidency in 2014.

According to Gaebler, the AARC is working to promote patient access to the respiratory therapist across the continuum of care. “For the future, I see disease management, respiratory protocols, discharge planning… I expect an explosion of opportunities,” he said. He also noted that plans are in the works to bring the Association’s Clinical Practice Guidelines (CPGs) in line with an evidence-based approach. “Our CPGs are getting a major overhaul,” he said. “You’re going to have great CPGs!”

Gaebler ended his talk by sharing his vision for the future of our profession. “The next three to five years will be the most challenging in history. Expect large changes,” he said. “My challenge to you is mentor people. I think the sky’s the limit for RTs. It’s our time to shine.”

Open Forum Posters

Hot Topics in the Lecture Halls

Congress attendees heard hundreds of presentations on the hottest topics in the profession presented by the leading names in the business. These are just a few.

- **The "New" Health Care Paradigm: Will RTs Survive or Thrive?** Garry Kauffman, MPA, RRT, FAARC, covered a range of new initiatives impacting respiratory therapy departments today.
- **Teaching Adults: You Better Make It Useful** — Bill Galvin, MSEd, RRT, FAARC, explained how to reach the adults under your care.
- **The Future of the Respiratory Therapist in Home Care** — Joseph Lewarski, BS, RRT, FAARC, cited the critical role therapists can play in this patient preferred, high-quality, and lower cost setting.
- **Palliative Care in Long-term Acute Care Hospitals** — Mary Hart, MS, RRT, FAARC, explained how a better understanding of palliative care can help therapists address end-of-life issues.
- **High-frequency Percussive Ventilation** — Robert M. DiBlasi, BSRT, RRT-NPS, FAARC, looked at what the evidence has to say about this commonly used rescue modality for patients failing conventional ventilation.
- **COPD Disease Management — A Model for All Settings** — Brian W. Carlin, MD, FAARC, reviewed model disease management programs aimed at cutting excessive readmissions down to size.
- **Aerosol Therapy: Yesterday, Today, and Tomorrow** — Bruce K. Rubin, MD, MEngr, FAARC, took his audience on a journey through time to see how aerosol therapy has changed and why RTs are crucial to its future.

(Continued on page 44)

Hot Topics (cont.)

■ **What's Working?** Greg Spratt, BS, RRT, CPFT, explained how the AARC's COPD Best Practices Repository is helping members share success stories when it comes to improving care and reducing readmissions for COPD.

■ **Preventing ICU Readmissions: Development of a Readmission Risk Assessment Checklist** — Charles G. Durbin, Jr., MD, FAARC, went over the AARC's Adult Risk Assessment Checklist for ICU Readmission and how it can help therapists ensure fewer patients return to the ICU.

■ **Introduction to the AIM Cycle** — Robert L. Chatburn, MHS, RRT-NPS, FAARC, explained how the AIM-ACT model can help us provide the most appropriate care for patients undergoing mechanical ventilation.

■ **Critical Care Transport: Evolution of a Profession** — Steven Sittig, RRT-NPS, C-NPT, FAARC, provided a retrospective on the use of RTs on these teams and delved into issues related to the Affordable Care Act that could impact their use in the future.

■ **Multi-institutional Collaboration To Establish a Ventilator Patient Weaning Unit** — Gene Gantt, BS, RRT, and Garry Kauffman, MPA, RRT, FAARC, shared first-hand knowledge on setting up one of these units.

■ **Promoting Patient Safety Through Teamwork and Communication** — Ira Cheifetz, MD, FCCM, FAARC, outlined common errors in teamwork and communication that can derail safe patient care.

■ **Real World ROI** — Crystal Dunlevy, EdD, RRT, explained how successful patient education and discharge planning can improve the bottom line.

■ **Preventing BPD: Search for the Holy Grail** — Sherry Courtney, MD, reviewed the medical literature and suggested ventilator strategies that may eliminate BPD.

■ **Understanding COPD Guidelines and Putting Them into Practice** — Scott Cerreta, BS, RRT, went over current guidelines and showed attendees how they can be incorporated into discharge planning modules.

■ **SDB Programs for the Pediatric Population** — Kathleen Deakins, MSHA, RRT-NPS, FAARC, described a screening and mask-fitting program at a children's hospital.

■ **What's the Big Deal with Twitters, Tweets, Blogs, and Status Updates?** Diane Oldfather, MHEd, RRT, made the case that social media really can have a positive effect in the classroom and workplace.

■ **How To Manage Different Generations** — Mark Babic, RRT, shared ways to bridge the gap between the baby boomers and millennials working in the typical respiratory therapy department.

■ **Lung Protective Strategies: ARDSnet for Everyone?** Ruben Restrepo, MD, RRT, FAARC, looked at the pros and cons of using low tidal volumes.

■ **Animation and Interactive Technology to Teach Mechanical Ventilation** — Ken Tegtmeyer, MD, FCCM, shared some novel 3D technology and cutting-edge animation to augment mechanical ventilation instruction.

■ **Artificial Airways and Airway Adjuncts: Summary of the 52nd Respiratory Care Journal Conference** — Charles Durbin, Jr., MD, FAARC, provided an overview of the cutting-edge information gleaned from this conference. ■

■ **NOTE:** In addition to receiving continuing education credits for attending the lectures, all AARC Congress attendees received a free pass code to let them access most of the lectures online at their leisure.

Donald F. Egan Memorial Lecture

9 Things Everyone Should Know About Lung Protective Ventilation

Rolf D. Hubmayr, MD, covered all the bases during his presentation on “The Current State of Lung Protective Ventilation: What Should Clinicians Be Doing?” According to the professor of medicine and physiology at the Mayo Clinic in Rochester, MN, clinicians should note the following:

1. Irrespective of the chosen ventilation mode, the resulting tidal volume is the most important determinant of ventilation-associated lung trauma.

2. Ideally, tidal volume ought to be scaled to the size of the recruitable lung.

3. Body habitus and posture should influence one’s choice of positive end expiratory pressure (PEEP) and one’s tolerance for allowing plateau airway pressure limits to exceed 30 cm H_2O.

4. PEEP titration should be guided by mechanics as opposed to oxygenation endpoints.

5. Double triggering or breathing with increased, albeit sustainable, effort should be avoided.

6. Patient/ventilator asynchrony in a patient who is managed with permissive hypercapnia typically requires the administration of neuromuscular blockers rather than sedatives alone.

7. Ventilators are pulmonary function testing instruments and should be used as such.

8. The adoption of the upright or prone posture should be considered in selected patients.

9. Respiratory therapists should take an interest in the sedation practice just as much as nurses need to take an interest in ventilator management. ■

Rolf D. Hubmayr

Phil Kittredge Memorial Lecture

Dealing with Electronic Distractions

In 2011, the *New York Times* popularized the term "distracted doctoring" to describe the consequences of providing health care in the age of personal electronic devices (PEDs). In his talk at the Congress, Peter J. Papadakos, MD, FCCM, FAARC, urged attendees to pay greater attention to what he termed "Electronic Health Etiquette." In other words, clinicians need to change their behavior in the workplace, not only when it comes to their own smartphones and tablets, but also when interacting with the electronic medical record in the presence of patients and families.

"Staff have developed new programming where they become impatient and can't wait to do later what we can do now, even if such behavior is inappropriate to the clinical environment. Thus, they think they must constantly check for emails, social media, and tweets," said the physician, who practices at the University of Rochester Medical Center in Rochester, NY. "We must develop new behaviors to modulate the addiction to our own electronic lives and remain focused on patient safety."

Ditching the PEDs during working hours is a given, but dealing with the explosion of electronic medical record technology is another story. "We have developed the so-called i-patient, where the health care worker focuses on the computer screen and not the patient at hand," said Dr. Papadakos. "The i-patient may be getting great care; but the living, breathing patient may feel rejection and isolation."

He believes the increasing importance being placed on our daily interactions with electronic devices is putting us all at risk of losing the skill or even the desire to communicate face to face. "RTs have a special skill to closely listen to the quality of the voice of patients, interpret multiple aspects of the work of breathing, and evaluate the level of obstruction and various other parameters through direct observation," he said. "Even with patients on mechanical ventilation, close observation of patient-to-ventilator interaction is much more important than downloaded data on a computer screen."

Dr. Papadakos called on the respiratory care profession to come to the forefront and help educate providers on electronic health etiquette. "This aspect of patient care needs to be included first in the curriculum of respiratory therapy education and then reinforced by departmental policies," he said. "Bedside therapists need to develop skills to integrate technology without losing the human skills that have been at the core of practicing the healing arts." ■

Peter J. Papadakos

Inaugural Thomas L. Petty Memorial Lecture

Dr. David Pierson Notes Lessons Worth Learning

A strong case can be made that Dr. Thomas L. Petty, who passed away four years ago, was the single most important physician in the history of respiratory care. In this first annual Petty Memorial Lecture, David J. Pierson, MD, FAARC, looked at Dr. Petty's most important contributions to respiratory care and the lessons his life and work have to offer respiratory therapists of today and tomorrow.

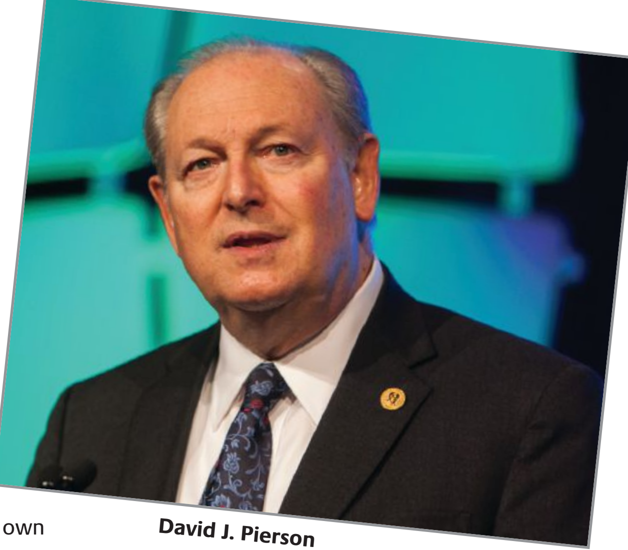
Born in 1932, Dr. Petty was on the faculty of the University of Colorado School of Medicine for 45 years. By the time he became head of its pulmonary division at age 38, he was already internationally known for describing and naming ARDS and first using PEEP to treat it, for establishing one of the first pulmonary rehab programs anywhere, for demonstrating the life-saving benefits of long-term oxygen therapy, and for creating the first true multidisciplinary approach to respiratory care.

Dr. Petty published more than 400 PubMed-cited articles, plus 45 books and hundreds of other publications during his long career; and his contributions to education include the training of dozens of the nation's most prominent pulmonary and critical care physicians. He also established numerous conferences and educational institutions such as the Snowdrift Pulmonary Conference and the National Lung Health Education Program. A strong advocate for patients, he reached out to patients and families via the "Ask Dr. Tom" column on YourLungHealth.com; and his own website, www.drtompetty.org, continues to provide a host of valuable and practical resources for patients and families even today.

While Dr. Petty is no longer here to offer his own lessons for today's respiratory care clinician, Dr. Pierson listed six points at the heart of Dr. Petty's teachings that he was confident would be endorsed:

1. Whatever your role, you need to be an expert in the most important, core areas of respiratory care — such as mechanical ventilation, ARDS, and COPD.

2. Respiratory care is a team sport, every member is important, and each needs to communicate well and work together.



David J. Pierson

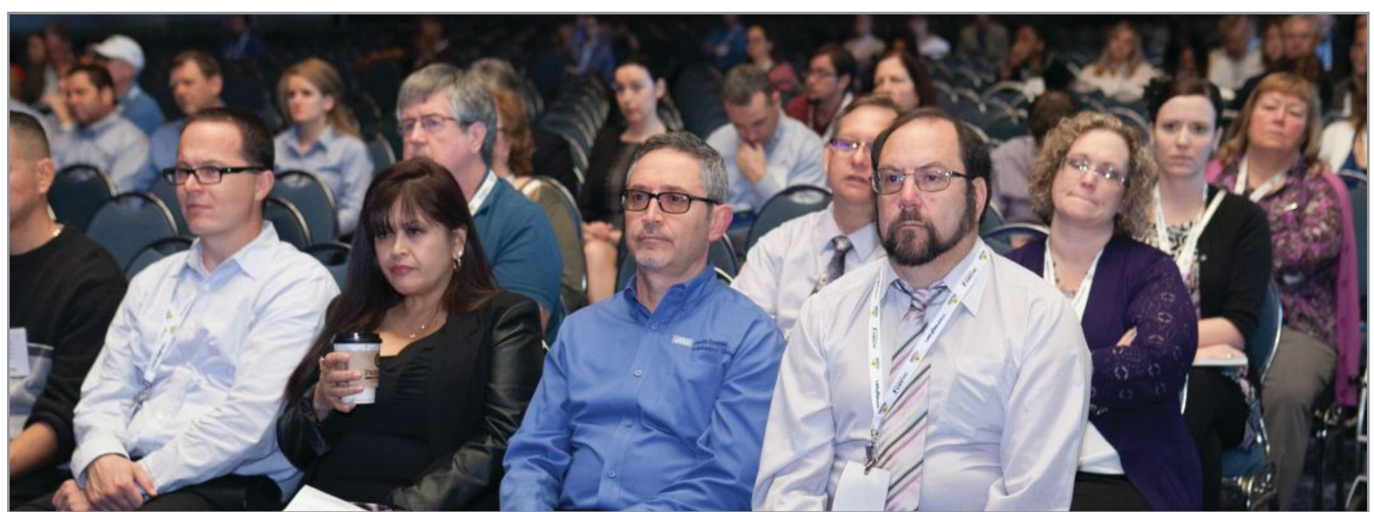
3. Education needs to be targeted at those in the best position to benefit the patient — including primary care providers and family members.

4. Everyone in the field needs to understand the important role of the respiratory care industry and deal with it responsibly.

5. Never forget that it's all about the patient.

6. Respiratory care should be exciting and fun.

The Thomas L. Petty Memorial Lecture was supported by an unrestricted educational grant from the Snowdrift Pulmonary Conference. ■



VAP Was Then, VAE Is Now

Dean Hess

Respiratory therapists have long been vigilant about looking out for "ventilator-associated pneumonia" or "VAP." AARC member Dean Hess, PhD, RRT, FAARC, sat on the Centers for Disease Control and Prevention's working group charged with coming up with a surveillance definition algorithm for a broader category called "ventilator-associated events" or "VAEs," and he explained what it all means for care at the bedside.

"Our approach to ventilator-associated events will change as the result of this program," says Dr. Hess. "Our focus will now be on ventilator-associated conditions rather than ventilator-associated pneumonia. It is incumbent on all of us to understand this program and its impact on respiratory therapists." An Executive Summary of the project was published in the November issue of Respiratory Care as well. ■

Shawna Strickland discussed the CPG project.

Banking on the Evidence

The AARC has published many Clinical Practice Guidelines (CPGs) over the years, but most have been based on a consensus process. In order to meet the need for more robust guidelines, the Association has now implemented an evidence-based approach, and the first of these new guidelines was published in the December issue of Respiratory Care.

Developed in conjunction with the Evidence Practice Center at Vanderbilt University, "Nonpharmacologic Airway Clearance Therapies in Hospitalized Patients" is expected to make a major impact on hospitals nationwide. "This guideline will have significant implications on practice and cost, as we found a lack of evidence to support many of our common practices," says AARC Associate Executive Director-Education Shawna Strickland, PhD, RRT-NPS, FAARC, who presented on the new evidence-based approach for AARC CPGs at the meeting. ■

AARC Congress: A Worldwide Phenomenon

The AARC Congress lived up to the "international" in its name at AARC Congress 2013 as attendees heard lectures and Open Forum presentations made by many of our colleagues from abroad.

These international colleagues presented during the regular sessions:

- Lluis Bland, from Spain, talked about noninvasive monitoring and the physiology of ventilation.
- Our colleagues from Portugal, Anna Caroline Braga, MSN, PT, Joao Preira MSc, and Anabela Cardoso Pinto, MD, PhD, offered up a neurorespiratory disease management symposium.
- Canadian colleagues Rita Troini, MA, RRT, and Veronique Adam, RRT, looked at best practices in the home.
- Norwegian clinicians Solfrid Indrekvam, MD, PhD, Ove Fondenes, MD, Siguard Aarrestad, MD, and Heidi Markussen, MHSc, RN, conducted a symposium outlining experiences with noninvasive ventilation in their country.
- Tom Piraino, RRT, from Canada spoke on the use of bladder pressure to set optimal PEEP.

International colleagues presenting in the Open Forums included:

- Hui-Quing Ge, MD, China
- Hsin-Chun Liu, RRT, Taiwan
- Xiaoke Chen, China
- Nimrod Adi, MD, Israel
- Miri Suh, MD, Republic of Korea
- Hilda Perry, PT, Canada
- Shu Wah Ng, MSc, RN, Hong Kong
- Hui-Ling Lin, MSc, RRT, FAARC, Taiwan
- Ibrahim A. Albalawi, BSRT, RRT, Saudi Arabia
- Li-Ting Kao, RRT, Taiwan
- Chin-Ming Chen, MD, Taiwan
- Sanjay Sasikumar, MSc, India
- Heera Lal Mahto, MScRT, India
- Pui Fan Chan, MSN, RN, Hong Kong
- Noel S Tiburcio, PhD, RRT-NPS, United Arab Emirates
- Vera Baturova, Russia
- Shu Wah Ng, MSc, RN, Hong Kong
- Rachell Ann Cruz Siute, MD, Philippines
- Kathy Murphy, PhD, MSc, RN, Ireland
- Pavanasam Ramesh, MD, United Kingdom
- Baskaran Chandrasekaran, MSc, India
- DongHyun Kim, MD, PhD, Republic of Korea
- Yusuke Chikata, MSc, RRT Japan

The AARC honored all of its international participants during an international reception sponsored by the AARC and ARCF, with special recognition going to our 2013 international fellows:

- Ana Cristina Okada, PT, Brazil
- Lysbeth Roldán, RT, Columbia
- Daisuke Tsukahara, MSN, RN, Japan
- Mohamad El-Khatib, MD, PhD, FAARC, Lebanon
- Mohammed Herrag, MD, PhD, Morocco

The winners of this year's Garza Award and Koga Medal were recognized as well, along with our city hosts and the sponsors of our International Fellowship Program: Draeger Medical Inc., Philips Respironics, AARC, Applied Measurement Professionals, Inc., and Aspirant Education Inc. ■

2013 International Fellows

Early Birds Catch Extra Continuing Education Credits

AARC Congress 2013 unofficially began the Friday before the opening ceremonies on Saturday with four pre-courses covering niche areas of respiratory care.

"Respiratory Care and the Trauma Patient" featured leading clinicians from across the country who addressed everything from airway management of the trauma victim to shock resuscitation.

"Tobacco Intervention and Cessation Aids" brought everyone up-to-speed on proven treatments and strategies to help people of all ages kick the habit, including hospitalized patients.

"Patient Safety and the Respiratory Therapist" delved into issues like NIV-skin breakdown; sentinel events, critical incidents, and near misses; the role checklists can play in keeping patients safe from harm; and more.

"Preparing for a Pandemic: The Strategic National Stockpile Mechanical Ventilators" offered a great overview of the RT's role during a national medical emergency, along with hands-on training on the SNS ventilators themselves. ■

Exhibit Hall Wows Attendees

With all the companies in the business on hand, the AARC Exhibit Hall gave attendees the chance to see everything that's new and innovative in respiratory care in one fell swoop. From the moment it opened on Saturday until the final minute of operation on Monday afternoon, the Hall was packed with respiratory therapists and other clinicians from across the country and around the world, who marveled at the latest that technology has to offer in the care of patients with lung conditions.

Vendors worked overtime to ensure everyone who came their way had a chance to speak one-on-one with a representative, and the result was a much more well informed group of clinicians by the end of the meeting than at the beginning. The knowledge shared during the lectures and symposiums was definitely enhanced by the quality time attendees were able to spend with our partners in industry to ask questions, raise concerns, and share experiences related to respiratory care. ■

Extra Added Attractions

The AARC Congress is a great place to learn the latest about respiratory care in the numerous lectures and symposia. But a lot more than this goes on at each annual meeting.

Blast from the Past

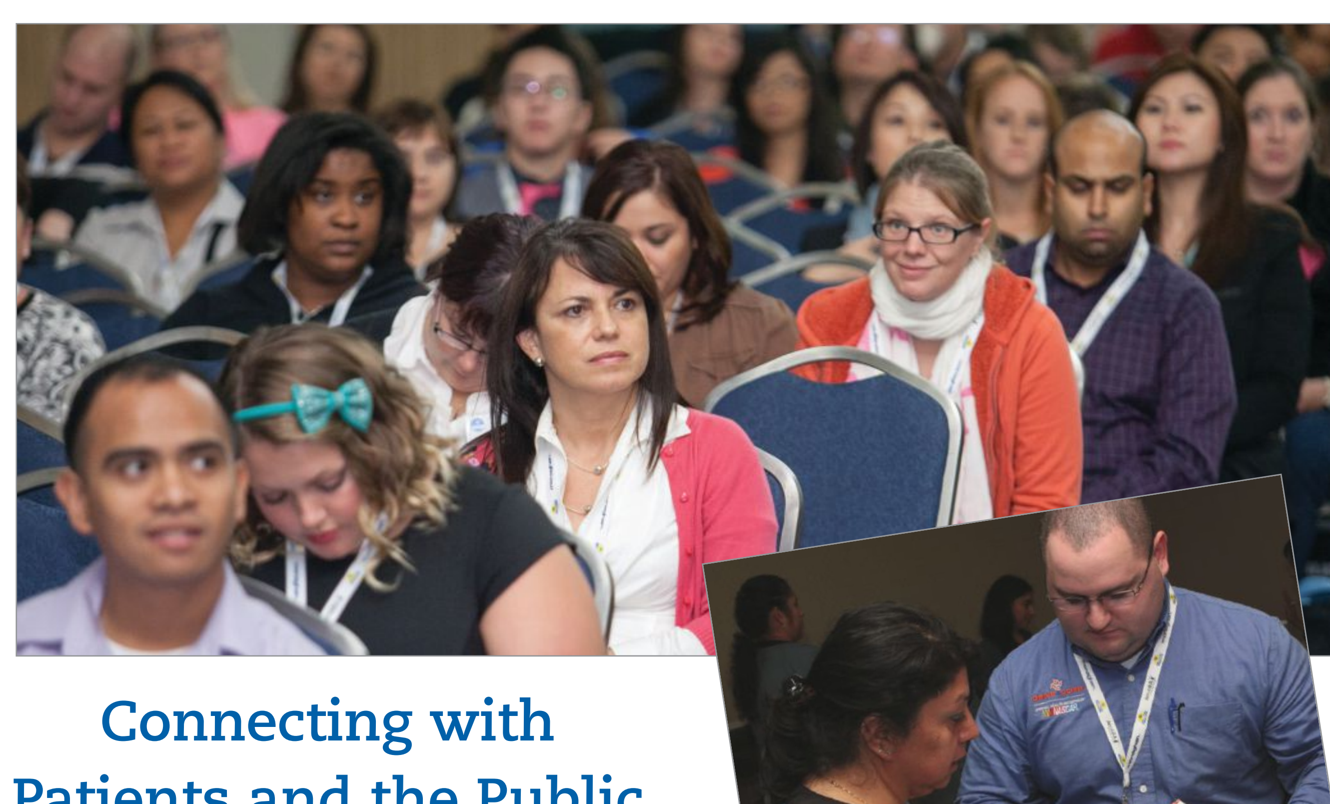
Antique respiratory therapy equipment took center stage at the American Respiratory Care Foundation's Night at the Museum, a fundraiser held on the Friday evening before the meeting began on Saturday to support the philanthropic efforts of the ARCF.

With comments ranging from "what the heck is that" to "can't believe we treated respiratory conditions with this," it was clear everyone was learning more about the history of their profession. Pianist Henry Oh, PhD, RRT-NPS, MT, provided the entertainment, and a brief program recognized Foundation donors. A special thanks went to the following people/companies for providing the equipment and other items on display: CareFusion, Barlow Hospital, ResMed, Dr. Brian Tiep, Dr. Rich Casaburi, Bob McCoy, Dr. Forrest Bird, AARC, Dr. Paula Anderson, Sechrist, Medical Graphics, and Monaghan. A new Virtual Museum was unveiled as well, and those on hand had a chance to purchase a "virtual brick" to lay the foundation. ■

ARCF Night at the Museum

Inventor Forrest Bird dropped by.

Photos by Lennie Sirmopoulos, Convention Photography, Tustin, CA



Connecting with Patients and the Public

Two events at AARC Congress 2013 reached out to people in the Anaheim area:

Respiratory Informational Session: As it has at every Congress over the past several years, the AARC hosted a special program to educate the public about chronic lung diseases and provide advice on the appropriate use of aerosol delivery devices. Respiratory therapy students from El Camino Community College, Orange Coast College, and American Career College were on hand to provide PFTs and speak to people about lung health.

Alpha-1 Foundation Education Day: The Alpha-1 Foundation took advantage of all the respiratory expertise in Anaheim by hosting one of its Education Days for patients, families, and caregivers affected by this genetic lung condition. Experts in town for the meeting volunteered their time to educate attendees about the value of pulmonary rehabilitation, offer tips on improving daily life for Alphas, provide information on the latest research, and encourage them to join the Alpha-1 Foundation Research Registry. ■

RT Jason Moury at the Alpha event

Cheryl Hoerr at the job event

Help for Job Seekers

We all know the job market for respiratory therapists has tightened up considerably in some parts of the United States, and nowhere is that more true than in California. For that reason, the AARC opened up its Saturday session on "Getting the Job: From Resume to Interview" free of charge to ALL AARC members who wanted to attend, whether they were registered for the Congress or not.

Congressman Visits with Leaders, Gets VIP Tour

Last fall, Rep. Robert E. Andrews (D-NJ) reached out to the AARC and requested a detailed briefing on the respiratory profession and our legislative agenda. When the congressman, who is a cosponsor of H.R. 2619, the Medicare Respiratory Therapist Access Act, learned he would be in Southern California on government business the same week as the AARC Congress, he requested an opportunity to come to Anaheim and meet with AARC and New Jersey Society for Respiratory Care leadership. He participated in the special salute to the military on Sunday, Nov. 17, and also enjoyed a VIP tour of the Exhibit Hall led by AARC CEO Thomas Kallstrom. ■

30-Minute Blocks Mean More CRCEs

A new scheduling paradigm at AARC Congress 2013 made it easier for more people to attend more sessions and earn more CRCE.

"In the past, sessions overlapped, which prevented attendees from earning some CRCE even though they attended the majority of a session," explains AARC Associate Executive Director-Education Shawna Strickland, PhD, RRT-NPS, FAARC. "By moving to mostly 30-minute blocks of sessions, attendees were able to learn from a greater number of presentations as well as earn more CRCE."

The program categorized sessions into specific content areas as well, which also made it easier for attendees to earn the CRCE they needed to maintain their license to practice. ■

Log on to www.aarc.org and see more photos and stories.

Congressman Robert E. Andrews with AARC CEO Thomas Kallstrom, MBA, RRT, FAARC, Joseph Goss, MS, RRT-NPS, AE-C, and military RTs

"Nutrition Guide" Promotes Interdisciplinary Care

Proper nutritional assessment and treatment is vital to the care of the critically ill patient, especially for those patients on mechanical ventilation. The use of predictive equations and indirect calorimetry allows the respiratory therapist to play a more vital role in the care of these patients. The AARC partnered with GE Healthcare to develop "A Guide to the Nutritional Assessment and Treatment of the Critically Ill Patient" that specifically addresses the unique nutritional challenges faced by ICU patients, which debuted at the GE Booth during the meeting.

The educational guide, passed out during the Congress, also speaks to the importance and outcomes related to interdisciplinary care, including collaboration between respiratory therapists, dieticians, and all other clinicians making up the patient's health care team. It is available free to AARC members at www.aarc.org/education/nutrition_guide/ and provides three CRCE hours. The cost for non-members is $15. ■

36th Annual Covidien Sputum Bowl

Teams from across the nation went head-to-head in the 2013 Sputum Bowl, with a rockin' Finals Night on Monday evening. New bracket methodology helped everyone keep up with the competition, and a new presence on social media ensured that folks back home could get into the spirit of things as well.

An audience participation game during the half-time show gave everyone the chance to compete for some great prizes, too, including a Kindle Fire HD 7", roundtrip limo transfer from McCarren Airport to the Mandalay Bay during AARC Congress 2014 in Las Vegas, a $100 Visa gift card, a free one-year AARC digital membership, and a Bluetooth wireless portable speaker.

Topping it all off was a fantastic performance by comedian Keith Alberstadt, a regular performer for our troops in Iraq and Afghanistan and a contributing writer for Saturday Night Live's "Weekend Update."

But the main attraction was, of course, the national and student competitions themselves. Congratulations to all the winners:

First place, nationals: Michigan
Second place, nationals: Minnesota
Third place, nationals: California and Pennsylvania

First place, student team: Nevada
Second place, student team: Ohio
Third place, student team: California and Minnesota

Sportsmanship Award: student team from California

The team from Michigan won the National Sputum Bowl.

The team from Nevada won the Student Sputum Bowl.

AARC Central Was Where It Was At

The AARC booth in the center of the Exhibit Hall was a hub of activity throughout the meeting. Visitors got to see some of the antique equipment featured at Friday evening's "Night at the Museum," and staff members were there to answer membership questions. DRIVE4COPD representatives explained how everyone can get more involved in this public health campaign in the coming year, and a few lucky attendees even got the chance to be in our new membership video (coming out soon).

But perhaps the biggest attraction was an Exhibit Hall drawing for some great prizes. Everyone at the Congress received a ticket provided with their badge receipt to enter, and prizes included airfare to Congress 2014 at the Mandalay Bay in Las Vegas; complimentary registration to AARC Congress 2014; roundtrip limo transfer from McCarren Airport to the Mandalay Bay; a one night hotel stay at the Mandalay during the Congress; a free AARC one-year digital membership; and a Kindle Fire HD 7". ■

AARC Honors Those Who Serve

The AARC held a flag-folding ceremony in front of the Exhibit Hall entrance on Sunday to pay tribute to all of our AARC members, past and present, who have served our country in the Armed Forces. We appreciate their service and the sacrifices they and their families have made to ensure the nation remains safe. ■

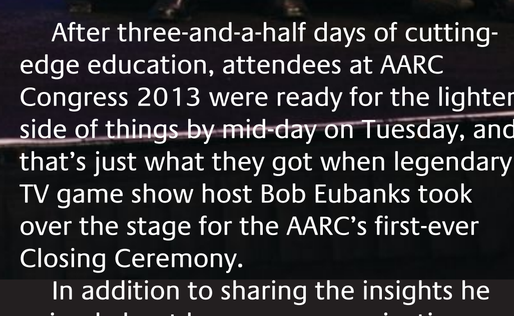
AARCTV Keeps Everyone in the Loop

Everyone attending the Anaheim Congress, and even people back home too, got the chance to watch special reports produced by Convention News Television on activities taking place each day of the meeting. The five- to seven-minute broadcasts ran every evening on a proprietary channel in the AARC hotels and on the monitors in the convention center. They were also streamed on www.AARC.org and our Twitter feed. ■

Flag ceremony with AARC military members

AARCTV interviewed Congressman Andrews and several attendees.

Bob Eubanks Hosted First-ever Closing Ceremony



After three-and-a-half days of cutting-edge education, attendees at AARC Congress 2013 were ready for the lighter side of things by mid-day on Tuesday, and that's just what they got when legendary TV game show host Bob Eubanks took over the stage for the AARC's first-ever Closing Ceremony.

In addition to sharing the insights he gained about human communications during his stint on "The Newlywed Game" and years as a concert producer for bands like the Beatles and the Rolling Stones, Eubanks offered lots of great information RTs could take home and put to good use as they deliver patient education and take on a larger role in disease management. To see how well therapists communicate, he also hosted a game called "Workmates" that pitted several teams of RT colleagues against one another in a friendly competition aimed at seeing just how much they really knew about each other. A good — and informative — time was had by all! ■

Bob Eubanks

Attendees Enjoy Congress at Home, Too

Even with the new 30-minute lectures in Anaheim, most attendees would have found it impossible to make it to every presentation they wanted to attend. As Congress registrants, however, they are still able to take advantage of those sessions. Everyone registered for the Congress received an email shortly after the first of the year with instructions on accessing free recordings of nearly all of the sessions featured over the four-day event. The free Congress recordings were made possible by an unrestricted educational grant from Draeger. ■

Open Forum Format Changes Coming

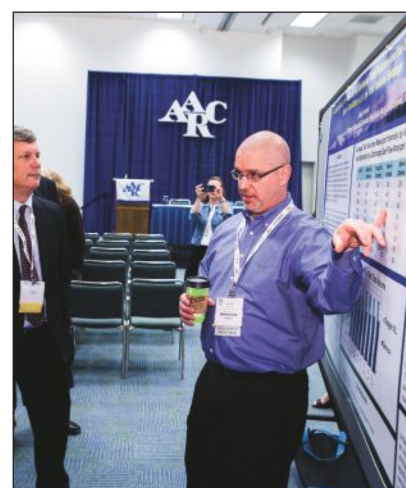
Attendees at AARC Congress 2013 heard hundreds of presentations in 19 Open Forums spread over the four days of the meeting. We have some exciting format changes underway for the 2014 session that promise an even better Open Forum in Las Vegas:

Editor's Choice: Authors of this select group of abstracts will prepare a poster for prominent display on the first two days of the Congress. On day three, each author will make a 10-minute slide presentation followed by a 10-minute discussion.

Poster Discussions: Authors will prepare a poster to be presented in a session grouped by topics. A brief oral presentation (no slides) will be followed by audience questions and discussion. (Most accepted abstracts will fall into this category.)

Posters: Authors will prepare a poster to be displayed during Exhibit Hall hours on an assigned day; authors will be present between noon and 1 p.m. on that day to discuss their work. ■

The deadline for submitting abstracts for the 2014 Open Forum is June 1.



On to the Mandalay Bay in 2014!

The AARC has convened its International Respiratory Convention & Exhibition in Las Vegas many times over the years, but next year's annual meeting is going to take the experience up a notch.

In 2014 we'll be at the Mandalay Bay Resort & Casino. Located right on the Las Vegas Strip, this cutting-edge facility includes the fifth largest convention center in the nation, offering 1.7 million gross square feet of meeting space.

But that's just the start. You'll also find amenities ranging from the beautiful Mandalay Beach to an onsite shopping mall. The Shark Reef Aquarium will bring you face to face with some of the Earth's most fascinating creatures, and you'll dine in style at restaurants created by world-famous chefs like Wolfgang Puck, Hubert Keller, and Rick Moonen. It's all respiratory-friendly too — the resort has installed a state-of-the-art ventilation system designed to address many of the concerns people have with secondhand smoke circulating in other Vegas establishments.

The 2014 AARC Congress will run from Dec. 9–12 (Tuesday–Friday), and registration is now open. If you plan to seek funding from your hospital to attend, now is a great time to get it on your boss's radar screen. Many institutions are budgeting for fall 2014 meeting attendance right now; and the sooner you get in your request, the more likely you'll have your attendance covered.

How can you convince your superiors to fund your attendance? Make a copy of this article on our 2013 meeting in Anaheim and include it in your written request. It's a great way to show them the value you'll receive by attending the International Respiratory Convention & Exhibition. ■

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.

ACCESS ARCF ONLINE AT WWW.ARCFOUNDATION.ORG

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.

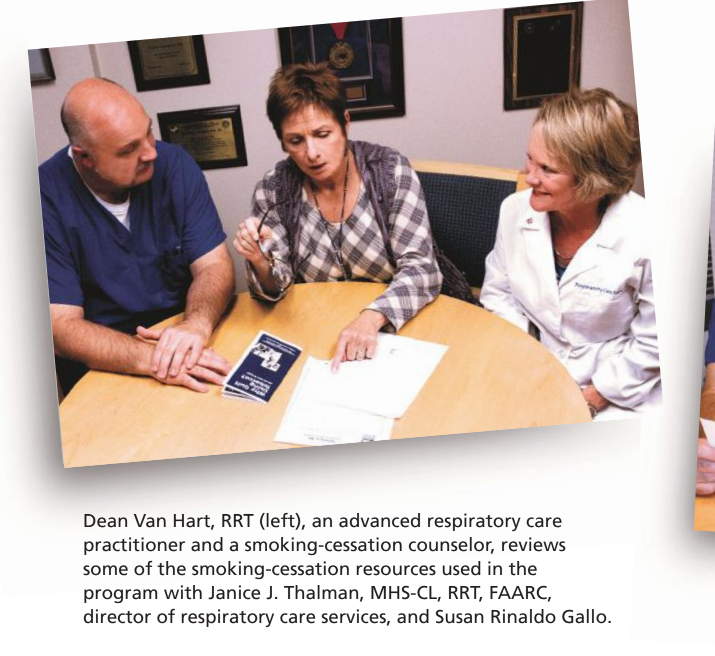
RTs at Duke Lead the Way in Smoking-cessation Counseling

Comprehensive program helps people quit

Many hospitals are still more focused on treating the diseases caused by smoking than getting people to quit. RTs at Duke University Medical Center are turning that thinking around.

by Debbie Bunch

Study after study has shown that quitting smoking can significantly improve a person's overall health, and nowhere is this more true than for patients with cardiopulmonary problems. Despite the overwhelming body of evidence, however, most hospitals have barely entered the area of smoking cessation — and we're not just talking about your average community hospital either. Major medical centers have lagged behind, too. That's where Duke University Medical Center in Durham, NC, was at about a year and a half ago when the respiratory therapy department decided to "take the bull by the horns" and do something about it.



Dean Van Hart, RRT (left), an advanced respiratory care practitioner and a smoking-cessation counselor, reviews some of the smoking-cessation resources used in the program with Janice J. Thalman, MHS-CL, RRT, FAARC, director of respiratory care services, and Susan Rinaldo Gallo.

Opportunity knocks

"As clinicians, we noticed that no single entity in the hospital was taking responsibility for this service," says Susan Rinaldo Gallo, MEd, RRT, CTTS, FAARC, health system user analyst at Duke. Given the recent Joint Commission mandate for the screening of inpatients for smoking, nurses and physicians were asking patients about tobacco use and providing minimal counseling; but no one was providing the comprehensive services these patients needed to really drive a quit attempt. Gallo and her colleagues heard opportunity knocking and decided to develop a full-blown smoking-cessation counseling service that would utilize RTs. "We saw this as an opportunity to improve patient care and to provide a valuable service," says the AARC member. "We also saw this as a way to expand our scope of services."

They designed their program around 20-35 minute, one-on-one sessions with specially trained RTs. "We proposed it to our administrator; and after we received his approval, a small group of interested therapists attended the American Lung Association's 'Freedom from Smoking' course," says Gallo. From there, she attended a 40-hour tobacco-cessation program leading to her certification as a certified tobacco treatment specialist (CTTS). She now serves as the trainer for the department and also coordinates the program.

With the basics covered, the department moved on to develop marketing brochures, communication strategies, and patient training materials using information gleaned from a range of sources, including the AARC, Mayo Clinic, and others. The program kicked off with a pilot program for cardiology patients in 2010.

Physicians and nurses were more than happy to have someone take on the challenge, and word soon began to spread. Thoracic surgery patients were added next, followed by the preoperative surgery clinic, which learned of the service and asked to be included to help more of their patients kick the habit before undergoing surgery. "Finally in June of 2013, we went live with a new hospital-wide computer system," says Gallo. "We were able to have an order set built into this system for 'Smoking Cessation by Respiratory Care,' and that is how we expanded this service over a period of 18 months."

Customized sessions

As noted earlier, the Duke program begins with a 20–35 minute individual session with the patient. "We start out with a short questionnaire — a standardized tool to rate the patient's level of addiction," says Gallo. Called the Fagerström Test, the tool helps to get the conversation going and encourages patient involvement in the session.[1] The rest of the session spins off of those results.

Duke's Awarding-winning Program

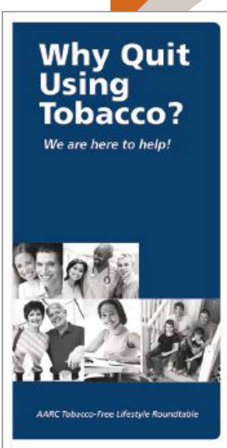
Photos courtesy of Malissa Lockamy-Dunn, RRT

Taking the initiative to build a smoking-cessation counseling service for their hospital has given Duke RTs the chance to improve patient care while earning the respect and admiration of their colleagues in nursing and medicine. Good deeds like this one deserve some recognition, and the team at Duke got just that last summer when the respiratory care department won the hospital's "It Takes a Team" Clinical Quality Award for their efforts.

"With an estimated 46.6 million smokers, the need for education and prevention is more important than ever," says Susan Rinaldo Gallo, MEd, RRT, CTTS, FAARC, who oversees the program. "Having a centralized group of practitioners provide this service is an integral part of the total health care plan with far-reaching benefits. Not only will this improve patient care, it has enhanced the role of the respiratory therapists."

For Jonathan Umbdenstock, RRT, and his colleagues who provide the bedside education, the award was a nice "thank you" for their efforts. "I was surprised, and then happy, for the department to receive the recognition," he says. "It is always good to have positive publicity for respiratory care." ■

Tobacco-cessation Resources from the AARC



The AARC has amassed a wealth of resources on tobacco cessation that can help kick-start any effort to develop an inpatient or outpatient program. Last spring, members of the Association's Tobacco-Free Lifestyle Roundtable also developed a patient guide for tobacco cessation titled "Why Quit Using Tobacco?" that is available in the AARC online store. Visit www.AARC.org for more information. ■

"Counseling sessions are customized based on the patient's responses, their level of knowledge, and their willingness to quit," says the respiratory therapist.

One of their key strategies is to stay focused more on quitting than on what smoking has done to the individual. "We cover the harmful effects of smoking as related to their diagnosis, but we don't dwell on this," Gallo says. "Most people know smoking is bad for them." After sharing some brief information on how smoking harms the system in question (cardiac patients hear about smoking's effects on the heart, pulmonary patients hear about the effects on the lungs, etc.) the RT quickly moves on to the subject of quitting, asking the patient about his personal reasons for wanting to give up smoking.

"We spend a lot of time discussing the behavior changes that will be required, such as how to deal with triggers and how to avoid triggers," says Gallo. "We try to prepare them for the urges they will have when they return to their familiar environment." RTs stress the fact that most of these urges will pass in five minutes or less, and then help their patients come up with substitute behaviors they can use to distract themselves when those urges strike.

Nicotine replacement therapy (NRT) is a big part of the process. Gallo says the therapists let their patients know

Getting Paid

According to Susan Rinaldo Gallo, MEd, RRT, CTTS, FAARC, Duke RTs provide smoking cessation under the "incident to" the physician's services provisions and, thus, are able to bill using the following CPT codes:

- 99406 — Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes.
- 99407 — Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes

For more detailed information on billing, please see the Coding Guidelines as posted on www.AARC.org. ■

NRT can improve their odds of quitting by 50%.[2] They go over all the options — gum, lozenge, patch — and talk about which type would be best for each patient. If the urge to smoke is plaguing the patient while she is in the hospital (Duke is a smoke-free facility), then the therapist will ask the patient's physician to place an order for NRT while the patient is still hospitalized.

Since Duke is smoke free, RTs also make sure they emphasize to the patient that he/she will have already gone through the hardest part of smoking cessation (the first few days) before he/she is even discharged. The hope is that this knowledge will serve as an incentive to help them keep the momentum going once they are discharged. To help patients continue the journey at home, they are all asked to give the RT department permission to send their contact information to 1-800-QuitNow so that a trained counselor can continue to work with them at home.

Approach with caution

Jonathan Umbdenstock, RRT, an advanced respiratory care practitioner at Duke, is one of the therapists who provides the service. He says he's called upon to deliver smoking-cessation counseling about once or twice a week and has learned a lot in the process, especially when it comes to helping patients get past their negative response to the idea of quitting. "To overcome negative reactions, I redirect my discussion and roll with the resistance," says the AARC member. "As an example, if a patient says, 'I have tried to quit before but nothing works!' I ask them to tell me about their quit attempts and what happened. This will get them talking, and then I can ease in a little advice and continued questioning."

He emphasizes the need to approach these patients with caution, because most of them are already frightened and anxious. They know smoking played a role in their hospitalization and are worried about what it's doing to their body, but they just haven't had the confidence to quit. However, with a compassionate approach, Umbdenstock finds most of these patients will become receptive, and even appreciative, of the advice and support he offers. "They know that quitting smoking will improve their health."

Since most patients have attempted to quit before, they almost always bring something new to the table as well. "One patient told me her method of reducing, which I thought was very inventive," says Umbdenstock. "She said when she really needed a cigarette she would smoke half of one. Then she would put it out in a container of water." That created a win-win situation because not only did dousing the cigarette in water prevent her from lighting it back up, it served as a visual reminder of how "nasty and dirty" the habit is.

Another patient told him she would give her pack of cigarettes to a neighbor to hold on to, which meant she would have to go outside and over to the neighbor's house in order to smoke. Having to make that effort was often enough to keep her from smoking.

Growing popularity

Once patients receive the initial smoking-cessation counseling session, a follow-up session lasting about 10 minutes will be scheduled to help reinforce the education and answer any questions the patient may have thought of in the interim. Right now, about five patients a week are referred for the service; but Gallo says she and her colleagues are actively working to increase that number. Since the service usually isn't time sensitive, the counseling sessions can be worked into slow times in the RT's day, making it scheduling friendly for the department as well.

While Gallo says the department has yet to acquire funding to collect outcomes from the program, feedback from the QuitNow telephone service indicates about 50% of the patients accept the service once they are discharged, which indicates they are persevering with their quit attempt at home. Physicians and nurses continue to be thrilled to have RTs spend this quality time with patients to encourage them to quit and believe it's having an impact as well. "Not every nurse or physician is comfortable going beyond very brief counseling, so having a group of specially trained RTs to provide this service is a relief," she says.

As for the RTs who provide the service, Gallo says they find it rewarding and appreciate having a new skill to add to their arsenal. But she emphasizes that smoking-cessation counseling probably isn't for everyone. "We were able to select the therapists who expressed an interest," she says. "Smoking-cessation counseling is not something that all therapists want to do."

That said, the growing popularity of the program at Duke means more RTs on staff will be doing it in the future. "We started with a group of five Registered Respiratory Therapists but are in the process of expanding this group to many more therapists," she says. The ultimate goal is to reach every Duke patient who smokes so more people can start down the road to cessation before they go home from the hospital. ■

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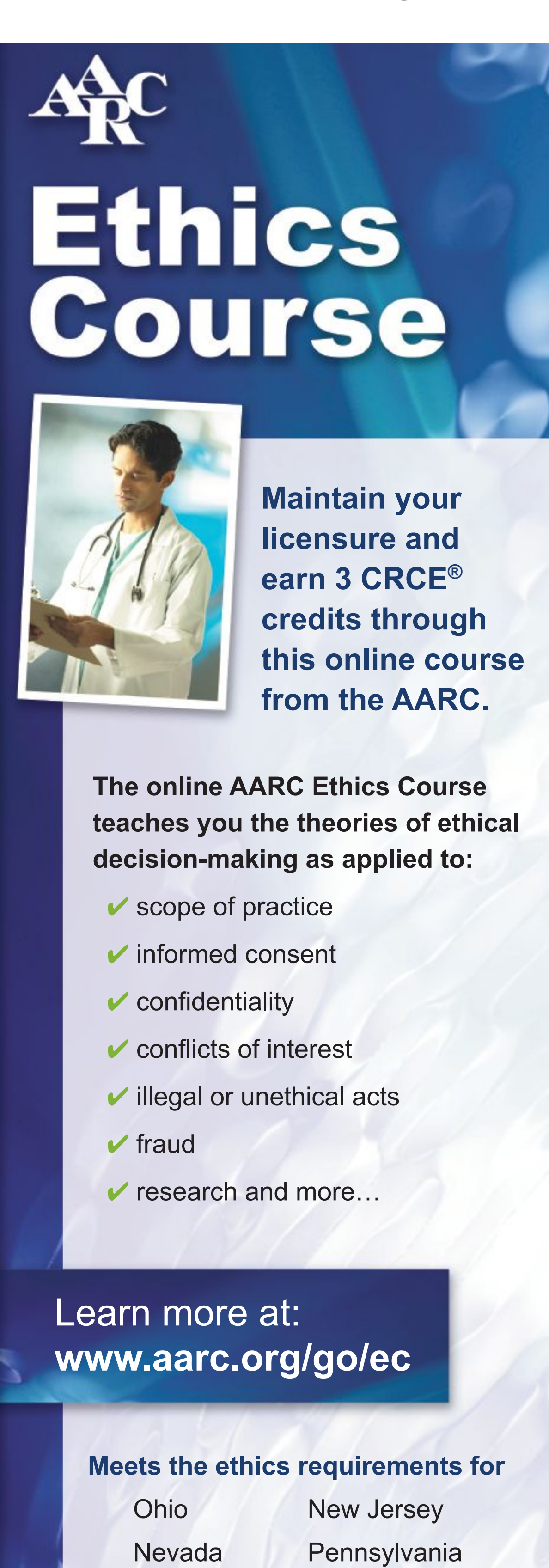
2. Jorenby DE, Leischow SJ, Nides MA, et al. A controlled trial of sustained-release bupropion, a nicotine patch, or both for smoking cessation. N Engl J Med 1999; 340(9):685–691.



12 Tax and Stress-saving Ideas for 2013

by Tony Lovio

It's tax time – are you ready?

Even though I deal with numbers all day, I still dread this time. I have to find all my documents and little receipt pieces and force myself to give an accounting to Uncle Sam. Tax laws and forms seem to change every year — and depending on how it goes, I might even have to write him a check. No fun. Hopefully, though, I can give you some thoughts on how to deal with this stressful time. There are potentially thousands of tax tips that have filled many books. I'll hit only a few that might be less commonly considered or that could potentially be of special interest to you.

While I can't guarantee anything, perhaps the following ideas may make your job a little easier. Remember also that the tips listed here are for general information purposes only. Your factual circumstances are unique to you; and if you think these points can possibly help, you should consult with a local tax professional. All publications referred to herein are available on the Internal Revenue Service (IRS) website at **www.irs.gov/**.

1 Organization

The first thing is to get organized … and this is something that, if done throughout the year, makes it much easier now. I have a drawer at home called my "tax drawer." Whenever I receive a potential tax-related document or receipt, it gets put in that drawer — nothing else. Then every February (when most tax reports from outside people are usually in), I sort through that drawer. I separate and categorize all income and expense items and ultimately create an accounting-type file that not only helps me prepare this year's return but also serves as a future reference ("Now, what did I do last year..?"). This is beneficial whether you do your own return or have a professional do it for you.

2 Electronic Filing

Assuming you do your own return and filing, I strongly recommend doing it electronically. I know that may be tough for some of us "older types" who like touching and shuffling the paper and don't trust someone else's calculations, but I made this change about five years ago and have never regretted it. Why?

- It saves time, especially after the first year as many of the programs remember your basic information from prior years and you just fill in the blanks in later years.
- All calculations are done for you. I'm not perfect and could easily mis-read a table or make some other error.
- The programs often recommend tax-saving ideas or deductions you can take and may not have considered.
- If you get a refund, you can have it wired to your bank, usually in less than two weeks rather than up to 8–10 weeks if you file manually.
- The program I use costs less than $10 each year — and it's tax deductible.

Education

If you pay college expenses for more than one student in the same year, you can claim credits on a per-student, per-year basis.

3 Credit for College Expenses

Going to college can be a stressful time for students and parents. The IRS offers these tips about education tax benefits that can help offset some college costs and maybe relieve some of that stress:

- **American Opportunity Tax Credit (AOTC).** This credit can be up to $2,500 per eligible student. The AOTC is available for the first four years of post secondary education. Forty percent of the credit is refundable. That means that you may be able to receive up to $1,000 of the credit as a refund, even if you don't owe any taxes. Qualified expenses include tuition and fees, course-related books, supplies, and equipment. A recent law extended the AOTC through the end of December 2017.
- **Lifetime Learning Credit (LLC).** With the LLC, you may be able to claim up to $2,000 for qualified education expenses on your federal tax return. There is no limit on the number of years you can claim this credit for an eligible student.

You can claim only one type of education credit per student on your federal tax return each year. If you pay college expenses for more than one student in the same year, you can claim credits on a per-student, per-year basis. For example, you can claim the AOTC for one student and the LLC for the other student. You can use the IRS' Interactive Tax Assistant tool to help determine if you're eligible for these credits. The tool is available at www.IRS.gov/. These education benefits are subject to income limitations and may be reduced or eliminated depending on your income.

4

Education Expenses

You may be able to deduct work-related educational expenses paid during the year as an itemized deduction on Form 1040, Schedule A. This can include the many seminars and online courses that AARC offers to you as well as education at the AARC Congress and Summer Forum. To be deductible, your expenses must be for education that:

- maintains or improves your job skills, or
- is required by your employer or by law to keep your salary, status, or job.
- However, even if the education meets either of these tests, the education cannot be part of a program that will qualify you for a new trade or business, or be needed to meet the minimal educational requirements of your trade or business.

Expenses that can be deducted include:

- course fees, tuition, books, supplies, lab fees, and similar items
- certain transportation and travel costs, and
- other educational expenses, such as the cost of research and typing.

If you are an employee, you generally must complete Form 2106. Educational expenses are deducted as miscellaneous itemized deductions on Form 1040, Schedule A. They are subject to the 2% of adjusted gross income limit.

If applicable, your employer may report any educational assistance payments made to you on your Form W-2 in the appropriate box under "other." For more information on educational expenses, refer to Publication 970, "Tax Benefits for Education."

5

Individual Retirement Accounts

This may be a good opportunity to save for retirement. An individual retirement arrangement (IRA) is a tax-favored personal savings arrangement, which allows you to set aside money for retirement. There are a couple of different types of IRAs, which you can set up with a bank, insurance company, or other financial institution.

- The original IRA is often referred to as a "traditional IRA." You may be able to deduct some or all of your contributions to a traditional IRA. If you are covered by a retirement plan at work, in 2013 you can take a full IRA deduction if your modified adjusted gross income (AGI) is less than $95,000 (married filing jointly) or $59,000 (single). The deduction is partial or eliminated at incomes above those limits. Amounts in your traditional IRA, including earnings, generally are not taxed until distributed to you.

- A Roth IRA differs from a traditional IRA in several respects. Contributions to a Roth IRA are not deductible (and you do not report the contributions on your tax return), but you also are not taxed on qualified distributions or distributions that are a return of contributions.

Refer to Publication 590, "Individual Retirement Arrangements" (IRAs), for additional information on the different types of IRAs, including information on contributions, distributions, and conversions from one type of IRA to another.

6

Other Miscellaneous Deductions

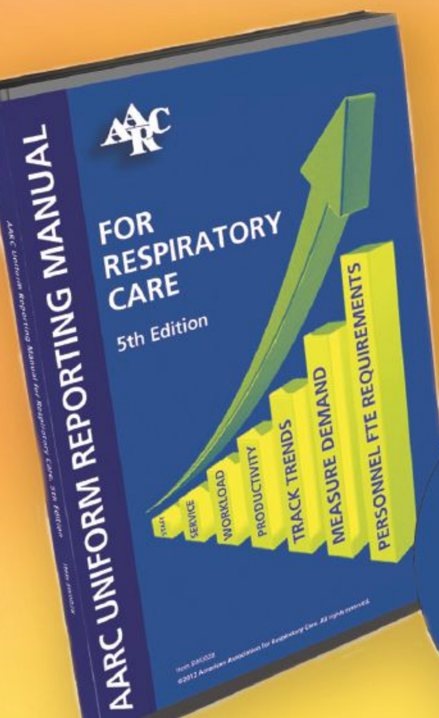
If you itemize deductions on your tax return, you may be able to deduct certain miscellaneous expenses. Here are some things you should know about miscellaneous deductions:

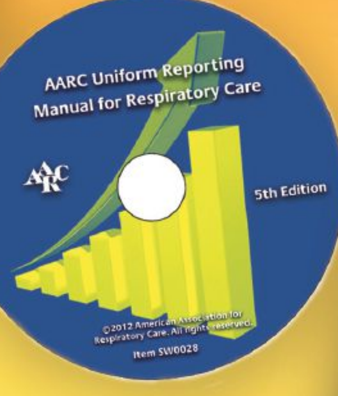
<u>Deductions are subject to the 2% limit</u>, that is, you can deduct most miscellaneous expenses only if they exceed 2% of your adjusted gross income. These include expenses such as:

- Non-reimbursed work-related travel, hotel, food, and transportation.
- Expenses related to searching for a new job in the same profession.
- Educational expenses, as discussed earlier. This can include expenses of going to the AARC Summer Forum, Congress, or educational classes.
- *Other unreimbursed* employee business expenses (i.e., mileage). Note: commuting expense is not deductible.
- Certain required work clothes and uniforms.
- Dues paid to professional associations. This includes the AARC (less non-deductible AARC lobbying estimate of 20%).
- Licensure fees.
- Tools or equipment purchased as needed or required for your job.
- Tax preparation fees.
- Certain investment fees.

<u>Some miscellaneous deductions are not subject to the 2% limit.</u> However, many expenses are not deductible at all. For example, you can't deduct personal living or family expenses. Report your miscellaneous deductions on Schedule A, Itemized Deductions. For more information, see Publication 529, Miscellaneous Deductions.

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.

ITEM # SW0028
Nonmember Price $225.00
MEMBER PRICE $175.00
Member Savings $ 50.00

Respiratory Care Patient-Driven Protocols, 3rd Edition

The pressure is on to efficiently operate a respiratory care department more economically. One of the most significant ways to accomplish safe and effective cost savings is through the use of protocols by respiratory therapists. Protocols have been scientifically validated as an effective method to reduce expenses and this manual is an excellent resource for the development, implementation, or refinement of care plans. Contains algorithms with each protocol. Copyright 2008 University of California San Diego, Respiratory Services.

ITEM # SW0025
Nonmember Price $130.00
MEMBER PRICE $ 90.00
Member Savings $ 40.00

Orientation and Competency Assurance Documentation Manual for Respiratory Care, 2nd Edition

Take the worry out of documenting orientation and competency in respiratory care. With its easy-to-use digital format, this manual provides tools for documentation of compliance for Respiratory Care Services with the 2010 standards for CMS, IHI (Institute for Healthcare Improvement), and The Joint Commission. Terminology is consistent with the AARC's Uniform Reporting Manual. Includes guidelines in chapter format with reference to over 90 detailed competency documentation forms. An "off the shelf" system that you can begin using right away. Copyright 2011 Daedalus Enterprises Inc.

ITEM # SW0027
Nonmember Price $159.00
MEMBER PRICE $119.00
Member Savings $ 40.00

More details and additional management and educational resources are available from the AARC Store.

www.AARC.org/store

7 Health Savings Accounts (HSAs) (not to be confused with a flex-spending or Sec. 125 cafeteria plan)

The AARC implemented this medical plan arrangement for our home office staff in 2005, and it works well for us. The Affordable Care Act (ACA) has changed some rules on HSAs, but they are still looked at favorably and becoming more popular.

You can contribute painlessly through your payroll with pre-tax money into these individual accounts that are used to pay for your medical expenses — even if some expenses are not allowable under your company's medical plan (e.g., eyeglasses). The account balances carry forward year to year (it's not "use-it-or-lose-it"). With medical expenses deductible now only if they exceed 10% of your AGI (for those under 65), these accounts can be very beneficial, but they are not for everyone. Their rules are special and complex; but if you're interested in how they could help you, you might suggest exploring this approach to your benefits department.

8 Mileage Rates

Don't forget if you use your car for business, charitable, or medical reasons, you have a potential mileage deduction. For any of these, especially a business deduction in, say, the home care field, remember to *keep a detailed log* of your trips. The 2013 rates are:

- 56.5 cents per mile for business miles driven.
- 24 cents per mile driven for medical or moving purposes.
- 14 cents per mile driven in service of charitable organizations.

9 Affordable Care Act

With so much in a state of flux as of this writing, I hesitate to say much — but as it stands at this moment, many ACA provisions will hit in 2014. This new health care law includes new health insurance coverage requirements and financial assistance options, including the Premium Tax Credit, for individuals and families purchasing insurance through the ACA Marketplace. You should have received notices from your employer on this recently. It would be very wise to pay close attention to current developments as the IRS administers the tax provisions included in the law affecting your 2014 tax return.

10 Don't Fall for Phony IRS Websites

Very few weeks go by that I don't get an email from a foreign dignitary wanting to make me a billionaire… for a small fee. Unsolicited emails from the IRS have about as much credibility. The IRS does not send taxpayers unsolicited emails about their tax situations, personal tax issues or, especially, requesting personal data. If you receive such an email, most likely it's a scam. IRS impersonation schemes flourish during tax-filing season. These schemes may take place via phone, fax, Internet sites, social networking sites, and particularly email. Sadly, many still fall prey to these official-looking scams. Please don't be one of them.

Many impersonations are identity-theft scams that try to trick victims into revealing personal and financial information that can be used to access their financial accounts. Some email scams contain attachments or links that, when clicked, download malicious code (virus) that infects your computer or directs you to a bogus form or site posing as a genuine IRS form or website.

Beyond hitting the DELETE key, if you want to go further:

- The IRS website has information that can help you protect yourself from tax scams of all kinds. Search the site using the term "phishing."
- If you get an unsolicited email that appears to be from the IRS, you can report it by sending it to phishing@irs.gov.

11

If You Receive an IRS Notice, Here's What To Do:

■ Don't panic. Follow the instructions in the letter.
■ There are many reasons the IRS sends notices to taxpayers. The notice usually covers a specific issue about your account or tax return. It may request payment of taxes, notify you of a change to your account, or ask for additional information.
■ If you receive a notice about a correction to your tax return, you should review it carefully. You usually will need to compare the information in the notice to the entries on your tax return. If someone else did your return, talk to them.
— **If you agree** with the correction, you usually don't need to reply unless a payment is due.
— **If you don't agree** with the correction the IRS made, it's important that you respond timely, as requested, with whatever explanation and/or documentation is appropriate.
— There is no need for you to call or visit an IRS office to answer most IRS notices.
— Keep copies of any correspondence with your tax records.

12

Make a Mistake on Your Tax Return Last Year?

Did you forget to take a credit or deduction — like maybe for education or miscellaneous expenses last year — or did you just realize you could claim one? Did you receive a very late 1099 relating to a previously filed return? These examples happen to everyone. Your already filed 1040 is not locked in stone. The solution is to file an amended return using Form 1040X. Amended returns must be filed on paper, take two-to-three months to process, and generally need to be filed within three years of the original filing date. I have done this before, and it doesn't necessarily trigger any suspicion.

When NOT to amend a return. In some cases, you don't need to amend your tax return. For example, the IRS usually corrects math errors when processing your original return. If you did not include a required form or schedule, the IRS will send you a request for whatever is missing.

Let me end with some brief, financially related bullet points to consider without going into much detail. If any one of them strikes you as pertinent to your situation, dig into it:

■ **Can't get your tax return filed on time?** Request an automatic six-month extension via Form 4868. But remember, you'll still have to pay an estimate of what you think you owe, if anything, by April 15.
■ **Upside down in your mortgage?** Talk to your mortgage holder about these federal refinancing programs: HAMP (Home Affordable Modification Program) and HARP (Home Affordable Refinance Program).
■ **Get a large increase in your property tax home appraisal?** If allowable, protest it. It likely will cost nothing but time and research and can save thousands of dollars.
■ **Do you know what is in your credit report?** Request a free copy annually from each of the credit agencies via www.annualcreditreport.com.
■ **Making charitable contributions?** Get a written receipt on anything above a small amount ($25).
■ **Realized any gains from investment sales?** Evaluate any investments in a loss position to see if selling makes sense. The realized loss can offset the realized gains and save tax.
■ **If possible, do some tax planning during the year.** Look at deferring income into the next year and accelerating expense into the current year as the next year end approaches. (Example: pay the January mortgage payment in December.)

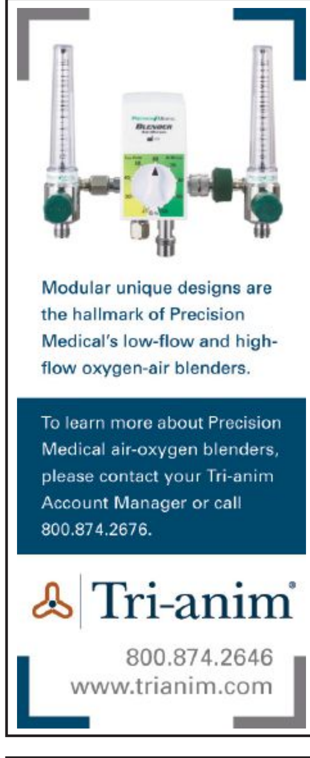
Well, I may not have made you feel better about taxes, but hopefully you found an idea or two helpful. ■

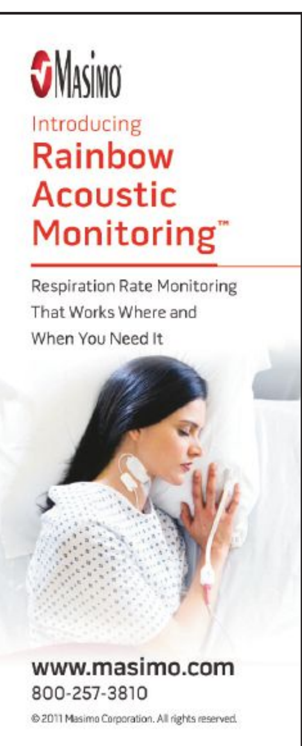
about the author…

Tony Lovio, AARC controller, is CPA certified in Michigan and Oklahoma, and his Texas certification is currently in process. He has more than 30 years' experience in public, private, and nonprofit accounting as a chief financial officer, controller, or finance director.

Industry Update

Featuring information on products and equipment from manufacturers





Medical Cart Battery

ICCNexergy Inc.'s U1LiFe long-life Lithium Iron Phosphate (LiFePO4) medical cart battery portfolio is specifically designed for mobile medical cart applications that require longer runtime, faster charge time, consistent power, and longer service life compared to traditional sealed lead acid (SLA) batteries. The entire portfolio is backed by a 3-year limited warranty and is available in 3 different capacity configurations — U1-40 (491Wh), U1-45 (573Wh), and the powerful U1-50 (655Wh) — all in the same industry standard U-1 case foot print of 208 x 137 x 185 mm. www.iccnexergy.com

Minimal Contact Nasal Mask

Designed to fit more than 98% of sleep apnea patients, the Wisp from Philips Respironics is a first of its kind minimal contact nasal mask that brings distinctive styling and patented technology for a better overall mask experience that may improve patient compliance. The new features include minimal headgear, quick-release tabs and headgear clips, contemporary frame options, patented auto-seal groove and unique tip of the nose cushion technology, and 3 interchangeable cushion sizes that fit on the same frame. www.philips.us/Wisp

Neonatal Resuscitation Technology

Dräger's new AutoBreath technology automates the neonatal resuscitation process, allowing clinicians to set and deliver consistent BPM, PIP, FIO_2, PEEP, and LPM, features that can contribute to a decrease or elimination of potential hazards such as air trapping, hemodynamic insult, and inadequate ventilation. Dräger offers AutoBreath as an advanced respiratory support option of the Resuscitaire® Radiant Sensitivity Warmer. www.draeger.com

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

Celebrating the Past. Building for the Future.

Donate to the American Respiratory Care Foundation and help build the AARC Virtual Museum

Sponsor the future construction of the AARC Virtual Respiratory Museum, a one-of-a-kind online exhibition that will explore the history, respiratory science, people and advancements throughout the existence of respiratory care.

Personal brick inscriptions display on the museum

- **Donate by purchasing a personally inscribed virtual brick, tax deductible for $25.***
- **Brick is permanently displayed at the virtual museum.**
- **Dedicate a brick to family, friends or patients.**

To Donate Call: 972-243-2272
To Visit the Construction Site Visit: www.aarc.org/museum/

* The ARCF is a Section 501 (c) 3 non-profit organization focused on supporting and growing respiratory-related research, education, and charitable activities. Donations to ARCF may qualify as a charitable deduction for federal income tax purposes. You should consult with your tax advisor to make a final determination.

RC Currents

IN THE NEWS

Profession Places in Top Quarter in Job Ranking

The career website CareerCast.com recently ranked 200 jobs from best to worst, with the findings based on data from the Bureau of Labor Statistics and other government sources. How did " respiratory therapist" fare?

We're happy to report RTs came out on the winning end! At No. 34 on the list, RTs not only placed in the top quarter but ranked ahead of several other health-related professions, such as physician assistant (#50), registered nurse (#55), and medical technologist (#67). We even outpaced physician, which came in at #45!

The website considered five main criteria when ranking professions: physical demands, work environment, income, stress, and hiring outlook.

See the entire list in this article in the *Wall Street Journal* at **http://tinyurl.com/jobrank.** ■

AARC "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.

Fencing Out Personal Apps

At AARC Congress 2013, Peter Papadakos, MD, FCCM, FAARC, presented an informative lecture on the use of personal electronic devices in the hospital setting. His take-home message: Put them away when caring for your patients.

That concept has been taken to heart by a Portland, OR-based facility. In just a few months, clinicians who walk onto the Tuality Healthcare campus will cross a virtual fence that will automatically enable a clinical documentation app linked directly to the electronic health record (EHR) while simultaneously disabling all of the personal apps on the device. When they cross the fence again to leave the campus, their personal apps will come back on and the EHR will shut down. Known as "geofencing," the technology is expected to relieve what a hospital official called the need to manage the mobile devices of its employees. A report on the hospital's plans was published in a recent issue of *Hospitals & Health Networks*.

You can read a brief recap of Dr. Papadakos' lecture in this issue. ■

Respiratory Care Education Annual

The American Association for Respiratory Care

Volume 19 Fall 2010

Original Contributions

Survey and Analysis of Baccalaureate and Graduate Respiratory Therapy Education Programs
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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. ■

AARC NOW ACCEPTING APPLICATIONS FOR THE 2014 INTERNATIONAL FELLOWSHIP PROGRAM

If you provide respiratory care outside of the United States and would like to share and expand your knowledge, please consider applying for our International Fellowship Program.

Since 1990, health professionals from more than 50 countries have shared experiences, knowledge, and lasting friendships through this exceptional program. The three-week program takes each participant to two host cities in the United States and concludes with attendance and acknowledgement at AARC Congress 2014 to be held Dec. 9–12 in Las Vegas, NV. For more information, contact lynch@aarc.org. ■

Educators: Help Recognize Outstanding Students

The American Respiratory Care Foundation (ARCF) is accepting applications for its undergraduate and postgraduate Education Recognition Awards now through June 15 and is asking RC educators to help get the word out to their students. So check out the list of available awards and then encourage your best and brightest students to apply.

The ARCF offers awards to students who are currently enrolled in accredited respiratory care educational programs and to respiratory therapists who are pursuing an advanced degree. For more information, contact lynch@aarc.org. ■

There's Not Really an App for That

Apps designed to help people improve their health abound these days; but when it comes to smoking cessation, they come up short. That's the take-home message from George Washington School of Public Health and Health Services investigators who analyzed the most popular smoking-cessation apps in February of 2012. They studied 47 for the iPhone and 51 for the Android operating system. Their results showed adherence to the U.S. Public Health Service's Clinical Practice Guidelines for Treating Tobacco Use and Dependence was low. The majority of the apps failed to provide counseling on how to quit, recommend approved quit-smoking medications, or refer users to a quit line.

While the findings on the quality of these apps are discouraging, Michael C. Fiore, MD, MPH, professor of medicine and director of the Center for Tobacco Research and Intervention at the University of Wisconsin School of Medicine and Public Health, believes just the fact that people are downloading them is promising. "Even though the study found that popular smoking-cessation apps have a low level of adherence to evidence-based guidelines, it is a hopeful sign that people want to quit and that scientists and technicians are coming up with applications to help them," he was quoted as saying.

The study's authors believe people would be better off turning to quit lines, which do provide evidence-based help to those who want to kick the habit. The research was published in a recent issue of the *American Journal of Preventive Medicine*. ■

Asthma and Cold Weather Don't Mix

It's cold outside in most parts of the country right now, and that can spell trouble for our respiratory patients. A new study out of Finland suggests this is especially true for young people with asthma.

The research looked at questionnaire responses from 1,623 adults aged 20–27 years who participated in the 20-year follow-up of a birth cohort study based in the city of Espoo, Finland. Overall, 10% of respondents had asthma (68% with concurrent allergic rhinitis). Twenty-one percent had allergic rhinitis without concurrent asthma.

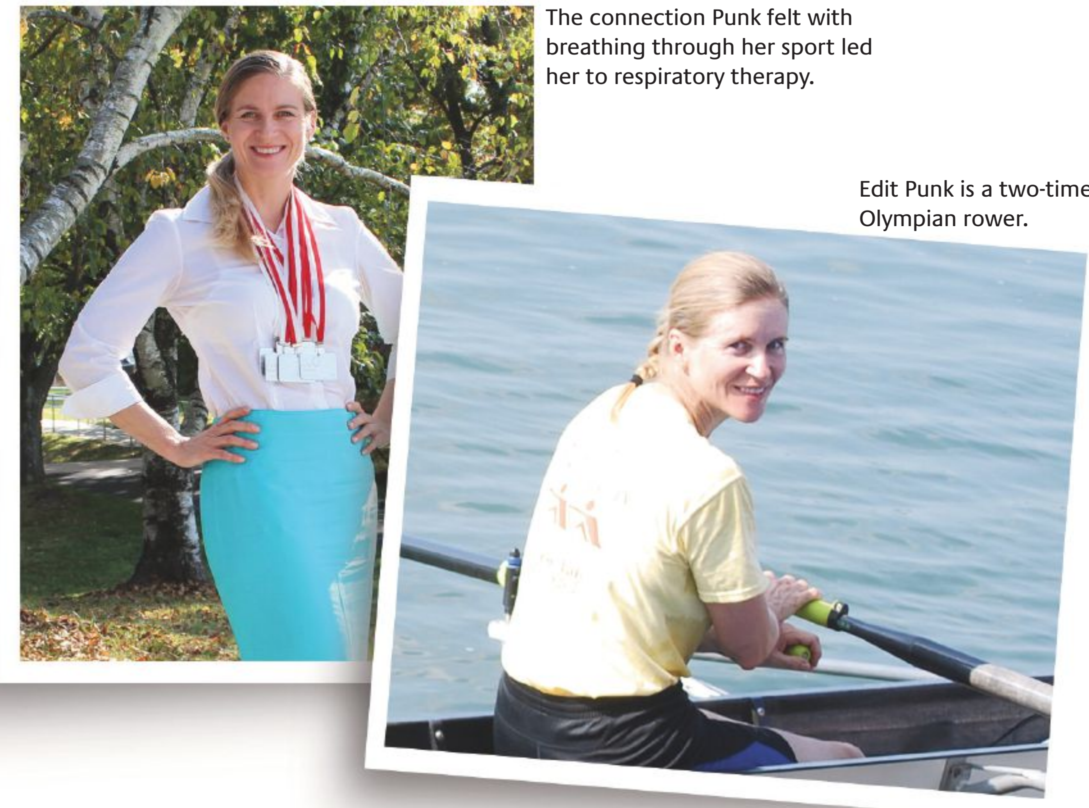
In the study years 2010 and 2011, there were four and three months, respectively, during which the mean temperature in Espoo was below 0° C. The researchers found that asthma and asthma plus allergic rhinitis both independently and synergistically increased the risk for cold weather related symptoms.

For example, while shortness of breath and wheezing were only slightly increased by the presence of allergic rhinitis, they were increased 4.5- and 10.7-fold, respectively, in patients with asthma, and 7.2- and 13.1-fold in patients with both conditions. Phlegm production was slightly increased in patients with allergic rhinitis, but it increased 2.7-fold in those with asthma and 3.7-fold in those with asthma and allergic rhinitis. The prevalence of cough was increased around fourfold, and the prevalence of chest pain around 2.5-fold in all patients with asthma. The study appeared in a recent issue of *Respiratory Medicine*. ■

CALL FOR OPEN FORUM ABSTRACTS FOR AARC CONGRESS 2014

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://tinyurl.com/open-forum-abstracts**. The deadline to submit abstracts for the OPEN FORUM is **June 1**. ■



The connection Punk felt with breathing through her sport led her to respiratory therapy.

Edit Punk is a two-time Olympian rower.

Enter the 2014 AARC Photo Contest

AARC Times is looking for creative members to enter our AARC Photo Contest so that the Association will have photos of how RTs enhance the lives of their pulmonary patients. Finalists will receive a free one-year membership renewal and have their photo entered into our Photo-of-the-Year Contest with the chance of it being chosen to appear on the March 2015 cover of *AARC Times*. For instructions and guidelines on submitting a photo, select the *AARC Times* icon on www.AARC.org and click on the "Photo-of-the-Year Contest" link. The deadline to submit photos is Oct. 15, 2014. ■

Olympian Turns to Respiratory Therapy for Career

Edit Punk, BHS, CRT, just finished her respiratory therapy program at the County College of Morris (CCM) in Randolph, NJ, last July and began working at Saint Barnabas Medical Center in Livingston shortly thereafter. In September, though, this newly minted RT took a break to pursue her other passion in life — competitive rowing.

The two-time Olympian and native of Hungary competed in the World Rowing Masters Regatta in Varese, Italy, capturing a gold medal in each of the eight events in which she participated.

Punk, who came to the United States in 1994, says she decided to pursue her degree in respiratory therapy because of the connection she felt it had with her athletic training through breathing. "It's also a profession where you get to help others." says the AARC member.

Her new profession complements her life-long love of learning as well. In addition to her RT degree, Punk also holds degrees in biology and physical education and is a certified yoga instructor, personal trainer, and massage therapist. "I've always been curious to learn about the ways the human body works," says Punk. "CCM gave me the opportunity to quench this thirst for knowledge and provided me with the prospect to pursue a stable career for my children and myself." ■

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! ■

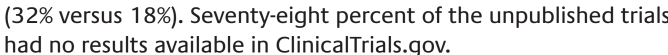
International Fellowship Program Looking for City Hosts

Every year the AARC sponsors an International Fellowship Program that brings physicians, therapists, and nurses from other countries to our shores to learn more about American-style respiratory care in two cities. It can't happen without city hosts in each of the localities, and now is the time to step up and volunteer.

The fellowships take place in the fall just prior to AARC Congress, scheduled this year for Dec. 9–12 in Las Vegas, NV. For more information, contact lynch@aarc.org. ■

Where Are the Results?

Researchers from the University of North Carolina who looked at 585 large, randomized clinical trials completed prior to January of 2009 to see what happened to them came up with some disturbing results. Among the group, 29% were never published. Non-publication was significantly more likely among trials that received industry funding than those that did not (32% versus 18%). Seventy-eight percent of the unpublished trials had no results available in ClinicalTrials.gov.

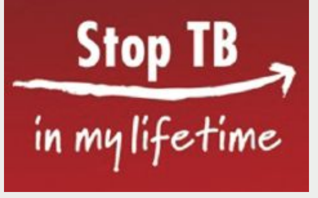


One of the fears is that trials funded by industry only get published when the results are favorable to the company in question, leading the authors of this study to recommend new rules calling for all such trials to be published regardless of their results. "Clinical trials are an essential source of information for how to care for patients," lead author Timothy F. Platts-Mills, MD, was quoted as saying. "Additional policies are needed to ensure that results of all large clinical trials are made publicly available in a timely manner." ■

National Health Observances

World Tuberculosis Day

March 24; World Health Organization; www.stoptb.org/events/world_tb_day



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. ■

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

- **Passenger with possible TB infection pulled from plane** — www.aarc.org/ headlines/index.cfm #professional
- **Paramedics making house calls to chronic patients** — www.aarc. org/ headlines/ index. cfm#professional
- **Brazilian polio survivor lives 43 years in hospital** — www.aarc. org/headlines /index. cfm#professional

- **FDA approves bird flu vaccine with adjuvant** — www.aarc.org/headlines/ index.cfm#professional

STRANGE BUT TRUE…

CPAP for moms-to-be: University of Michigan investigators report more frequent C-sections and significantly smaller babies among women who snore. The solution? Assess these women for obstructive sleep apnea and then treat them with CPAP.

Facing up: Ohio researchers confirm smoking takes its toll on a person's looks. Their results showed even an additional five years of smoking by one identical twin compared to the other translated to more facial aging. The investigators found their subjects at the annual Twins Day Festival held each year in Twinsburg, OH.

Saxophone lung: A study presented at the recent American College of Allergy, Asthma and Immunology meeting finds improperly cleaned reed instruments can be a breeding ground for funguses leading to an allergic disease. Proper diagnosis is critical, since symptoms will persist despite treatment if the reeds are not cleaned.

Great ball of fire! Italian physicians finally found the cause of a farm worker's yearlong battle with a bloody cough: a 2.75-inch by 2.5-inch ball of fungus in his lungs. The man underwent surgery to remove the fungus, and by a 16-month follow-up was symptom free. (In Oct. 24 issue of *BMJ Case Reports*.) ■

50 Years Later…

It's been 50 years since the first Surgeon General's Report on smoking was released; and despite widespread public health campaigns, researchers from the University of Texas MD Anderson Cancer Center find myths about smoking are still prevalent throughout the country:

Tobacco Myth #1: Almost no one smokes anymore.

Fact: About 43.8 million people still smoke. That's almost one in five people in the United States.

Tobacco Myth #2: e-Cigarettes, cigars, and hookahs are safe alternatives.

Fact: All tobacco products, including e-cigarettes and hookahs, have nicotine. And it is nicotine's highly addictive properties that make these products harmful.

Tobacco Myth #3: Infrequent social smoking is harmless.

Fact: Any smoking, even social smoking, is dangerous.

Tobacco Myth #4: Smoking outside eliminates the dangers of secondhand smoke.

Fact: There is no risk-free level of exposure to secondhand smoke. Even brief secondhand smoke exposure can cause harm.

Debunking these myths for our patients could help them take the first steps toward quitting. "Being educated and sharing this knowledge with others are ways to action," Ernest Hawk, MD, vice president of cancer prevention and population sciences at MD Anderson, was quoted as saying. "For smokers, it's never too late to quit smoking and reap health benefits." ■

VITAMIN C MAY EASE SKELETAL MUSCLE WEAKNESS

The skeletal muscle weakness inherent in COPD has been blamed in part on oxidative stress. Researchers from the George E. Whalen VA Medical Center and the University of Utah find IV infusions of vitamin C can help.

They randomized 10 COPD patients to perform a set of knee extension exercises after receiving either an IV infusion of vitamin C or an IV infusion of saline. Neither the patients nor the providers knew which patient received which treatment. The treatments were switched two to three days later, and the same exercises were repeated.

Results showed the patients had significantly less muscle fatigue and breathed better and slower after receiving the IV infusions of vitamin C. They also had significantly higher blood antioxidant activity when compared to levels measured after the saline infusions. Resting blood pressure and blood flow were lowered as well.

The authors believe these findings suggest antioxidants could be a treatment for the skeletal muscle dysfunction common to COPD. The study was published in the online edition of the *American Journal of Physiology-Regulatory, Integrative and Comparative Physiology* in November. ■

Be A Part Of The AARC Now!

Your Membership Makes A Difference

Membership Application

ACTIVE MEMBER

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

ASSOCIATE OR SPECIAL MEMBER

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

STUDENT MEMBER

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

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

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

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

Last Name ______________________ First Name ______________________

Social Security No. (last four digits only) ____________ Home Address ______________________

City ______________________ State ____________ Zip ____________

Phone No. (_______) ______________ Email Address ______________________

Your AARC dues includes membership in your state society. A portion of your money will be given to them.
You are automatically assigned to a state society based on your **home address**. If you wish to be assigned to a different state society, please indicate which state that is here: ______________

Work Information: Place of Employment ______________________

Address ______________________ City ______________________

State __________ Zip ______________ Phone No. (_______) ______________

Preferred Fax No.(_______) ______________ Preferred Email Address ______________________

Preferred Mailing Address: ☐ Home ☐ Business

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

For Student Member (Required)

School/RC Program ______________________ Address ______________________

City ______________________ State __________ Zip __________

Phone No. (_______) ______________ Program Director ______________________

Expected Date of Graduation Month _______ Year _______

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

Primary Job Responsibility (check one only)

☐ Clinical Specialist ☐ Director of Clinical Education ☐ Director ☐ Disease Manager
☐ Diagnostic Technologist ☐ Instructor/Faculty/Professor ☐ Medical Director ☐ Manager
☐ Marketing ☐ Nurse ☐ Owner ☐ Other
☐ Program Director ☐ Patient Educator ☐ Pulmonary Function Technologist ☐ Product Management
☐ Sales ☐ Supervisor/Coordinator ☐ Sleep Technologist/Polysomnographer ☐ Sleep Technologist/Specialist
☐ Staff Therapist ☐ Student

Type of Business

☐ DME/HME ☐ Educational Institution ☐ Home Health Agency ☐ Long Term Acute Care/Rehab
☐ Manufacturer/Distributor/Pharma ☐ Military ☐ Hospital ☐ Other
☐ Physician's Office ☐ Skilled Nursing Facility ☐ Sleep Lab Free Standing ☐ Sleep Lab Hospital Based
☐ Student ☐ Temp ☐ Outpatient Facility

Check the Highest Degree Earned

☐ PhD ☐ EdD ☐ DHSc ☐ MEd ☐ MBA ☐ MS ☐ MHA ☐ MHS ☐ MPA ☐ MPH ☐ MSEd ☐ MSN
☐ MA ☐ BSRT ☐ BSRC ☐ BS ☐ BHS ☐ BSEd ☐ BSN ☐ BA ☐ AAS ☐ AS ☐ AA

Job Status ☐ Full Time ☐ Part Time ☐ Years in Respiratory Care ________

Credentials ☐ MD ☐ DO ☐ RRT-NPS ☐ RRT-SDS ☐ RRT-ACCS ☐ RRT ☐ RPFT ☐ CRT-NPS ☐ CRT-SDS ☐ CRT-ACCS
☐ CRT ☐ CPFT ☐ RN ☐ RPSGT ☐ AE-C ☐ CTTS ☐ EMT-P ☐ LPN ☐ LVN

Honorary Credentials ☐ FAARC ☐ FACHE ☐ FAACVPR ☐ FCCM ☐ FCCP

Date of Birth ____________ **Sex** ____________

American Association for Respiratory Care

AARC An Excellent Investment

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

PLEASE SIGN

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

A yearly subscription to Respiratory Care journal and *AARC Times* magazine includes an allocation of $11.50 from my dues for each of these publications.

NOTE: Contributions or gifts to the AARC are not tax deductible as charitable contributions for income tax purposes. However, they may be tax deductible as ordinary and necessary business expenses subject to restrictions imposed as a result of Association lobbying activities. The AARC estimates that the nondeductible portion of your dues — the portion which is allocable to lobbying — is 20%.

Signature ____ **Date** _________________________

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Membership Fees (U.S. dollars only)

Payment must accompany your application to the AARC. Fees are for 12 months. These fees contain the $12.50 new members processing fee. **Renewing members (except students) can deduct $12.50.**

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☐ Active $102.50 ☐ Associate (Industrial or Physician) $102.50 ☐ Associate (Foreign) $137.50 ☐ Special $102.50 ☐ Student $50.00

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Or

AARC 1+1 MEMBERSHIP (Choose one publication) I want ☐ *AARC Times* magazine **or** ☐ Respiratory Care journal

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PLUS UPGRADE ☐ $35.00 per year (Includes one **free** specialty section – please mark your choice below.)

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

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

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

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

Payment Information

Enclosed is a check for the membership fee I selected ***plus*** any specialty section fees ***plus*** any contributions to AARCPAC or ARCF for the total amount of

$__________. Please make checks payable to the AARC.

Please charge my dues to: ☐ MasterCard ☐ Visa ☐ American Express

Card Number ________________________________ Card Expires _______ /______ Signature ___________________________________

Send this application and fees to:
American Association for Respiratory Care
9425 N. MacArthur Blvd., Suite 100, Irving, TX 75063-4706 (if using a credit card)
or P.O. Box 650097, Dallas, TX 75265-0097 (if sending a check)
Fax: 972-484-2720 • Phone: 972-243-2272

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

Thanks for Being Part of the Team

American Association for Respiratory Care

Revised July 2013

Help your school's **clinical preceptor program meet CoARC** standards with

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Practices of Effective Preceptors

The American Association for Respiratory Care

www.aarc.org/education/clinical_pep/

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Clinical PEP: Practices of Effective Preceptors is an educational program of the American Association for Respiratory Care.

Classifieds

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The new ET-CARE™ Endotracheal Tube Fixation Device — no tape, built-in bite block, sliding track for oral hygiene, includes NG-tube holder. The firm fixation with ET-CARE lessens excessive x-rays, decreases the potential for VAP, reduces accidental extubation. Manufactured in USA (patent pending) by IPI Medical Products Inc. (561) 330-7820, www.ipimedicalproducts.com.

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AARC Members: $50 for 50 words or less; each additional word, $1. Free Internet placement. Nonmembers: $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 February 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

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VAP to VAE: Implications for the Respiratory Therapist

Item # PR20137

Dean Hess, PhD RRT FAARC and

Kathy Deakins, MHA RRT-NPS FAARC

Because there is no reliable definition for ventilator-associated pneumonia (VAP), the CDC convened a multidisciplinary group to develop a new surveillance definition. The result is a tiered approach that focuses on ventilator-associated events (VAE). VAE definitions will detect a wide variety of complications in patients on mechanical ventilation. VAE prevention presents many opportunities for respiratory therapists, including use of noninvasive ventilation, implementation of lung-protective ventilation strategies, ventilator discontinuation protocols, and VAP prevention strategies.

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Activate Your Online Subscription:

Enter your Customer Number (included with your payment confirmation letter): Submit

5. Create a password and you're done.

You will receive an email confirming your subscription has been activated. If you have questions related to online access or need your AARC member number, please contact AARC Membership Services at info@aarc.org or call (972) 243-2272. Office hours are Monday–Friday, 8:00 am–5:00 pm Central Time. RESPIRATORY CARE is the science journal of the American Association for Respiratory Care.

Calendar of Events

AARC & State Society Programs

February 5–6
Wilsonville, Oregon
Pacific Northwest Respiratory Care Conference 2014
Contact: David Buckwalter, (503) 418-5858; www.regonline.com/osrc2014

April 13–15
Spokane, Washington
The Respiratory Care Society of Washington's 41st Annual Pacific Northwest Regional Respiratory Care Conference and Scientific Assembly
Contact: Garth Arkell, mlungs@yahoo.com; Patti Martin, bapjmartin82@hotmail.com; www.rcsw.org

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

May 14–15
Portland, Maine
Maine Society for Respiratory Care's annual conference
Contact: Amanda S. Albee, amandaalbee@gmail.com, www.mesrc.org

Other Meetings

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ATS 2014: American Thoracic Society's International Conference
Contact: http://conference.thoracic.org/2014/

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