AARC
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President Frank Salvatore, Jr., Vows To Promote, Advance, and Advocate

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Frank Salvatore, Jr., MBA, RRT, FAARC, addressed the membership after taking the helm as president of the AARC at Congress 2014 in Las Vegas, NV.

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Cover photo by Lennie Sirmopoulos, Convention Photography, Tustin, CA

Introducing the New AARC Mission and Vision Statement

The American Association for Respiratory Care has a new Strategic Plan that includes its Mission and Vision Statements for 2015-2020.

Bookmark this page: http://www.aarc.org/member_services/mission/.

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- On average, each respiratory therapist reported caring for about 6 patients receiving mechanical ventilation.
- It takes an average of between 4-5 weeks for to orient a new employee in an acute care hospital
- Turnover rate in acute care hospitals for both full and part-time therapists has not changed since 2009
- Acute care hospitals remain the major employer of respiratory therapists; however, this survey identified that more therapists are transitioning to long term acute care, from 4.4% in 2009 to 7.6% in 2014

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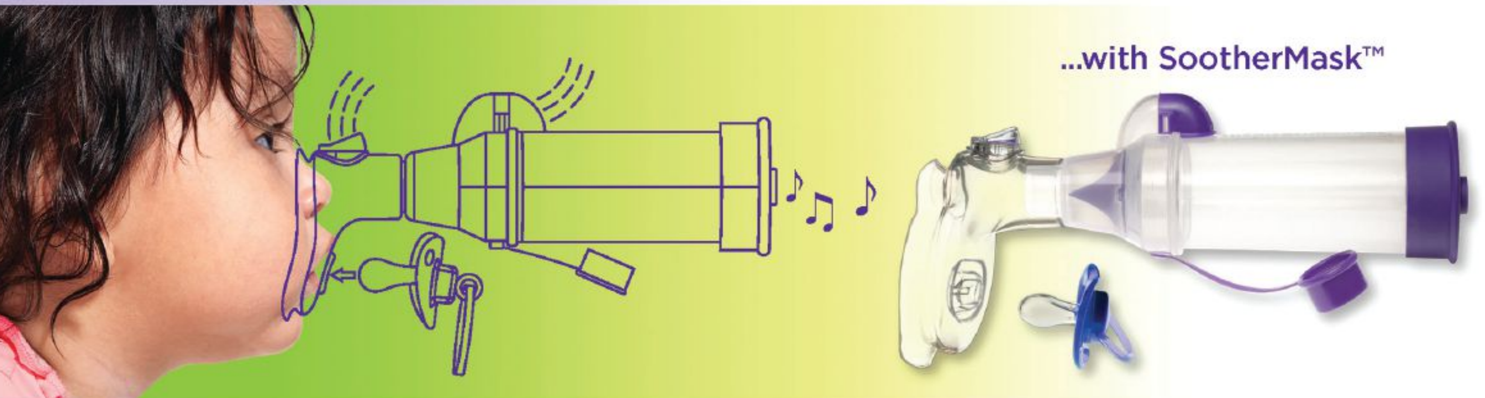

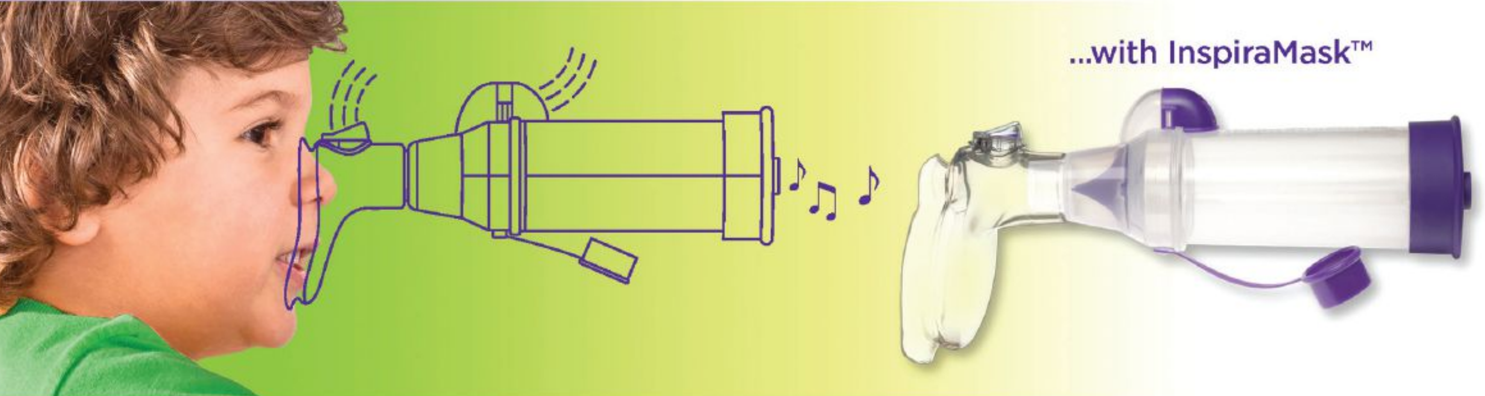

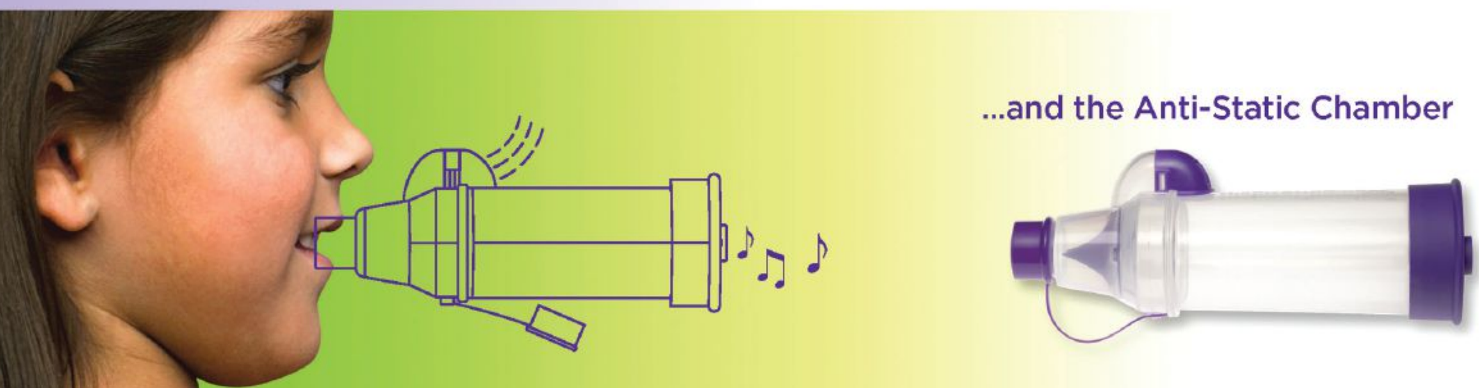

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Home Care: No Reimbursement Code for New Technology: Does It Prevent Hospitalizations?

by Kimberly S. Wiles, BS, RRT, CPFT

Avoiding hospital readmissions is the primary focus of the evolving pay for performance model that is leading the paradigm shift in health care. This requires forward thinking and a complete transition from the way health care has been provided in the past. Health care is plagued by models that are driven by reimbursement rather than value-added service. With penalties in place for 30-day readmissions, neither home care agencies nor hospitals can operate status quo. Home care entities must position themselves to meet the demands of the changing system.

CMS reimbursement methodology

Home health agencies: Home care has two distinct entities providing services: the home health agency (HHA) and a durable medical equipment (DME) company. HHAs are reimbursed under the prospective payment system (PPS). PPS pays HHAs a predetermined base payment, which is based on a 60-day "episode of care" as long as the individual meets home-bound status. The HHA gets the same payment regardless of the number of skilled visits that are performed within the 60-day episode. Skilled visits include nursing, physical therapy, occupational therapy, speech pathology, and social services. PPS encourages agencies to continually review and improve outcomes and to utilize the most appropriate resources for each episode. A respiratory therapist is not considered a skilled entity under the PPS system. RTs could provide additional staffing flexibility when caring for patients with respiratory diseases. Additionally, RTs can be a resource for staff education in the care of patients and be an active member of performance improvement groups participating in the processes to improve outcomes.[1]

about the author...

Kimberly S. Wiles, BS, RRT, CPFT, is vice president of respiratory services at Klingensmith HealthCare in Ford City, PA.

DME companies: DME companies are reimbursed by HCPC codes, which is a standardized coding system for describing the specific items and services provided in the delivery of health care. Where does the RT's expertise get billed? The short answer to that is it doesn't. The respiratory therapist is required to deliver and educate on respiratory equipment, but the company cannot bill for the RT's expertise since it is considered "part of the rental payment." The RT is typically used when state licensure mandates it but is not used in the capacity that creates added value — respiratory disease management.

Emerging technology

The emergence of new technology is crucial to the development of home-based programs that promote independence and self-management. The process for manufacturers to secure a new HCPC code and payment for that code is cumbersome and lengthy. In order for the manufacturer to submit for a new code, the product must have approval from the U.S. Food and Drug Administration (FDA). Once the technology has FDA approval, the process for obtaining a code begins. This involves a systematic process established by the Centers for Medicare and Medicaid Services (CMS) through its Council on Technology and Innovation.[2] The agency specifically evaluates issues involving coverage, coding, and/or payment with respect to certain technological advances. The basic analytical framework falls into the following three categories.

Coverage: The Council on Technology and Innovation has the authority to develop coverage determinations for particular items and may choose to develop national policy for particular products. Policies are more likely to

be developed when CMS sees a spike in utilization of a product or when the medical community is divided about the merits of an item. An example of this is the Respiratory Assist Device (RAD) policy. In the late 1990s, physicians began utilizing noninvasive ventilation for various respiratory diseases in the home. Utilization increased over a short period of time, which resulted in the creation and implementation of the policy in 1999. The industry must be cautious when deploying new technology without significant studies clearly showing positive outcomes or we are forced to live under the confines of a strict policy.

Coding: Currently, CMS uses the International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) and the Healthcare Common Procedure Coding System (HCPCS) for processing claims. Disease states are tied to specific HCPCS codes. In many instances new technologies are adequately described by existing codes. If not, a specific HCPC may need to be assigned for new technology.

Payment: As new technology is used, its relative use will be reflected in payment for the service using the technology. This can be done by using a miscellaneous code for a new product prior to a code being assigned. There is no guarantee of payment for either the item or the amount that will be reimbursed. Unfortunately, this is risky for a DME company; and most tend to shy away from this practice. To merit additional payment, the new technology must represent substantial clinical improvements relative to existing technologies and meet specific cost thresholds.[3]

Unfortunately, the process of securing a new code or additional payment of an existing code is a lengthy process and may take several years. Is it in the DME companies' best interest to provide the product in the interim if it clearly shows improvement in self management while decreasing readmission? With steep cuts in reimbursement over the past few years, it is extremely difficult to provide products as part of a program if there isn't any reimbursement for the product. New technology is expensive; and without payment to support the purchase, it is difficult to dispense.

We tend to think of CMS as the only payment source for home care services. There is a plethora of private payer sectors that are also trying to decrease hospital readmissions. Think outside the box and begin the discussions with these alternate payer sources, but be armed with solid outcomes that drive quality improvement in patient care while reducing costs.

Charting a new course

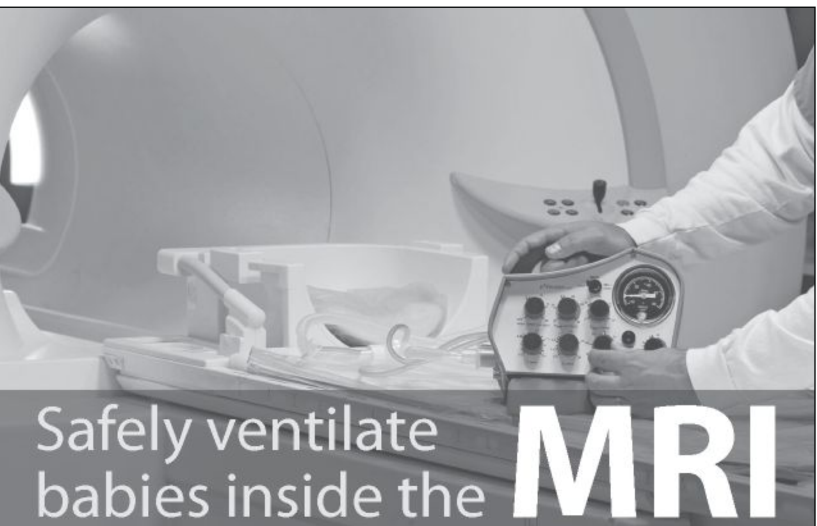
In the two entities, DME and HHA, the missing link is the respiratory therapist. The RT is visible in the DME company, but as the "equipment" expert. In essence, they are the respiratory disease experts — and that is the value RTs bring. They have been trained to be independent thinkers in critical situations. Why not use the RT in the capacity that they have been trained for: managing the respiratory patient? The RT's expertise needs to be deployed where it creates the most value.

Why not utilize the RT to determine the risk and the need for additional therapy regardless of the reimbursement qualifications but based on their ability to recognize the need for additional therapies?

CMS has included COPD as one of the conditions that hospitals will be penalized for readmission. RTs represent the single best resource to mitigate penalties for readmissions of COPD patients. Due to the readmission penalties, neither home care nor hospitals can continue operating as they have in the past. Hospitals are deep in the trenches of creating effective transition of care programs with the goal of transitioning patients effectively to home care providers. Hospitals have a greater incentive to partner with providers that have effective programs focusing on readmissions prevention and are least likely to readmit their patients. For this reason, it is imperative for DME companies as well as HHAs to have a program with cutting-edge technology, service, and patient-centered outcomes for the respiratory patient. With that said, is it in the best interest of the company to provide the RT as a value-added service and deploy all technology available?

Questions to ponder

With health care in a state of transformation, is it time to re-vamp the post acute care reimbursement system? Instead of assigning HCPC codes or the need to determine homebound status for skilled care, what if care was provided based on risk? Consider the concept of categorizing care based on low, medium, or high risk with reimbursement coinciding to the risk level. If the true intent is to prevent readmissions, why not utilize all available resources on the highest risk patient? Despite all coordinated efforts, populations of high-risk patients exist that continue to put stress on the health care system by repeated readmissions. Why not utilize the RT to determine the risk and the need for additional therapy regardless of the reimbursement qualifications but based on their ability to recognize the need for additional therapies? This hypothetical model would allow the RT to take the wheel and be the driver down the road of patient-focused respiratory home care. As a profession, we can't be stuck at the intersection and be unclear of our direction. We need to take the wheel and drive innovative models aimed at quality patient care and cost reductions to the health systems. ■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Safety Considerations When Transitioning the Elderly from Hospital to Home

by Mary Hart, MSHCA, RRT, FAARC

Elderly patients often leave the hospital with a host of discharge instructions, medications, and follow-up visits to make after getting home. Ideally, the hospital discharge planner will facilitate the care needs for the patient and caregiver, offering the patient an uneventful transition home. However, not all hospitals are successful in this.

According to Dr. Jennifer Lee, The Transition of Care Consensus Policy Statement developed by a coalition including the American College of Physicians and Society of Hospital Medicine emphasizes accountability, communication, and involvement of the patient and family members in plans of care. Yet, interventions to reduce readmissions and improve quality and safety of care transitions remain only modestly and inconsistently effective.[1] To assist health care providers, The Joint Commission (TJC) offers a wealth of literature that is focused on patient safety relating to transition of care and hand-off communication; but even with this information, health care facilities still struggle.[2]

In fact, as cost of care rises and fragmentation of health care increases, care transitions have become critical parts of the health care system. The hospital health care team of providers has the responsibility to communicate to subsequent providers, but this communication occurs far less than optimal.[1]

Patients and families or care providers often leave the hospital confused about their discharge instructions given to them by the discharging nurse. Most elderly patients are contending with multiple chronic diseases, conditions, and medications. They are often readmitted for an adverse event within 30 days of discharge because they do not understand or did not follow instructions given to them.[3] If there is no care coordination across the settings, there is often conflicting and confusing information in the care plan or discharge instructions from different providers.[5]

Care transition programs are being developed to help address these issues and to contend with these challenges. One initiative empowers patients and their caregivers by educating and equipping them with tools to manage their own care and prepare them for transitioning to and from each setting. Many care transition models promote care coordination that begins when the patient is first admitted to the hospital. Utilizing a comprehensive assessment of the patient, their support system and home environment is crucial to a safe transition home. The basics of a discharge should include an evaluation of the patient, discussion with the patient and caregivers, a plan for the homecoming, determination of needed support, referrals for home care and support organizations, and an arrangement for follow-up appointments or tests.

about the author...

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Safety considerations for the home

Care fragmentation impacts many aspects of the care continuum, including patient safety. Common safety measures to take with an elderly chronic patient when discharged home are:

Communication and emergencies: Keeping a list of important phone numbers in a place in the home where they can easily be found and in the patient's wallet will help facilitate care, especially when emergency care is needed. The list should include the person to call in case of an emergency, physician, pharmacy, durable medical

equipment provider, and home care provider. Having a list of chronic conditions, medications, and any devices (implantable defibrillator or pacemaker), and known drug allergies will also help communicate the need to health care providers. It is important to keep these lists current.

Medication management: Sixty percent of the medication errors occur during times of transition.[5] Chronic conditions usually call for many different medications and delivery devices being prescribed for the patient. Proper training on how to take medications and use medication-delivery devices should occur prior to the patient being discharged from the hospital. For using delivery devices, hands-on education and a return demonstration by the patient are more effective than being handed a prescription and telling the patient how and when to take it. Reconciling medications with each encounter is important to prevent duplicating or causing adverse events. Being able to afford medications is another issue for some patients. The care coordinator and physician can assist the patient and family in finding the resources to obtain their medications.

Oxygen therapy: Home oxygen is commonly prescribed for patients with COPD or other lung diseases. Patients and their caregivers should be trained in how to use oxygen according to the physician's order. Knowing that oxygen is considered a medication and the amount or liter flow the doctor prescribes are important. Training should include oxygen safety in the home and portable use for activity or travel. Having a good oxygen provider who checks on the patient at home and evaluates the home environment to help prevent falls (such as tripping over the oxygen tubing) is very important in providing a safe patient environment.

Fall prevention: Most falls occur in the bathroom, bedroom, or stairs due to slippery floors, poor lighting, electrical wires or cords in the pathway, loose rugs, raised thresholds, and clutter.

Tips for preventing falls in the home:

- Bathroom: Use grab bars in shower, tub, and toilet area; consider using a shower stool to bathe; remove area rugs; and use an elevated toilet seat.
- Bedroom: Keep a lamp close to the bed (easy to reach without getting out of bed); use a television remote, telephone at bedside, and a nightlight in the bedroom and hallway.
- Stairs: Pick up things that accumulate on stairs (books, laundry, etc.); keep stairs well lit; repair broken or loose steps.

General safety tips:

- Install a smoke detector; check and replace the battery regularly to make sure it is working.
- Wear skid-free shoes.
- Keep back-up oxygen for the oxygen concentrator if electricity goes out.
- Check hearing and eyesight.
- Exercise regularly to improve balance and flexibility.
- Wear alarm device that will bring help in case of a fall, or carry a cell phone or lanyard.

Patient safety action plans: Many of the above safety tips are general. For patients who are capable of self-care management, a formal, written action plan could be developed outlining values to be measured and monitored. Examples are: COPD and asthma action plans, peak flow, oxygen saturation, symptoms, weight, blood

As cost of care rises and fragmentation of health care increases, care transitions have become critical parts of the health care system.

pressure, etc. Patient instructions and education would include acceptable values for monitoring and actions to take when values fall outside the acceptable values. This form of preventive action/education empowers the patient and can help reduce safety issues.

Loss of cognitive ability and motor skills in patients with chronic conditions

Elderly patients may have poor eyesight or problems hearing or understanding that can impact their daily lives and alter their ability to care for themselves. Studies have shown that COPD patients have cognitive deficits in attention, psychomotor speed, verbal and visual memory, constructional ability, and executive function.[6]

Many older patients show signs of depression but are undiagnosed because they often believe it is part of aging. Characteristics of depression such as memory problems, confusion, or social withdrawal can go undiagnosed and create barriers for patients to fully live a quality life.[7]

Performing activities of daily living (ADLs) that are learned in early childhood and taken for granted as we mature are often impacted by aging and chronic illnesses. These include self-care activities such as bathing, grooming, dressing, preparing meals, shopping, driving, writing checks, and getting out of bed. Inactivity, increased shortness of breath, and decline in physical condition is often seen in patients with chronic lung disease. This decline can make patients more susceptible to injury and play a major role in their quality of life.[8] This may relate to patient injury through:

- Cognitive skills — not remembering to take medications or how to take them, forgetting follow-up care visits, loss of ability to manage finances
- Motor skills — difficulty walking, opening pill bottles, using medication delivery devices, turning on oxygen, changing oxygen tanks, carrying portable oxygen, driving, ability to cook, clean, dress, bathe (self-care).

A good ADL assessment in the home environment may help identify ways to modify patient activities, offering a safe environment, self-care, and quality of life.

Safety considerations in the home environment

Respiratory therapists have been patient educators throughout their careers. Patients, family members, and care providers can benefit from the education RTs provide for patients transitioning home.

RTs have an exceptional, broad-range set of skills where they offer patient assessment, evaluation, and treatment in all areas of health care, from hospital to home, and even in physician offices. Some of the services they provide are: oxygen delivery and safety, pulmonary function testing, pulmonary medications and delivery devices, airway clearance techniques, airway management and mechanical ventilation, pulmonary rehabilitation, and lung disease and evidence-based practice. In addition, RTs perform home assessments for patients to identify safety issues. These are discussed with the patient and family, solutions are offered, and issues are communicated to the other health care team members.

In a study by Carlin in *Chest* about COPD and congestive heart failure, patients requiring oxygen therapy (an RT-based patient-centered management program) utilized Discharge, Assessment, Summary at Home (DASH) to provide ongoing care and management for the patient in the home. Utilizing face-to-face visits with respiratory therapists and phone calls decreased hospital readmissions by 80%.[9]

(continued on page 71)

How a (Medicare) Bill Becomes a Law… at Least in the U.S. Congress

by Cheryl West, MHA

I often get questions from AARC members who ask: "Has Congress passed that RT bill that we support yet?" or "When do you think Congress will pass that bill we want?" And taking the questions literally, the answer will be "well no" and "it depends…."

Now before anyone gets too discouraged, read on. First, one needs a baseline of the legislative process, a bit of a Civics 101 class that reality isn't quite what you learned in high school.

Just the basics

To start, Congress meets for a two-year session. We've just started the 114th session of the U.S. Congress. Legislation introduced at any time during a two-year session receives a bill number ("HR" for the House of Representatives, "S" for the Senate), and the bill number is "good" throughout the remainder of the two-year session. However, once Congress adjourns (i.e., the end of the two-year session), any bill not actually passed by Congress will "die," in the vernacular of Capitol Hill. Then, if the members of Congress who introduced the bill (i.e., the sponsors) are willing, the same exact bill can be re-introduced when the new Congress convenes for the next session and receive another (different) bill number; and the process of gaining congressional co-sponsors and moving toward enactment starts all over again.

The AARC develops a legislative agenda that is based upon a number of variables, including:

- what legislative changes we believe need to be addressed for the betterment of the pulmonary patient and respiratory therapy profession;
- whether other advocacy partners and organizations might be willing to actively lobby the issue we are focused on (or assess if there will be any outright opposition), or
- if other organizations have a legislative agenda, will there be an issue for which AARC can take a supportive role (working on tobacco-control legislation is an example of a secondary but very supportive role).

about the author…

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

Quite frankly, whatever the mindset Congress is in (which party holds which House), that is what the publically announced congressional agenda will be. The majority of AARC's legislative efforts are aimed at revising the Medicare law so that it will better address the respiratory therapy profession in the 21st century and the needs of the pulmonary patient as they are impacted by the change in how health care is delivered (i.e., less acute hospital care and more alternate-site care).

Precipitating change

When pushing for a Medicare change, the focus of any association, organization, coalition, or special interest group must be on the members of Congress who sit on the committees of jurisdiction. For Medicare, those committees are: the House Energy and Commerce Committee, the House Ways and Means Committee, and the Senate Finance Committee. Once introduced, Medicare legislation will be sent to these committees to debate, decide, and vote as a committee whether a bill should move forward to the full chamber. Clearly, the goal of advocacy groups is to have one of the members of the health committees step forward and introduce their bill. It is all well and good to have a senator or House member who sits on, for example, the Armed Services Committee and is willing to introduce your Medicare bill; but you don't really want that. You want a member of the Committee of Jurisdiction to be the sponsor of the bill and formally introduce the legislation. After that, it's great if the member of Congress who sits on the Armed Services Committee or any other

(continued on page 14)

INTRODUCING

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The Vibralung Acoustical Percussor is a gentler form of ACT than oscillatory PEP devices, or those that make contact with the external chest wall. It may be especially useful for airway clearance therapy when other means like vests and hand-held chest percussors cannot be used. It's the ideal choice whenever airway clearance is the goal and patient comfort is preferred.

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- Easy to operate; battery-powered, lightweight and portable, can be used almost anywhere
- Requires only minimal patient effort with normal breathing
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(continued from page 12)

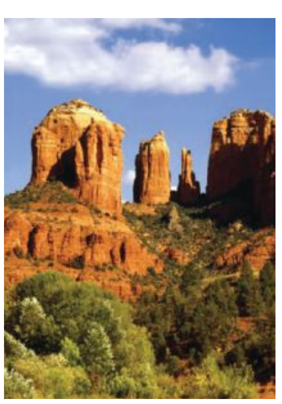
member wants to join in as a co-sponsor; in fact, organizations want that. The way you move a bill down the path toward passing it into law is to show support — the more co-sponsors, the more support. There are 435 House members and 100 senators. Technically, by gathering 218 House representatives and 51 senators (one more than half), you've reached the tipping point; and presumably your bill will move forward.

In this past two-year session of Congress, there were 2,890 Senate bills and 5,617 House bills introduced; and those are all separate bills. The number of congressional bills has increased exponentially over the last 15 years. Realistically, there is simply no way that each bill will be separately heard though public hearings — let alone be separately voted on in the chambers. So how do bills work their way into law? Your organization, association, etc., finds a willing congressional member who understands what the intent of the change to the Medicare law will be and why the change is needed. That member then directs the House (or Senate) Legislative Counsel's Office (one of the many entities in the congressional infrastructure you don't hear much about) to write up your idea or change in legislative language (that is, noting the statute and statute paragraphs and sub-paragraphs where the bill's provisions will be inserted into current law). The bill is introduced and is assigned a bill number, and now the gathering of co-sponsors begins — that is, finding support from other members. If the bill is a highly personal issue for the congressional member who introduced it, it will be the member's congressional staff who will contact other offices looking for co-sponsors for the bill. However, for bills where outside advocates have been the impetus for the bill being introduced, more than likely it will be the advocacy groups that become responsible for meeting with staff from other congressional offices and requesting that those members become co-sponsors. A crucial component to get those congressional co-sponsors is to generate grassroots' support from the voters back home. If a member (House or Senate) hears from their constituents that they want that bill, it goes a long way toward gaining co-sponsorship from the congressional members.

What happens with individual Medicare bills?

The answer leads back to the opening paragraph. Individual health bills, especially Medicare bills, are rarely if ever passed as standalone bills. What does happen is that usually every year or so there is a "must-pass" Medicare bill. Over the last five years, that has been the "doc fix" that every year must be passed to avoid draconian reimbursement cuts to physician payments under Medicare. The "must pass" bill becomes the locomotive engine, and any health- or Medicare-related bills that have enough co-sponsors (and that is the key) are stripped of their bill numbers and just the provisions of the bill are simply tacked on (like rail cars to a locomotive). There is always the need to closely monitor the track of the "must pass" bill that holds one's provisions as somewhere along the way the provisions can be deleted. For the most part, however, once "you're in, you're in."

That is why it is accurate to respond with "the separate bill AARC wants enacted into law will not pass Congress, but the provisions of our legislation surely can." ■



Summer Forum 2015

Continuing Ed Meets Family Fun

The Summer Forum will be heading to Phoenix July 13–15, so make plans now to be there for this premiere mid-year meeting of managers and educators in the profession.

The Program Committee is already hard at work planning an agenda that will cover the topics you're most interested in learning more about, and our venue will ensure you and your family can team up continuing education with a wonderful summer vacation. To find out more, stay tuned through our News Now@AARC email announcements and www.aarc.org. We hope to see you there!

AARC
American Association for Respiratory Care

Home Care Ventilation for the Child

by Joseph Lewarski, BS, RRT, FAARC, and Angela King, BS, RRT-NPS, RPFT

There are myriad reasons we provide pediatric home mechanical ventilation (HMV); but if one wants to consolidate these, it seems there are two driving forces — clinical and economic.

Clinically, over the last 30 years we have experienced improved survival rates of premature infants and other infants and children with birth complications and chronic, progressive disorders contributing to respiratory failure. Common conditions associated with HMV include, but are not limited to, bronchopulmonary dysplasia (BPD), progressive neuromuscular diseases (such as muscular dystrophy and spinal muscular atrophy), chronic lung disease, and spinal injury.[1] Many HMV patients have multiple conditions and require multiple medical devices and supplies; therefore, they are often referred to as technology-dependent patients.

The economic drivers are more obvious. Since the introduction of diagnosis-related groups (DRGs) in the mid-1980s, acute care hospitals have been searching for ways to transition chronic-care, high-need patients to lower cost settings. Although the push to move complex, technology-dependent children from hospital to home has been a slower process, it is growing to become a standard of care since the early 1990s as home care technology and services steadily adapted to meet the demand.

about the author...

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Angela King, BS, RRT-NPS, RPFT, is the clinical director at Mobile Medical Maintenance in Spencerville, IN.

The size of the market

The incidence and prevalence of pediatric HMV is a bit elusive.[2] In the United States there is no single data source for tracking ventilation applications in the home, as there are various payers with no standardized or required reporting. In many cases, this is a dynamic process, as patients are discharged to home and many subsequently weaned without any informational trail. Some published data from the 1980s suggested the prevalence of pediatric HMV was 0.7 to 2 per 100,000. More recent reports from individual states suggest this may be higher, such as in Utah, where in 2004 the prevalence was 6.3 per 100,000.[3] Morbidity and mortality data is equally challenging, as objective reporting is also lacking.

Past to present

Managing a pediatric home ventilator patient is much more complex today than it was 35 years ago when there were really only two ventilators in use at home: the Life Products LP Series ventilator and the Lifecare PLV 100 Series ventilator. Modes of ventilation were limited to Volume Assist-Control and Volume SIMV used in conjunction with single-limb, non-heated circuits with active exhalation valves. Both the LP and the PLV used similar deep-cycle, external marine batteries, and all patients who required humidity generally used the Cascade heated humidifier.

Today, there are at least eight home ventilators commercially available in the United States. This vast array of ventilators offers different circuit configurations, different modes of ventilation, and different features — unfortunately, without a standardized nomenclature.

One of the biggest changes for RTs providing home care ventilation that has been recognized over the past few years is the expanding variety of ventilator circuits available. Besides determining whether an adult or pediatric circuit is appropriate, therapists also must decide between heated and non-heated circuits, and disposable or reusable circuits. Importantly, the RT must understand the benefits and limitations regarding the selection of the ventilator circuit. Choosing a passive exhalation valve circuit, a single limb circuit with an active exhalation valve, or a dual-limb circuit with an active exhalation valve may have a profound effect on the patient's clinical outcome, although published evidence of such is lacking. Experience suggests that the circuit, much like other device and supply items, is not just a commodity but can impact care and outcomes.

Broad clinical competency

Besides being an expert on the wide variety of home ventilators and circuit types, home respiratory therapists must be competent with numerous other medical devices. The heated humidifier has become a *de facto* standard of care because of the broad availability of high-quality systems. As a result, this is a requirement for most home pediatric ventilator patients. Many patients also require cardiorespiratory monitoring, oximetry monitoring, end-tidal or transcutaneous CO_2 monitoring, stationary oxygen, portable oxygen, cool or heated mist to the tracheostomy for periods off the ventilator, stationary and portable suction equipment, nebulizer therapy, cough-assist therapy, intermittent percussive ventilator therapy, chest physical therapy, and tube feeding via an enteral pump. In many ways, the home begins to mirror the neonatal ICU or pediatric ICU, without the on-site experts.

The complexity of patient monitoring has also increased exponentially. Twenty-five years ago, there was no way of "downloading" the ventilator memory, or any of the peripheral monitoring equipment. Today, most ventilators have proprietary software that allows various reports to be generated. Additionally, the cardio-respiratory monitors, pulse oximeters, end-tidal CO_2 monitors, and even cough-assist devices can all be downloaded. All this data capability requires the therapist's expertise, both to access the information and generate reports, as well as to interpret the reams of data.

The home often feels like a remote and disconnected environment. In the hospital, an RT can access assistance from other on-duty therapists or pulmonologists if a problem or question occurs. The home care RT typically has limited access to clinical and peer support, especially when on-call. Because of the complexity and array of home care equipment, it can realistically take at least a year before an RT with no previous home care experience becomes fully proficient in the care of the pediatric ventilator patient. In most cases, it will be several months before a new home care RT can function with confidence independently on-call.

As the equipment complexity has increased, the physician and hospital-based RT's ability to keep up with the unique details of each device has been impaired. A hospital-based physician and RT can't be expected to know which brand/model of home ventilator has which mode, circuit type, and alarm availability. Today, the referring physician generally depends on the expertise of the home RT to recommend the ventilator, circuit type, and mode of ventilation that may best meet the patient's clinical and lifestyle needs. It is also up to the home care RT to choose appropriate alarm settings; no longer can a simple high- and low-pressure alarm be considered adequate to ensure the safety of the home pediatric ventilator patient.[4]

The increased functions and features of today's home ventilators can be both a bonus and a problem for families. Today's home ventilators offer almost ICU-level patient data and waveforms. The challenge for the home care RT is to teach the patient and family the *essential* information initially, gradually providing more

The modern, progressive home care RT is a multi-skilled individual who is a hands-on clinician, educator, diagnostician, technical supporter, reimbursement specialist, and patient advocate.

information and training as the family becomes more comfortable.

Finding supplemental caregivers for the home is an ongoing issue for families of pediatric ventilator patients. Families of technology-dependent children cannot simply employ the typical "teenager next door" to babysit their child. Even mature neighbors with extensive parenting experience may shy away from babysitting for the ventilator-dependent child. Training a lay person to provide care for a pediatric ventilator patient takes a *minimum* of three educational sessions: one for tracheostomy care, suctioning and resuscitation bagging, at least one for the ventilator, and one for review and practice. If the patient has a feeding tube, a fourth training session may be required. Even the home health nurse is not always an option for respite care, since there is a shortage of qualified nurses, which leads to uncovered nursing shifts for ventilator patients. Parents of ventilator-dependent children frequently report a sense of hopelessness associated with the nursing shortage and the related unfilled nursing shifts they themselves must cover.[5]

Today, again due to the economic drivers, it often feels like the home RT is under tremendous pressure to get the hospitalized pediatric home-ventilator patient discharged home as fast as possible. Often the insurance case manager wants the patient moved to home as fast as possible due to the lower cost of care per day.[6] If there is no insurance, the hospital typically wants the patient discharged home as soon as feasible to reduce their financial exposure. Of course, many families are anxious to take their child home as well. The critical element is to ensure that the home environment, the family, the nursing staff, and the patient are all adequately prepared for a safe and clinically effective discharge to the home.

The home care RT must be knowledgeable about reimbursement issues, as differing coverage and payment policies directly impact technology and supply choices and limitations. The health policy and coverage around HMV is deficient. Because of archaic legislation and outdated regulations, the DME benefit covers only equipment; and since a ventilator is "equipment," professional respiratory therapist payment for care and management of technology-dependent and HMV patients is currently non-existent, it is considered a part of the device payment. This, coupled with limited standards of care, results in great variability in care models. Reforms are needed to address changing health care models, technology, and services.

Putting it all together

The modern, progressive home care RT is a multi-skilled individual who is a hands-on clinician, educator, diagnostician, technical supporter, reimbursement specialist, and patient advocate. Today's home care RT plays an absolutely crucial role in determining whether the complex, technology-dependent HMV pediatric patient can be safely and effectively managed in the home. ■

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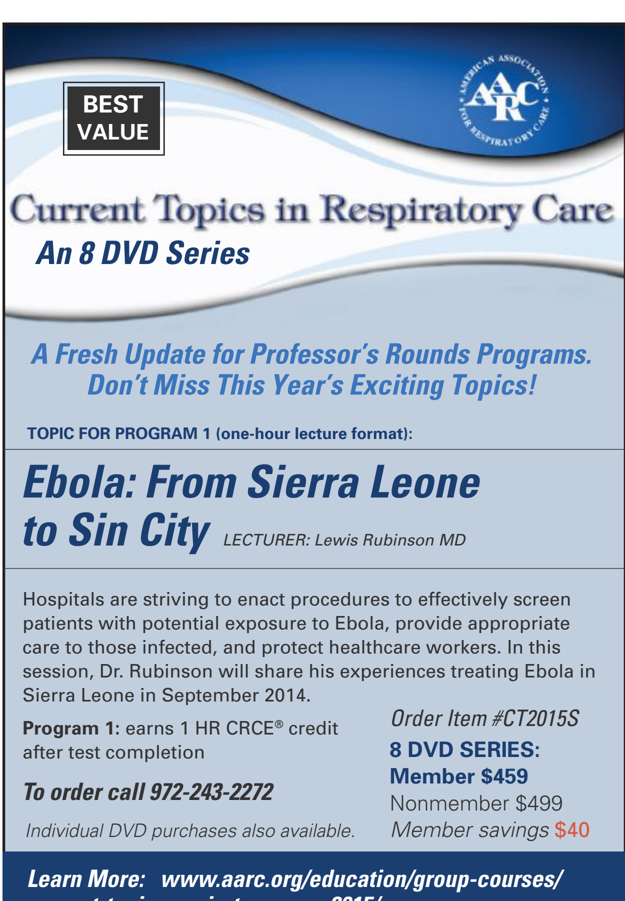

Freedom of Speech

by Anthony L. DeWitt, JD, RRT, FAARC

"Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances."

– *First Amendment to the Constitution*

Recently Carol* called and told me that she'd been fired. She had posted a picture to her Facebook page involving an offensive hand gesture when she was inebriated. Taken late on a Friday night while still wearing her scrubs, the photo would probably not have gotten her fired but for the background of the photo in which the hospital's sign could be seen clearly. Between sobs she wanted to know: Am I not protected by freedom of speech?

First Amendment rights

Very few parts of the Constitution, and very few of the amendments to it, are as expansively interpreted as the First Amendment. If you ask most people what the First Amendment stands for, they will tell you it stands for freedom of speech; but few people have read the details as fully as they should. While the First Amendment does provide for free speech, it is both broader and narrower than that.

Recently a truck driver flashed his lights at an oncoming truck to let the driver know that there was a speed trap ahead. A police officer witnessed this and issued the light-flashing driver a ticket for "unlawful headlight use." In dismissing the ticket, the court looked at the purpose of the ticket — to discourage passing along a friendly warning to an approaching truck — and found that it violated the First Amendment. Even though flashing your lights is not "speech," the First Amendment is designed to protect the expression of ideas; and so it must be expansively interpreted.

Until the late 1800s the First Amendment had only been applied to the federal government ("*Congress shall make no law…*"). The Supreme Court since that time has interpreted the protections for speech and religion to apply to state governments as well. What many people do not understand, however, is that the protections for free speech and expression only protect the individual from *government action*.

Mom's first rule

Emma believes that Sarah Palin is a great leader. Frank believes Hillary Clinton is a great leader. Both are entitled to their opinion because opinions are protected under the First Amendment. If the state Fire Marshall decides to close Frank's dry-cleaning business because of Frank's political opinion, the First Amendment protects that opinion and prevents the government's action. However, if Emma wears a shirt to work at Frank's dry-cleaning business and that shirt condemns Clinton and praises Palin, the First Amendment offers her no protection when Frank says she must change the shirt or lose her job. This is because the First Amendment protects from governmental action, but not from private action.

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.

*The names, locations, and conduct have been changed to protect the guilty.

Lots of employees find this out by violating "Mom's First Rule" on Facebook. "Mom's First Rule" is "if you can't say something nice, don't say anything at all." A brief check of Facebook on any given day will reveal dozens of people complaining about their boss or saying inflammatory things about other people. AOL even has a webpage devoted to the top 10 Facebook firings[1] that details some of the truly unwise things people say online about their jobs and bosses. Getting fired may not be the worst thing. Once something is on the Internet, it is there to stay; and it could make your next job search much more difficult if your Facebook page demonstrates that you are a complainer or a whiner or someone who can't get along with team members.

Even the National Labor Relations Board (NLRB), the federal entity that protects employees from oppressive workplace conduct, finds social media a real challenge. The NLRB released memos in 2011 and 2012 detailing the results of investigations into dozens of social media cases.

The first report described 14 cases. Four cases involved Facebook where the NLRB found that the employees were engaged in "protected concerted activity" because they were discussing terms and conditions of employment with fellow employees. When employees use Facebook to organize and communicate about grievances with their employer, this is usually protected under labor laws.

The NLRB also examined employer policies on social media that were in some instances unlawfully broad. It examined cases involving discharges of employees after they posted comments to Facebook. In one case, the discharge was upheld despite an unlawful policy because the employee's posting was not work related. Regarding the NLRB and social media, it is important to remember:

- Employer policies should not be so overly broad that they prohibit the discussion of wages or working conditions among employees.
- An employee's comments on social media are generally not protected if they are mere gripes.

Some employees do merit protection from their employers under the First Amendment. Those include public employees (those working at state-owned or state-managed entities) and even members of the armed forces under certain conditions. Cases like these are difficult to win. Very few lawyers take them, and they take them only when there is a strong fundamental right being violated. For more information on the NLRB guidelines, see the NLRB website.[2]

Often people come to me for legal advice, and I wind up just giving them the advice their mother already gave them. Praise often; criticize gently. Praise in public; criticize in private. Never say to others what you would not say to a person's face. You will never regret not sending an email or not making a Facebook post. When on social media, it is always better to avoid a problem than litigate over it later. Remember that it will probably feel really good to say that really ugly thing about your boss — right up to the point where the security guard comes to oversee you cleaning out your locker. ■

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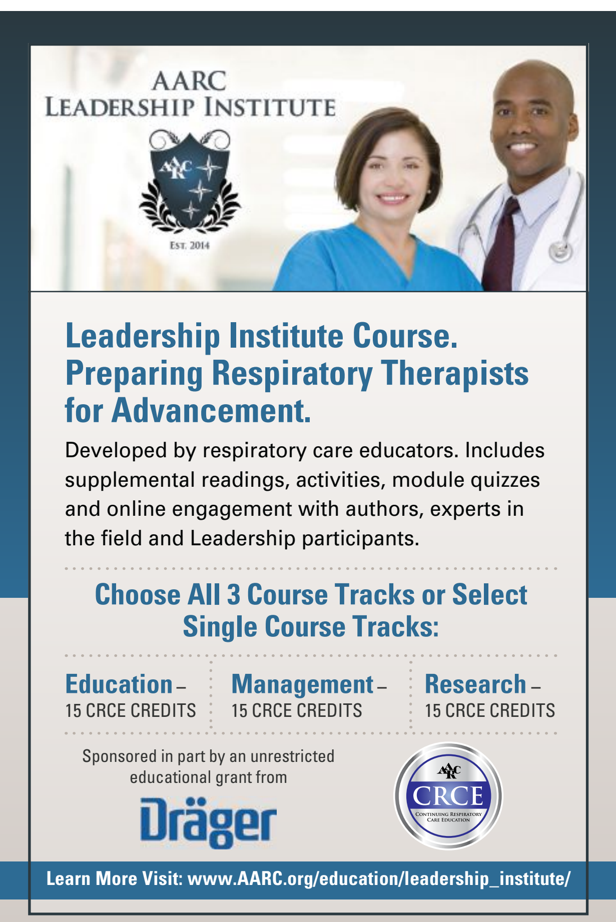
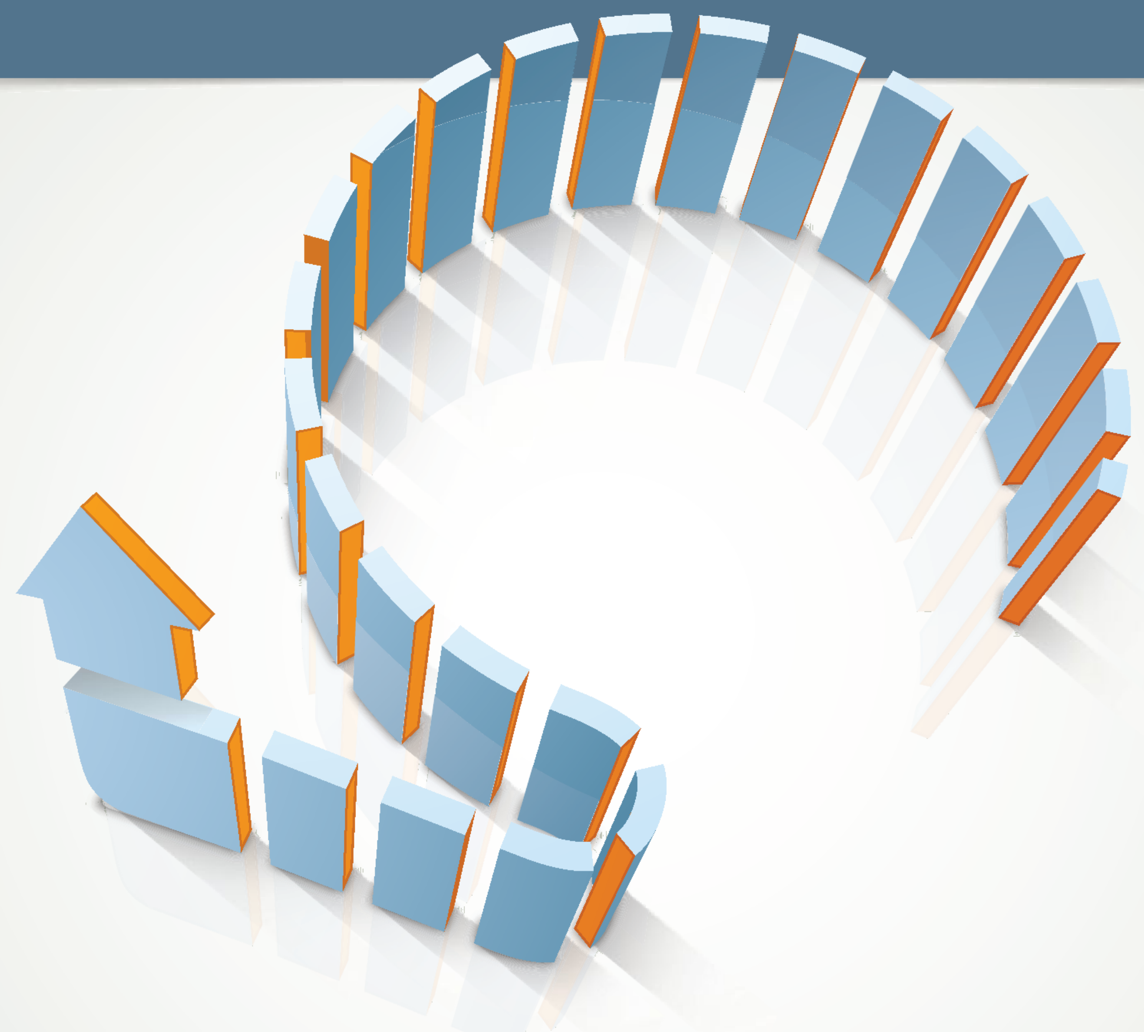


AARC Strategic Plan — 2015–2020



AARC Mission Statement

The American Association for Respiratory Care (AARC) will continue to be the leading national and international professional association for respiratory care.

AARC Vision Statement

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.

Objectives and Strategies for Implementation:

Objective 1 — Refine and expand the scope of practice for respiratory therapists in all care settings.

Description — Promote advanced practice and practice expansion for respiratory therapists. Assure that the science that demonstrates the value and role of the respiratory therapist is provided to those stakeholders whose decisions and actions need to be guided by that information.

Strategies

1. Continue to promote the development of specialty tracks and/or specialty programs for respiratory therapists (e.g. leadership development, case management, and disease management).
2. Collaborate with NBRC and CoARC to expedite the development of standards for education, credentialing, and avenues for reimbursement for the Advance Practice Respiratory Therapist.
3. Collect and disseminate information that documents the costs in dollars, length of stay, and effect on patient lives when respiratory care is provided by persons other than respiratory therapists.
4. Assist respiratory therapists in the provision of evidence-based respiratory care.
5. Increase the access of underserved populations to the services of respiratory therapists.
6. Promote positive models of excellence in respiratory care.
7. Develop model position descriptions for respiratory therapists in various roles that emphasize quality, access, and cost control.
8. Develop model, evidence-based protocols and respiratory care plans for clinical practice, to include disease management.

Objective 2 — Advance the knowledge base and educational preparation of respiratory therapists to ensure competent patient care and to foster patient safety initiatives.

NOTICE
The American Association for Respiratory Care has a newly updated Strategic Plan effective for 2015–2020. It is also available online at www.aarc.org/members_area/resources/strategic.asp.

Description — The AARC will promote the continuing development of the respiratory care workforce both nationally and internationally by promoting formal educational programs and continuing education in order to ensure competent, safe, and effective patient care, and to provide for the transfer of new knowledge to clinical practice.

Strategies

1. Support existing educational programs in colleges and universities.
2. Support existing and future articulation agreements between associate and baccalaureate respiratory therapy programs or a health science field.
3. Expedite the continuing development of baccalaureate and graduate degree education in respiratory care with the goal of the baccalaureate degree as entry level.
4. Encourage respiratory therapists to pursue advanced and continuing education.
5. Encourage state licensure acts to include minimal requirements for continuing education.
6. Actively engage and support state affiliates in the movement toward registered respiratory therapist as entry level for licensure.
7. Support the development of new specialty credentials, as appropriate, and encourage current practitioners to seek and obtain credentials for advanced and specialty practice.
8. Assist educational programs in recruitment of quality students by developing materials that will present the profession positively and promote the profession.

Objective 3 — Support research and scientific inquiry to strengthen the scientific foundation and promote best practice for patient care.

Description — Demonstrate the value of the respiratory therapist in providing respiratory care by supporting, conducting, and publishing research information. Research should compare the value of the respiratory therapist to others who may provide respiratory care services. Information generated should consider the needs of employers, legislators, regulators, other health professionals, and patients. Research efforts will, when appropriate and possible, be conducted in collaboration with other health care stakeholders.

Strategies

1. Financially support research that seeks to advance the science and practice of respiratory care provided across all care sites.
2. Publish scientific information that advances the science and practice of respiratory care.

Objectives and Strategies for Implementation:

3. Work collaboratively with other health professions to conduct research to demonstrate the value of allied health professionals.
4. Demonstrate the effectiveness of the respiratory therapist in health promotion and disease prevention.

Objective 4 — Establish professional standards and outcomes that are supported by scientific evidence.

Description — The AARC will continue to develop and disseminate position statements, issue papers, consensus conference reports, evidence-based Clinical Practice Guidelines and other professional standards that promote safe and effective care, and provide guidance on all aspects of respiratory care.

Strategies

1. Continue to develop and revise evidence-based Clinical Practice Guidelines to reflect the science of respiratory care and the role of the respiratory therapist.
2. Conduct scientific conferences to advance the science and practice of respiratory care.
3. Develop and publish papers and position statements related to respiratory care practice, education, and management.

Objective 5 — Advocate for federal and state health care policies that enhance patient care, patients' access to care, and professional practice.

Description — Advocate at the federal and state level for health care policy that promotes access to appropriate, safe, and effective respiratory care for patients and the public. Develop and implement promotion/marketing of the respiratory therapist targeted to legislators, policy makers, and payers. Messages will emphasize the value of the respiratory therapist in controlling the utilization of services, creating cost savings, improving outcomes and patient safety, and increasing access to respiratory care as provided by a respiratory therapist.

Strategies

1. Legislators: Provide information to assist them to advocate for their constituents with a focus on safety and cost advantages of respiratory care provided by respiratory therapists.
2. Regulators: Emphasize regulatory actions that support the patient with chronic disease and the role of the respiratory therapist with a focus on cost savings, quality of care, and improved patient safety from utilizing respiratory therapists.
3. Payers: Emphasize cost effectiveness due to improved outcomes and lower cost than other providers.
4. Decision Makers: Emphasize provision of high-quality care by respiratory therapists while controlling costs of that care. Focus on the value of respiratory care and the respiratory therapist as the best practitioner to provide that care, control inappropriate utilization of respiratory care, and ensure patient safety.

Objective 6 — Partner with governmental agencies, community organizations, third party payers, professional societies and the public to promote healthy behaviors and prevent cardiopulmonary disease.

Description — Promote partnerships with interested stakeholders to improve lung health, prevent cardiopulmonary disease, and identify and maximize the care of patients with chronic disease.

Strategies

1. Participate in consumer, professional, and governmental coalitions to promote lung health.
2. Support efforts to encourage smoking cessation and tobacco control.
3. Partner in public education efforts to advise the public on lung health and cardiorespiratory disease.
4. Participate in efforts to educate patients, their families and the public on the importance of disease management for chronic respiratory disease (e.g. asthma and COPD).

Objective 7 — Broaden consumer and health care providers' knowledge and understanding of the value of respiratory therapists in providing safe, competent, and evidence-based care.

Description — Develop and implement promotion/marketing of the respiratory therapist targeted to health care providers, patients, and the public. Educate respiratory therapists on the importance of health promotion, effective smoking-cessation and tobacco-control programs, pulmonary health screenings, patient education, and disease management.

Objectives and Strategies for Implementation:

Strategies

1. Consumers: Provide information on higher mortality and increased costs when respiratory care is not provided and when it is provided by someone other than a respiratory therapist. Promote public awareness of the respiratory therapy profession by focusing on quality, safety, and cost issues.
2. Other Health Professionals: Provide information and assistance to assure that respiratory care is provided by appropriate personnel when such care falls outside of the domain covered by the training and demonstrated competence of those individuals.
3. Respiratory Therapists: Provide information to assist therapists in developing and maintaining their skills as chronic disease educators and experts in tobacco cessation.

Objective 8 — Assure the Association has the resources to meet the mission and strategic goals of the organization.

Description — Assure that the AARC has the financial, volunteer, and staff resources needed to accomplish the implementation of the strategic plan of the Association. It is necessary to have sufficient income to support the ongoing and new initiatives of the Association if we are to accomplish the goals of the AARC. In addition to financial resources, it is essential that there be active participation of sufficient numbers of effective leaders and an effective and efficient Executive Office to support the efforts to be a leader in health care.

Strategies

1. Increase the national and international membership of the Association.
2. Increase the diversity of the members of the Association by providing information to encourage persons who are members of underrepresented groups to enter the respiratory care profession and actively participate in the AARC.
3. Develop and increase the revenue sources needed to support the activities of the Association.
4. Participate collaboratively with strategic partners for mutual benefit.
5. Provide mechanisms to assure a continuous supply of interested, qualified leaders.
6. Increase the involvement of members in the activities of the Association.
7. Ensure the responsiveness of the leadership to the rapidly changing environment today and in the future.
8. Educate respiratory therapists about the benefits of AARC membership.
9. Provide information to educators and managers to encourage active participation of students in the AARC and its chartered affiliates and to assure they are fully informed of the science of respiratory care.
10. Align incentives with state affiliates. ■

AARC Congress 2014

The 60th International Respiratory Convention & Exhibition

Show Hours

Tuesday 11:00 am - 4:00 pm
Wednesday 9:30 am - 3:00 pm
Thursday 9:30 am - 2:00 pm

60th International Respiratory Convention & Exhibition

AARC Congress 2014: Where Challenges Met Opportunity

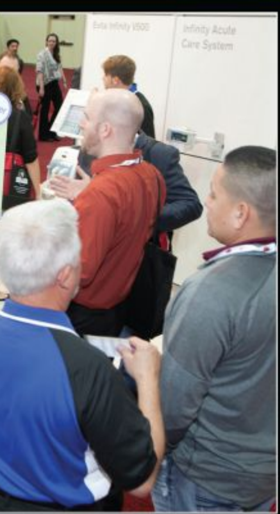
As respiratory care professionals gathered for AARC Congress 2014 in Las Vegas, the nation was still reeling from the ebola outbreak that hit our shores in September. Attendees came to the meeting with thoughts of their colleagues at the affected hospitals still foremost in their minds, and they were eager to learn more about advances in the profession so they would be ready should ebola or another deadly outbreak make its way to their facilities.

The AARC Congress delivered. Over the four-day session, attendees heard about everything from ebola, to the new penalties for COPD readmissions, to cutting-edge developments in critical care. The Keynote Address, delivered by Michael A.E. Ramsay, MD, FRCA, along with patient advocate Patricia LaChance, told attendees about the crucial role they have to play in curtailing preventable medical errors, while the lectures and symposia delved into a range of issues important to the profession and patients.

"Health care faced many challenges last year, and respiratory therapists were key players in helping their organizations meet them head on," said 2013–2014 AARC President George Gaebler, MSEd, RRT, FAARC. "AARC Congress 2014 was designed with those challenges in mind. Our meeting provided the take-home knowledge RTs need to be successful this year."

The following pages recap the 60th International Respiratory Convention & Exhibition. Once you see the value that it provided RTs last year in Las Vegas, surely you will want to attend the 61st AARC Congress coming up in Tampa, FL, this Nov. 7–10 (Saturday through Tuesday). ■

Photos by Lennie Sirmopoulos, Convention Photography, Tustin, CA



Everything You Wanted To Know and More

Respiratory professionals who came to Las Vegas hoping to hear the latest information on the hottest topics in respiratory care were not disappointed. Here are some highlights from the 60th AARC Congress this past December.

Photos by Lennie Sirmopoulos, Convention Photography, Tustin, CA

AARC
CONGRESS 2014

Keynote Session Emphasizes Ways To Prevent Patient Care Errors

Michael A. E. Ramsay, MD, FRCA, and patient safety advocate Patricia LaChance discussed how RTs can minimize adverse patient events during the Congress Keynote Address during Congress opening ceremonies. "*You* are the frontline of patient safety, you're out there salvaging our patients who get into trouble," said Dr. Ramsay. "I just think there is a lot more that we can have you do. We need to involve you more in patient pre-op assessment of the fit, healthy patients so they will not get into major trouble."

"Patients, nurses, respiratory therapists, hospital administrators, and equipment manufacturers are coming together in the Patient Safety Movement to build a culture of patient safety that is all about fighting the lack of education and technology and eliminating blind spots in order to ensure patient care safety," he said.

Dr. Ramsay pointed out that a major problem is opioid-induced respiratory depression, in that it can be masked by the use of post-op supplemental oxygen because the O_2 saturation is normal. What caregivers may not see is that the CO_2 has gotten very high and the respiratory rate has dropped very low. "These adverse events should not happen… particularly with your help," Dr. Ramsay told RT attendees. He noted that RTs should be involved right up front to be sure patients don't get into trouble with opioid-induced respiratory depression. "It's so simple if we have the tools and the knowledge that you all have to prevent these adverse events," he emphasized.

Dr. Ramsay talked with Patricia LaChance, the wife of a patient who died from a preventable hospital error who is now an advocate for ensuring patient safety through better education and monitoring.

"My husband and I didn't understand how dangerous his sleep apnea was," she explained. She said she wished she had known then what she knows now so she could have pushed further the issues she brought up to each of the staff caring for him. "I trusted the caregivers," she said. After his death, it was learned that 13 errors had taken place in his care. "It's very important that respiratory therapists be brought in at pre-surgery to assess each patient like my husband and be a part of the care plan," she said.

"I appreciate being here. Thank you so much for inviting me. I believe that we can make a change — each of us who has suffered through it," she emphasized.

The AARC was honored to have Dr. Ramsay and Patricia LaChance present the 2014 Keynote Address, supported by an unrestricted educational grant from Masimo. ■

Cutting-edge Topics Packed the Lecture Halls

The leading names in respiratory care were on hand to educate attendees on the latest advances in respiratory care and the governmental and managerial issues with the potential to impact the profession in the next year and beyond.

Pediatric Acute Lung Injury: Do We Have Consensus? Neal J. Thomas, MD, MSc, highlighted the pediatric-specific definitions for ARDS and recommendations regarding treatment and future research priorities.

New ATS/ERS Recommendations for Field Testing, (e.g. Six-Minute Walk and Other Field Tests): Carl D. Mottram, RRT, RPFT, FAARC, provided a thorough review of the updated ATS/ERS guideline on the six-minute walk test (now called "Field Testing" to broaden the scope) focusing on changes since the original guideline was published.

PEEP and Recruitment Maneuvers: Dean Hess, PhD, RRT, FAARC, reviewed the evidence related to recruitment maneuvers and PEEP titration.

Implementing Improvements To Reduce COPD Hospital Length of Stay: Francis A. Gott, III, MBA, RRT, covered emerging best practices driving reductions in hospital length of stay for the COPD population.

Respiratory Therapy 2015 and Beyond: Applied Adult Acute Care Case Study: Daniel D. Rowley, MSc, RRT-ACCS, FAARC, offered an in-depth example of how RTs may systematically apply patient assessment, pathophysiology, laboratory and diagnostic imaging data, medical literacy, mechanical ventilation, advancements in patient monitoring, and clinical leadership skills to help direct respiratory care management of acutely ill patients.

An Interactive Quiz: What Is Your Home Care IQ? Angela King, RRT, and Gary Jeromin, RRT, took a closer look at the home care setting and then administered an interactive quiz to attendees that covered a mix of factors involved in home respiratory care — from ventilators, NPPV, and oxygen administration to respiratory-assist devices and airway clearance.

(Continued on next page)

Current Topics in Tobacco Cessation: Ralph W. Stumbo, Jr., RRT, CPFT, and Susan Rinaldo Gallo, MEd, RRT, FAARC, addressed vaping, smoking-cessation reimbursement, and tobacco policies in the workplace during this symposium.

Specialty Care Transport: 2014 and Beyond: Tabatha Dragonberry, BSRT, RRT-NPS, RRT-ACCS, and Alex Brendel, MBA, RRT-NPS, reviewed the results of a recent survey on respiratory therapists involved in transport and also addressed licensure laws and their impact on the transport RT.

Distance Learning in the Not-So-Distant Future: Georgianna Sergakis, PhD, RRT, CTTS, and Crystal Dunlevy, EdD, RRT, tackled the pros and cons of distance learning in an engaging session that ultimately provided attendees with a nuts-and-bolts approach to building a great online course.

Oxygen Therapy: Doing It Right: Brian Carlin, MD, FAARC, discussed the science behind the use of supplemental oxygen, how to choose the appropriate delivery devices for individual patients, and what the future holds for this life-preserving technology.

Outcomes in Pulmonary Rehabilitation: The Science and Best Practices: Chris Garvey, FNP, MSN, MPA, highlighted strategies for identifying, collecting, and interpreting outcome measures in pulmonary rehabilitation.

Doing More with Data — How To Seamlessly Incorporate Bedside Data To Improve Quality: Brian Walsh, MBA, RRT-NPS, FAARC, discussed the past, present, and future of data utilization and how recent advancements will allow us to easily discover the successes and failures inherent in the services we provide.

ALS Management in the Home: Joseph Lewarski, RRT, FAARC, John Cahill, RRT, and Lee Guion, MA, RRT, FAARC, provided an overview of amyotrophic lateral sclerosis today and reviewed successful home airway clearance and mechanical ventilation strategies and tactics.

COPD and Post-Acute Care... Connecting the Dots: Stephanie Williams, BS, RRT, explained how respiratory therapists are redefining their role in the care of COPD patients outside of the hospital setting.

Patient Safety: Amber Galer, BS, RRT, Julie Jackson, BAS, RRT-ACCS, and Cheryl Hoerr, MBA, RRT, FAARC, emphasized the important role RTs can play in screening hospitalized patients for obstructive sleep apnea and provided attendees with the tools to go home and champion the creation of a comprehensive screening program in their organizations.

Transitioning from Student to Professional: Getting Credentialed and Employed: Bill Galvin, MEd, RRT, FAARC, Crystal Dunlevy, EdD, RRT, Cheryl Hoerr, MBA, RRT, FAARC, and Debbie McAllister, BHS, RRT, shared their wisdom in a symposium that covered all the bases for newly minted RTs.

In the Spotlight

Attendees in Las Vegas noticed a special tag line on some of the sessions in their program last year — "Program Committee Spotlight." According to AARC Program Committee Member Cheryl Hoerr, MBA, RRT, FAARC, the goal was to "highlight information deemed of critical importance to the membership." With so much going on at the Congress, she said it is easy to miss something, and the committee wanted to ensure its most important sessions stood out from the crowd. The overall objective was to draw attention to these presentations so everyone would put them on their radar screens — especially those who only had limited time to devote to the meeting.

Recap: Donald F. Egan Scientific Memorial Lecture

What Have We Learned About Noninvasive Ventilation in the Past 20 Years?

by Laurent Brochard, MD

Dr. Laurent Brochard is the Keenan Chair for Critical Care and Respiratory Medicine at the Keenan Research Centre at St. Michael's Hospital and director of the interdepartmental division of critical care medicine at the University of Toronto, both in Toronto, Canada.

Noninvasive ventilation (NIV) appeared both in the world of home ventilation and in ICUs at the end of the 1980s and beginning of the 1990s. I was involved in research in the early assessment of pressure-support ventilation in intubated patients, and it rapidly seemed obvious to me that this improvement in synchronized ventilation could be used through a face mask to treat acute hypoventilation and respiratory acidosis.

Patients with COPD were obvious candidates. The use of NIV in these patients resulted in at least three consequences. First, it enormously helped us understand the pathophysiology of acute respiratory failure in these patients and the importance of supporting the work of the respiratory muscles. Second, it allowed us to avoid the need for endotracheal intubation, reducing many of the ICU complications and considerably changing the prognosis for these patients. More than 20 years later, NIV has become the gold standard for treating acute exacerbations of chronic respiratory failure.

Third, it opened the door to all kinds of other indications for NIV. A frequent one became cardiogenic pulmonary edema, especially when associated with ventilatory failure. The field of hypoxemic failure includes heterogeneous patients, and NIV was shown to be efficient at avoiding intubation. Indications had to be very carefully selected, however, and simply delaying intubation could become a risk for these patients. Patients with immunosuppression seemed to particularly benefit from NIV. I am convinced that NIV will find its right place in this indication, but more work is needed to delineate indications, timing, technique, and clinical criteria for intubation.

Interestingly, alternatives to the classical NIV techniques are emerging, such as high-flow oxygen therapy, which will also play a role. NIV has been found to have interesting effects to prevent reintubation in patients at risk of extubation failure or in the post-operative period as well. In these indications, NIV should not be applied to all patients nor at a late stage. Preventive use in patients with risk factors seems to be the key. In sum, NIV has enormously changed the way we deliver ventilatory support in the ICU, reducing the need for endotracheal intubation and sedation and improving the outcome of many ICU patients. ■

Recap: Phil Kittredge Memorial Lecture

Ebola: From Sierra Leone to Sin City

Lewis Rubinson, MD PhD

The current outbreak of Ebola virus disease (EVD) caused by the Zaire species originated in Guinea and continues to plague West Africa. By the end of November, nearly 16,000 persons had been infected and almost 7,000 had died. As a consultant clinician for the World Health Organization at Kenema Government Hospital in Sierra Leone, I was the clinical lead during a September 2014 deployment and had the opportunity to witness the clinical features of the disease as experienced by several hundred people under our care.

Sporadic cases of EVD are likely to continue in the United States as long as the EVD outbreak in West Africa continues at its current magnitude. Since some people with EVD develop critical illness, respiratory care professionals may be involved in caring for these patients. We can all benefit from lessons learned from the West African experience to develop preparedness and response recommendations for U.S. health care responders. Many of these recommendations will focus on respiratory care issues. ■

Lewis Rubinson is director of the Critical Care Resuscitation Unit at the R. Adams Cowley Shock Trauma Center at the University of Maryland in Baltimore. He previously served as chief medical officer (acting) of the National Disaster Medical System.

Recap: Thomas L. Petty Memorial Lecture

Current Management of the Refractory Asthmatic Patient: Importance of Accurate Phenotyping

by James T. Good, Jr., MD, FACP, FCCP

James Good is a professor of medicine at National Jewish Health in Denver, CO.

Asthma is a heterogeneous condition. Its natural history includes acute episodic exacerbations against a background of chronic persistent inflammation that is frequently associated with persistent symptoms and reduced lung function. Because many other cardiopulmonary disorders may present with similar symptoms of cough, wheeze, shortness of breath, and chest tightness, it is essential to establish the diagnosis of asthma with a 12% improvement in FEV_1 following bronchodilator and/or a positive provocative test such as a methacholine challenge.

Once a diagnosis of asthma is established, a therapeutic plan using National Asthma Education and Prevention Program guidelines should be implemented based on the severity of the disease and the need for control. When these guidelines are followed and adequate asthma control is not accomplished, we must look for those factors (such as allergies, infection, and environmental irritants) that result in poor control. The refractory asthmatic represents a different type of patient who generally continues to have symptoms and abnormal pulmonary function in spite of high doses of inhaled corticosteroids with or without systemic steroids.

We have developed a system using fiberoptic bronchoscopy with endobronchial biopsies, brushes, and bronchoalveolar lavage to identify five asthmatic phenotypes:

1. Gastroesophageal/laryngopharyngeal reflux
2. Tissue eosinophilia
3. Subacute bacterial/fungal infection
4. Combination (1, 2 and 3)
5. Nonspecific.

We have demonstrated that specific, directed therapy based on phenotype results in improvement in the asthma control test and pulmonary function in all groups except for nonspecific. Bronchoscopic evaluation of the airway can provide important information toward characterizing refractory asthma so as to better individualize therapeutic options and improve asthma control and lung function in patients with difficult-to-treat asthma. This lecture was supported by an unrestricted educational grant from the Snowdrift Pulmonary Conference. ■

New Open Forum Formats Debut

Congress attendees saw some changes in the Open Forum in Las Vegas. Thanks to a revamped format, the original research accepted for last year's event was presented in three categories.

Editors' Choice: Posters of the top six abstracts were on prominent display on Tuesday and Wednesday, and then on Thursday each author made a 10-minute slide presentation followed by 10 minutes of audience questions and discussion. Editors' Choice abstracts and authors included:

Lack of Compliance with Lung-Protective Ventilation Is Not Due to Inaccurate Height Measurement, Terry L. Forrette, MHS, RRT, FAARC, New Orleans, LA

Accuracy of the Electronic Health Record Patient Height, Matthew C. Jurecki, BS, RRT, Cleveland, OH

End-Tidal Capnography Utilization in Determining Cardiac Arrest Outcomes in the Emergency Department, Nancy G. Graff, RRT, RPSGT, Grand Rapids, MI

Use of a Respiratory Care Practitioner Disease Management (RCP-DM) Program for Patients Hospitalized with COPD, Robin Kidder, RRT, AE-C, St. Louis, MO

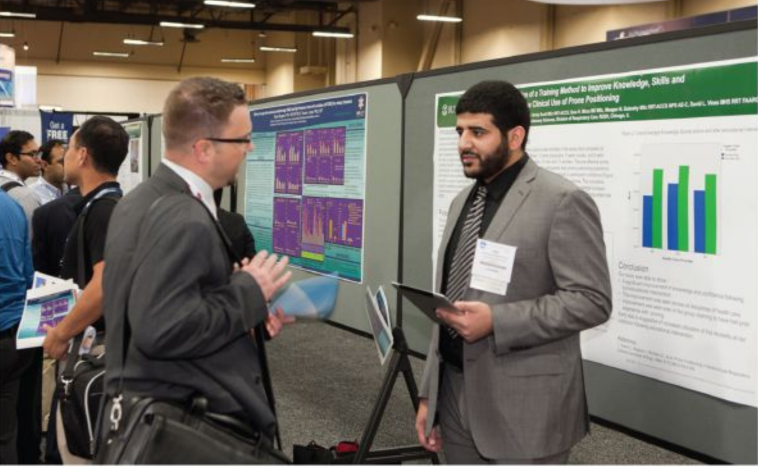
A Comparison of Positive-Pressure Modalities in a Respiratory Therapist Driven Protocol for Patients Post Anatomic Lung Resection, Jenny Hsieh, RRT, Chicago, IL

Infant Pulmonary Function Testing and High Resolution Controlled Ventilation Chest CT as Predictors for Extubation in Endotracheally Intubated Infants with Severe Bronchopulmonary Dysplasia, Courtney R. Cira, MS, RRT, Columbus, OH

Poster Discussions: Posters in this group were presented Tuesday–Friday in 16 sessions grouped by topic, similar to the traditional Open Forum format. Brief oral presentations were followed by audience questions and discussion.

Posters: Posters in this category were displayed during Exhibit Hall hours Tuesday–Thursday. These authors (many of whom presented at the Open Forum for the first time) then gathered between noon and 1 p.m. on their assigned day to discuss their work.

The deadline to submit an abstract for the 2015 Open Forum in Tampa, FL, is May 1. Submissions may be made online at www.rcjournal.com. The 2014 Open Forum was supported by an unrestricted educational grant from Monaghan. ■



New Horizons Symposium Zeroes In on Refractory Hypoxemic Respiratory Failure

Treating patients with refractory hypoxemic respiratory failure can be a real challenge for respiratory professionals. Leaders in the area reviewed the therapeutic goals, offered a comparison of HFOV versus APRV, took a closer look at PEEP and recruitment maneuvers, examined the role that can be played by extracorporeal life support, and addressed prone positioning and when it would be beneficial in this patient population in the 2014 New Horizons Symposium. The symposium was supported by an unrestricted educational grant from InspiRx. ■

An Unprecedented International Gathering

AARC Congress 2014 truly was an international meeting, with speakers and exhibitors from all over the globe in attendance. The Egan Lecture was delivered by Laurent Brochard, MD, from Canada, and the Open Forum illustrated the growing international focus of the meeting, with presentations by these colleagues from abroad.

- Chin-Jung Liu, MSc, Taichung, Taiwan
- Ghazi Alotaibi, PhD, RRT, Dammam, Saudi Arabia
- Caio Cesar Morais, Recife Pernambuco, Brazil
- Hui-Ling Lin, MSc, RRT, RN, FAARC, Taoyuan, Taiwan
- Sigurd Aarrestad, Oslo, Norway
- Teramachi Ryo, Seto, Japan
- Toshiki Yokoyama, MD, PhD, Seto, Japan
- Wang Sheng-yu, Xi'an Shaanxi, China
- Armele Dornelas de Andrade, PhD, Recife Pernambuco, Brazil
- Constance Teo, Singapore
- Ping-Hui Liu, Kaohsiung City, Taiwan
- I-Chun Hou, Kaohsiung, Taiwan
- Naoya Nishida, Bunkyo-ku, Tokyo, Japan
- Tetsuro Hirayama, Shinagawa-ku, Tokyo, Japan
- Tomomi Ichiba, PhD, Hachioji, Tokyo, Japan
- Kyoko Honda, Iwakuni, Yamaguchi, Japan
- Yuuki Homma, Itabashi-ku, Tokyo, Japan
- Wei Jian Matthew Tan, BSRC, Singapore
- Jie Li MSc, Beijing, China
- Tetsuo Miyagawa, PhD, Yokohama, Kanagawa, Japan
- Nasser Al Homoud, Riyadh, Saudi Arabia
- Etiene Fittipaldi, PhD, Recife, Brazil
- Chia-Chen Chu, MSc, Tai Chung, Taiwan
- Naomi Nakagawa, PT, MSc, PhD, São Paulo, Brazil

The AARC's 2014 International Fellows attended the conference to learn more about respiratory care, American style, to take back to their home countries. They included:

- Rania El-Farrash, MD, Egypt
- Chulee Jones, PhD, PT, Thailand
- Yang Liu, MD, China
- Nicolas Roux, PT, Argentina

The following entities generously supported the International Fellowship Program: the AARC House of Delegates, AARC, AMP/NBRC, Aspirant Education, PIMA Medical, Draeger Medical, Inc., and Philips Respironics. ■

2014 International Fellows

AARC Pre-courses Added Value to the Congress

Congress attendees who came in a day early for the meeting got the chance to learn more about the latest thinking in respiratory care during five well-attended pre-courses:

Preparing for a Pandemic: The Strategic National Stockpile — Mechanical Ventilation Workshop: Attendees got an up-close look at the mechanical ventilators they may be called upon to use in the event of a pandemic. This hands-on experience with the three stockpiled vents should prove invaluable should they be required to care for patients in a fast-moving and chaotic situation.

Current Practice of Mechanical Ventilation: A Case-based Audience Interactive Session: The approach we take to mechanical ventilation can significantly affect patient outcomes. This course covered all the current best practices, with important points emphasized using a case-based audience interactive approach.

Pulmonary Function Testing: The four major areas of testing were covered, with an eye toward helping both seasoned pulmonary function RTs and those who only infrequently perform these tests better understand how to obtain accurate test results.

ECMO: A Comprehensive Approach for Pediatric and Adult Practitioners: Both pediatric and adult populations are increasingly benefiting from ECMO; and this state-of-the-art, interactive course provided attendees with a better understanding of this life-saving approach to refractory respiratory and/or cardiac failure.

Sleep & Wellness 2014: The latest information on sleep testing and diagnosis was presented in this course, which was tailored to both the respiratory therapist and sleep technologist working in the sleep clinic.

All of the Congress pre-courses were approved for CRCE. ■

AARC Exhibit Hall Delivers the Goods

With all the vendors in the industry, the Exhibit Hall at AARC Congress 2014 offered attendees the chance to peruse the latest technology and services available in the field all under one roof. Attendees took full advantage of the opportunity, visiting as often as they could to check out innovations in respiratory care equipment they could put to work in their hospitals back home.

Navigating the Exhibit Hall was easier than ever before, too, thanks to a new Exhibit Hall website. The interactive tool allowed users to find exhibitors, plan their visits, check out eBooths for more information, and even email manufacturers' reps while they were still at the meeting. Show specials were available as well, which in some cases ended up saving attendees enough money to cover the cost of their trip. ■

Richly Deserved Recognition!

AARC members who have gone above and beyond for their profession received some well-deserved recognition by their peers during Congress 2014.

Photos by Lennie Sirmopoulos, Convention Photography, Tustin, CA

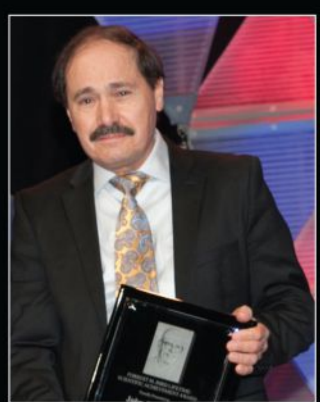
Awards Ceremony Honors Top Professionals

The following top performers in the AARC, American Respiratory Care Foundation (ARCF), National Board for Respiratory Care (NBRC), and Commission on Accreditation for Respiratory Care (CoARC) received these awards during the Awards Ceremony on Dec. 9 in Las Vegas.

- Jimmy A. Young Medal: Charles G. Durbin, Jr., MD
- NBRC/AMP William W. Burgin Jr. MD and Robert M. Lawrence MD Education Recognition Award: Christina Rocks
- William F. Miller MD Postgraduate Education Recognition Award: Janelle Gardiner, MS, RRT, AE-C
- NBRC/AMP Gareth B. Gish MS RRT Memorial Postgraduate Education Recognition Award: Sherry Whiteman, BS, RRT
- Morton B. Duggan, Jr., Memorial Education Recognition Award: Amelia Andrews
- Jimmy A. Young Memorial Education Recognition Award: Tori Theobalt
- Charles W. Serby COPD Research Fellowship: Kim Bennion, MHS, RRT, CHC
- Monaghan/Trudell Fellowship for Aerosol Technique Development: Kari Armstrong
- Philips Respironics Fellowship in Non-Invasive Respiratory Care: Zachary Gantt, RRT
- Philips Respironics Fellowship in Mechanical Ventilation: Sigurd Aarrestad, MD
- CareFusion Fellowship for Neonatal and Pediatric Therapists: Howard Stein, MD
- Forrest M. Bird Lifetime Scientific Achievement Award: John J. Marini, MD
- Dr. Charles H. Hudson Award for Cardiopulmonary Public Health: Stanton A. Glantz, PhD
- Thomas L. Petty MD Invacare Award for Excellence in Home Respiratory Care: Angela King, BS, RRT-NPS, RPFT
- Mike West MBA RRT Patient Education Achievement Award: Timothy Op't Holt, EdD, RRT, FAARC
- NBRC/AMP H. Frederick Helmholz, Jr. MD Educational Research Grant: Kathy Myers Moss, PhD, RRT-ACCS
- Ikaria Best Paper Award by Best First Author: Edward D. Shepherd, MD
- Dr. Allen DeVilbiss Best Paper Award: Daniel F. Fisher, MSc, RRT

Jimmy A. Young Medal awarded to Charles G. Durbin, Jr., MD

Education Recognition and Literary Awards, Special Fellowships



Forrest M. Bird Lifetime Scientific Achievement Award went to John J. Marini, MD

Thomas L. Petty MD Invacare Award went to Angela King

Mike West MBA RRT Patient Education Achievement Award went to Dr. Timothy Op't Holt

- Draeger Literary Award: Azadeh Bojmehrani, PhD, MSc, Eng
- Albert H. Andrews Jr. MD Memorial Award: Thomas M. Fuhrman, MD, FCCM, FCCP
- Dr. Ralph L. Kendall Outstanding Site Visitor Award: Diane Flatland, MS, RRT-NPS, CPFT
- Héctor León Garza MD Achievement Award for Excellence in International Respiratory Care: Dean R. Hess, PhD, RRT, FAARC
- International Fellows: Rania El-Farrash, MD, Egypt; Chulee Jones, PhD, PT, Thailand; Yang Liu, MD, China; Nicolas Roux, PT, Argentina
- Specialty Practitioners of the Year: Adult Acute Care, Hui-Qing Ge (Grace), MS, RRT; Continuing Care/ Rehabilitation, Susan Pfanner, CRT, LRCP; Diagnostics, Ann Wilson, BS, RRT, RPFT; Education, Helen Sorenson, MA, RRT, FAARC; Long-Term Care, Zachary Gantt, RRT; Management, Allen Wentworth, MEd, RRT, FAARC; Neonatal-Pediatrics, Karl Kaminski, BSRT, RRT-NPS; Sleep, Bernadette White, MS, RRT, RPSGT; Surface and Air Transport, Jennifer Watts, BS, RRT-NPS, C-NPT
- Zenith Awards: Draeger, CareFusion, Teleflex, Masimo, Covidien, ResMed
- Honorary Membership: Edna Fiore, Colorado COPD Connection
- Life Membership: Debra J. Fox, MBA, RRT-NPS, FAARC
- AARC Fellows: Gene Andrews, BS, RRT, FAARC; Floyd E. Boyer, BS, RRT, FAARC; Eileen M. Censullo, MBA, RRT, FAARC; Sue Ciarlariello, MBA, RRT-NPS, FAARC; Joe Dwan, MSEd, RRT-ACCS, FAARC; Michael Scott Gibbons, BS, RRT, NRP, FAARC; Denise M. Johnson, RRT, MA, FAARC; Shane Keene, DHSc, RRT-NPS, FAARC; Lon W. Keim, MD, FACP, FACCP, FAARC; Raymond Pisani, BS, RRT-NPS, FAARC; Douglas M. Pursley, MEd, RRT-ACCS, FAARC; Jenni L. Raake, RRT-NPS, FAARC; John A. Rutkowski, MBA, RRT, FAARC; Jonathan Brady Scott, MS, RRT-ACCS, FAARC; Georgianna G. Sergakis, PhD, RRT, FAARC; Carl W. Willoughby, RRT, RCP, FAARC
- Outstanding Affiliate Contributor: John Hughes, MEd, RRT, FAARC
- Jerry Bridgers Delegate of the Year: Kerry McNiven, MS, RRT
- Summit Award: Michigan Society for Respiratory Care

Héctor León Garza MD Achievement Award went to Dr. Dean R. Hess.

International Fellows Rania El-Farrash, MD; Chulee Jones, PhD, PT; Yang Liu, MD; Nicolas Roux, PT.

Honorary Membership was awarded to Edna Fiore.

Literary Awards and Fellowships

Fellows of the AARC

Life Membership was awarded to Debra J. Fox.

Outstanding Affiliate Contributor John Hughes

Jerry Bridgers Delegate of the Year: Kerry McNiven

Summit Award: Michigan Society for Respiratory Care

ResMed, Covidien, Masimo, Teleflex, CareFusion, and Draeger won the Zenith Award.

Specialty Practitioners of the Year

AARC Installs 2015 Leadership

The Association's 2015 officials were installed during the Annual Business Meeting held on the second day of the Congress. Frank Salvatore, Jr., MBA, RRT, FAARC, was installed as president, and other officers include Lynda Goodfellow, EdD, RRT, AE-C, vice president for internal affairs; Cynthia White, MSc, RRT-NPS, FAARC, vice president for external affairs; and Karen Schell, DHSc, RRT-SDS, RPFT, secretary-treasurer. Directors at large are Timothy Op't Holt, EdD, RRT, AE-C, and Lisa Trujillo, DHSc, RRT.

Three Specialty Sections also held elections this year, and these individuals were elected: Continuing Care/Rehabilitation, Arianna Villa, BS, RRT; Long-Term Care, Gene Gantt, RRT; and Transport, Tabatha Dragonberry, BS, RRT-NPS, EMT.

New House of Delegates officers (pictured) include: speaker, John Wilgis, MBA, RRT; speaker-elect, Jackyn Grimball, MA, RRT, AE-C; secretary, Teresa Miller, MEd, RRT, CPFT; and treasurer, Curt Merriman, BA, RRT, CPFT. Debra Skees, MBA, RRT, CPFT, is now the past speaker. ■

New House of Delegates officers

New Literary Award Supported by Draeger

The list of awards presented during the Awards Ceremony was a little longer last year, with the addition of a new literary award supported by a $50,000 endowment bestowed on the ARCF by Draeger Medical. The 2014 award, which went to Azadeh Bojmehrani, PhD, MSc, Eng, to recognize the author of the best paper focused on mechanical ventilation published in RESPIRATORY CARE.

"Innovation and new clinical practice in mechanical ventilation require research and evidence-based outcomes," says AARC member Ed Coombs, MA, RRT-NPS, FAARC, director of marketing–intensive care at Draeger. "Establishing an annual award for the best paper that examines mechanical ventilation encourages both new and veteran RTs to continue scholarly work both on the bench and at the bedside." ■

Masimo won "Best of Show" among the Exhibit Hall booths.

Stateside Recognition for Great Efforts

The AARC would not continue to exist without the hard work of members in the state societies who make sure therapists in their areas have easy access to CRCEs through state and local conferences, organize fast responses to quick-moving legislative issues, and serve as patient advocates.

To acknowledge these important efforts, the Association bestows three awards every year to the state societies. The 2014 Outstanding Affiliate Contributor Award went to John Hughes, MEd, RRT, FAARC, from Pennsylvania. The Summit Award, which honors a state society that went above and beyond, was won by the Michigan Society for Respiratory Care.

Our Delegate of the Year Award, which has now been renamed the "Jerry Bridgers Delegate of the Year Award" in honor of the late Jerry Bridgers, CRT, who served in the House of Delegates for many years and was an active participant in the AARC's legislative efforts, went to Kerry McNiven, MS, RRT, from the Connecticut Society. ■

Best of Show Second Place went to ResMed.

2015 Corporate Partners Announced

The AARC has announced the 2015 Corporate Partners: CareFusion, Masimo, Covidien, Monaghan, Philips Respironics, Draeger, Maquet, Teleflex, Boehringer Ingelheim, Forest Laboratories Inc, Ikaria, Sunovion, and ResMed.

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

Leading Companies Honored with AARC Zenith Award

The AARC was pleased to bestow its annual Zenith Award on the following companies:

- Draeger
- CareFusion
- Teleflex
- Masimo
- Covidien
- ResMed

All of these companies were selected by 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. ■

Best of Show Third Place went to Draeger.

Extra Added Attractions Liven Up the Meeting

While continuing education always takes precedence at any AARC Congress, the meeting is also a place for attendees to address other issues important to the profession — and just kick back and relax with their peers.

Photos by Lennie Sirmopoulos, Convention Photography, Tustin, CA

AARC
CONGRESS 2014

"Night at the Vineyards" Raised Funds for ARCF

Attendees gathered in the Mandalay Bay the evening before the official start to the Congress for a fabulous Night at the Vineyards fundraiser for the American Respiratory Care Foundation (ARCF). In addition to great entertainment provided by AARC member Henry Oh, PhD, RRT, attendees participated in a "wine grab," with 125 bottles going to event participants and all proceeds going to the ARCF to help fund research in the profession.

The grand prize of the evening — an all-expenses paid trip to the world-famous Bird Air Lodge run by the legendary Dr. Forrest Bird in Idaho — went to Ani Manougian, RRT, of Glendale, CA (pictured above, center).

Association member and former AARC President Jeri Eiserman, MBA, RRT, FAARC, was also there to be honored by the profession and Teleflex, which made a special endowment to the ARCF in her name.

Special thanks go to Vapotherm for serving as the Platinum sponsor of the event. Other sponsors included Drs. Forrest and Pamela Bird, Belinda Hayden, City Winery, Willamette Valley Vineyards, Total Wine & More, Gargiulo Vineyards, Millbrook Vineyards & Winery, Jefferson Vineyards, Vineyard Vines, Mercury Wine, Lukas Liquor Superstore, and Steve and Lois Rowland. ■

New ARCF Endowment Serves as a Lasting Legacy

As noted on the previous page, Teleflex presented a $50,000 endowment to the American Respiratory Care Foundation in honor of 1986 AARC President Jeri Eiserman. The Jeri Eiserman, RRT, Professional Education Research Fellowship Endowment will help ensure that respiratory therapists from now on will have the opportunity to conduct the kind of research that is needed to improve care for patients with respiratory conditions.

The new fellowship joins several other ARCF fellowships, research grants, and awards presented each year to advance the art and science of respiratory care. The ARCF has been supporting scholarship, research, and other philanthropic activities in respiratory care for 40+ years, with the goal of enabling bright students to enter and build the profession.

The ARCF began raising funds for the profession in 1974, thanks to the generous support of respiratory manufacturers and others in our community. The students who received the ARCF awards were able to complete their education, with many going on to become leaders in the respiratory care profession, essentially repaying the advancement they had received early in their careers through the publication of scientific work that has markedly improved our understanding of respiratory care and fostered clinical improvements at the bedside. Today the ARCF continues to move the profession forward by helping students and clinicians who have the desire to do important respiratory research and write papers that will ensure that our practices remain on the cutting edge.

The advancement of professionalism also extends to the globalization of the RC profession through a joint effort of the Foundation and the AARC to improve respiratory care around the world through communication and interaction among leading practitioners in the United States and RC leaders abroad. For more than 25 years, the ARCF has administered funding for this program to advance the science of respiratory care worldwide.

Since its inception, the International Fellowship Program has brought to our shores more than 130 health care professionals from abroad. They tour respiratory care facilities in two U.S. cities before traveling to the AARC International Respiratory Congress, where they can attend the presentations and network with international colleagues to strategize on the best ways to promote the development of a respiratory care profession in their own countries.

The ARCF also provides funding for Journal Conferences on a regular basis. These "meetings of the mind" bring the best and brightest physicians and respiratory therapists together to discuss the scientific evidence on the key treatments and modalities used in our profession and to meet a consensus that can serve as a basis for clinical and policy decisions. Journal Conference proceedings are regularly published each year in the AARC's science journal, RESPIRATORY CARE.

In receiving the surprise news of the new endowment named after her at the Night at the Vineyards event, Jeri Eiserman said, "I am humbled and honored and grateful to Teleflex for their generosity to the Foundation in my name. I'm especially pleased that the endowment will help support and recognize original research, which is so important to our profession and the patients we serve." ■

Jeri Eiserman

Jeri Eiserman (second from right) was surprised with a special endowment in her honor.

AARC Sputum Bowl Educates and Entertains

Sputum Bowl teams from around the country, including those in a new category dubbed the "Renegades" (teams coming in without having won on the state level), competed on Tuesday and Wednesday; and then on Thursday evening attendees gathered to watch as the leading contenders battled it out in the finals competition.

Half-time entertainment was provided by David Crowe, a 20-year veteran of the comedy stage who has been featured in his own comedy special on Showtime and has also appeared numerous times on Comedy Central and on several well-known radio networks. In the end, these Sputum Bowl teams came out on top:

National Bowl
First place: Texas Renegades Team (pictured above)
Second place: California
Third place: Minnesota and Michigan
Fred Helmholz Award for Sportsmanship: Maryland/DC

Student Bowl
First place: Colorado Team (pictured below)
Second place: Maryland/DC
Third place: Michigan and Texas

The Sputum Bowl was supported by an unrestricted educational grant from Covidien. ■

Honoring Those Who Serve

Attendees gathered in front of the Exhibit Hall entrance on Wednesday morning to witness a moving flag-folding ceremony — the AARC's way of honoring those among us who are serving in our armed forces today and those who have so willingly given of their service in the past.

AARC offers special thanks to these RT service members for participating in the ceremony: MSgt Patricia Bellotte, TSgt Joshua Powell, TSgt Patricia Wagner, SSgt Sylvia Eldridge, SrA Cody Rothlisberger, A1C Makaila Erdody, and A1C Angela Knowles. ■

AARC Information Center Wows the Crowd

Congress attendees found plenty of great activities to keep them busy in the AARC Information Center in the Exhibit Hall. A number of iPads were available to allow visitors to peruse the products and services available from their professional organization, and everyone was invited to take a short survey about their AARC membership.

For just a small donation to the American Respiratory Care Foundation, visitors could even have their picture taken and placed on a souvenir cover of *AARC Times*. AARC staff members were there to answer questions and network with everyone who came by. ■

The AARC Virtual Museum: How One Member Made It Happen

At the Awards Ceremony on Tuesday morning, 2013–2014 AARC President George Gaebler, MSEd, RRT, FAARC, inducted the first group of respiratory professionals into the Leaders and Legends exhibit in the AARC Virtual Museum. This groundbreaking repository of RT memorabilia kicked off just last year, but the idea for the project dates back to 2007 when AARC member (and a past president) Trudy Watson, BS, RRT, FAARC, decided something needed to be done to preserve our past.

"Although the AARC has historical documents dating back to the establishment of the professional association, I felt we were missing a critical aspect of respiratory care's history — a pictorial chronology that highlighted the inventions, equipment, modalities, pioneers, and leaders of the profession," she says. She proposed the idea to the President's Council (consisting of past presidents of the AARC); and after several years of discussion with the Executive Office staff, the concept was approved.

The ARCF held a fundraiser to benefit the museum at the 2013 AARC Congress, and Teleflex Medical generously stepped up with a $25,000 donation to launch the project.

By January of 2014, the museum's infrastructure was in place; and representatives from the AARC, American Respiratory Care Foundation (ARCF), Commission on Accreditation for Respiratory Care (CoARC), and the National Board for Respiratory Care (NBRC) were invited to help develop the galleries. "For the initial galleries, we featured modalities and equipment utilized by practitioners in the 1940s and 1950s," says Watson. More than 50 AARC members in four countries have contributed vintage images and other resources.

Watson believes the Virtual Museum offers RTs a chance to look back at equipment and modalities used in the early days of the respiratory care profession and will help student therapists better understand how those things have evolved over time. It's a work in progress as well. "We plan to launch a minimum of six new galleries this year," Watson says. ■

An important invention noted in the Virtual Museum.

The Exhibit Hall was packed.

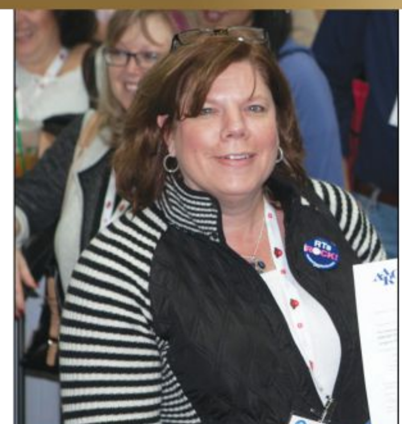
6 Lucky Congress Attendees Win Big in the Exhibit Hall

Attendees in Las Vegas received a ticket provided with their badge receipt to enter into a drawing for some cool prizes, and the winners were announced in the AARC Information Center on Wednesday. Jason Moury, BS, RRT, presented the prizes to:

- Betty Menard: Airfare to AARC Congress 2015
- Sheena Bernard: Complimentary registration to AARC Congress 2015
- Cheryl Paulson, BHS, RRT: Roundtrip ground transportation from the Tampa International Airport to the Tampa Marriott Waterside Hotel & Marina
- Sherry Davis: 1-night hotel stay at the Tampa Marriott Waterside Hotel & Marina
- Catherine Sullivan, MBA, RRT-NPS, RPFT: Free AARC 1-year digital membership
- Jenea Perkins, BS, RRT-NPS: $100 Visa gift card

Betty Menard with Jason Moury

Sheena Bernard


Cheryl Paulson

Sherry Davis

Catherine Sullivan

Jenea Perkins

DRIVE4COPD Contest Winner Announced

Last summer, the AARC launched a friendly competition to see who could screen the most people for COPD using the COPD Foundation's digital population screener. In 2014, over 150 members accounted for 500 screens. Michelle Murray, MBA, RRT-NPS, AE-C, was declared the winner at the Congress and won a complimentary registration to the 2015 AARC Congress to be held in Tampa, FL.

The contest marked an end and a beginning of sorts for the AARC's involvement in the Foundation's ongoing mission to ensure more people are diagnosed with COPD while there is still time to make a significant difference in the prognosis of the disease.

As the COPD Foundation transitions to its new COPD360social campaign, the Association thanks them for their support of COPD patients and is looking forward to a new chapter in its long-term relationship with this premier patient advocacy organization. ■

The Verdict Is in!

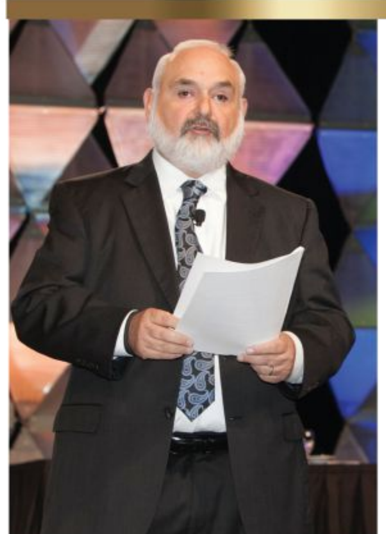
We gave away a Bird Mark VII!

AARC Congress 2014 went out with a bang, as Anthony L. DeWitt, JD, RRT, FAARC, put the profession on trial during a rousing Closing Ceremony on Friday afternoon. Featuring an array of witnesses who were questioned about the profession's ability to meet the challenges posed by the Affordable Care Act head on, the session kept everyone on the edge of their seats until the final verdict came in. Justice was done: Respiratory care is here to stay and will be stronger than ever before. DeWitt noted, "We have to look to the future. We have to make sure we deliver evidence-based care… Your effort is fully within your reach."

At the end of the ceremony, three lucky audience members went home considerably richer as well. Alden Jaspe Aggabao, BS, RRT, won the $5,000 prize, Heather S. Van Horn won the $2,500 prize, and Sunitha Palanidurai the $500 prize in the Congress grand finale drawing.

And last, but not least, Rick Donaldson Phd, CRT, RN won the Bird Mark VII ventilator autographed by the legendary Dr. Forrest Bird!

The Closing Ceremony was supported by an unrestricted educational grant from Monaghan. ■



The Closing Ceremony was moving and unforgettable.

Family Members of Patients Attending Congress Make Known Their Appreciation of RTs

Two people seemingly unrelated to the respiratory care profession, but nonetheless in Las Vegas during AARC Congress 2014, had some nice things to say about respiratory therapists.

Sharman Lamka's husband passed away in 2005 from complications of a lung disease. "As a former caregiver and family member of a person suffering from a lung disease, I learned the value of the respiratory therapist first hand," she said. Lamka was there to represent The Faces Foundation, a family and caregiver education and support group based in Milford, MI, at its booth in the Exhibit Hall. "The AARC Congress gives the profession an opportunity to come together to share their achievements and struggles and to experience the latest in trends and treatments."

Matt Silva, a member of the Mandalay Bay Resort hospitality staff, told the documentary film crew covering the Congress that he was aware of the excellent care RTs provide because ALS is prevalent in his family. Seven of his family members have already succumbed to the disease. He explained on camera that an RT had helped one of his uncles be more comfortable in his final days due to the use of bi-level PAP. "I just can't say enough about what they do," he said with emotion. ■

Tampa, FL, Here We Come!

AARC Congress 2015 will head to Tampa, FL, Nov. 7–10; and the Association's Program Committee is already hard at work on the program. Our venue promises to deliver as well. The meeting will take place at the Tampa Convention Center, where sparkling waterfront vistas bring the Florida sunshine right into the meeting halls. Our headquarters hotel, the Tampa Marriott Waterside Hotel & Marina, offers a fabulous downtown location with all the amenities you expect and is also only a short walk from the bay.

The city also offers a range of entertainment and outdoor activities. Home to Busch Gardens, the Lowry Park Zoo, Florida Aquarium, and other top sites, Tampa has plenty of tourism options for those who want to come in a few days early or stay a couple days after the meeting. With a distinct heritage, authentic culture, delicious cuisine, and premier shopping, the city will more than meet your after-hours demands, too. Tampa's vibrant waterfront district, culturally engaging venues and museums, and countless activities offer unique experiences for every taste. ■

See you in Tampa Nov. 7-10

See You Next Year!

Dräger

Frank Salvatore Has Big Plans for the AARC

Positioning respiratory therapists to meet 21st century demands is job one.

Photos by Lennie Sirmopoulos, Convention Photography, Tustin, CA

Our 2015–2016 president plans to promote, advance, and advocate his way through his two-year term in office

by Debbie Bunch

Frank Salvatore, Jr., MBA, RRT, FAARC, has spent his 20+ years in respiratory care working to elevate the stature of the respiratory therapist, both on the job at Danbury Hospital in Danbury, CT, and Orange Regional Medical Center (ORMC) in Middletown, NY, and through his volunteer work with the Connecticut Society for Respiratory Care (CTSRC) and the AARC. In December, all those efforts reached a pinnacle as he was inducted as the 2015–2016 AARC president at the International Respiratory Convention & Exhibition in Las Vegas.

Setting his life's journey

Like a lot of people, Salvatore came to the profession of respiratory care by way of another aspiration that didn't pan out. He planned to go to medical school, but when his first-semester grades at the University of Hartford in West Hartford, CT, didn't live up to those expectations — a fact he credits now to the freedom that comes with college life — he looked around for other options and found respiratory therapy. "I marched myself down to Peter Kennedy's office; and from that day forward, my life's journey was set," he told his audience at his swearing-in ceremony at the Annual Business Meeting.

Graduating with a BS in respiratory therapy, he left school well equipped to become a leader in the field; and he has lived out that promise throughout his career. When he took over as department manager at Danbury in 2001, he decreased outpatient insurance denials from over $400,000 to under $4,000, grew the sleep center from four to six beds, and improved reimbursement for the pulmonary rehabilitation program. He also brought respiratory therapists into patients' homes through a collaborative with the Danbury Visiting Nurse Association and led a multi-disciplinary team that reduced the ventilator-associated pneumonia rate from the double digits to zero.

In his current position as department director at ORMC, he was charged back in 2009 with bringing together two respiratory departments situated approximately six miles apart on different campuses. This was done in preparation for the two departments coming together in August of 2011 in a new hospital building. Salvatore is championing therapist-driven protocols at ORMC as well. Five protocols have been implemented within the department so far, and another three are in the approval process. He has also led the way in an effort to bring total wound care to the hospital system and has worked closely with vendors, helping to cut costs while maintaining quality care for the facility.

Salvatore is quick to point out that his ability to take on the presidency of the AARC was supported by the leadership at ORMC. "I am very grateful for their encouragement of leaders being active in their professional organizations," he said.

On the volunteer side

On the volunteer side, our new president has served the CTSRC in many capacities over the years, receiving not one but two of the state society's leading awards, the President's Award in May of 1998 and the John and Louise Julius Award in May of 2013. The latter is especially poignant because John Julius was also an AARC president and, until now, the only president to ever serve from the state of Connecticut.

Salvatore's foray into the national arena began early on in his career too, with service on a range of AARC committees aimed at furthering the art and science of the profession. Many know him best, however, for his unwavering support of the Association's legislative efforts. As the long-time chair of the Government Affairs Committee, he has helped to formulate the AARC's agenda in Washington, DC, and has been an active participant in the Political Advocacy Contact Team (PACT) and our annual treks up Capitol Hill to educate lawmakers about legislation vital to respiratory care and the patients it serves. Indeed, AARC members who serve on the PACT are no strangers to Salvatore's dogged determination to ensure the RT's voice is heard loud and clear by those with the power to impact the care they deliver and, most importantly, the care their patients receive.

In his presidential address at Congress 2014, Salvatore credited his long record of service to his parents, whom he said, "instilled in me the desire to serve others." As

our new president, he said he plans to follow in the footsteps of his predecessor, George Gaebler, MSEd, RRT, FAARC, by focusing on issues and concerns with the potential to make the greatest impact on respiratory therapists and their patients.

"Under George's direction… the work we did on creating objectives and strategies toward meeting the strategic goals of the Association definitely moved us in the right direction," he told his audience. "It has helped me to realize that I'm not just going to carry forward previous goals, but I'm going to look toward ensuring the goals are relevant toward meeting our strategic plan."

Promote, advance, advocate

Salvatore said a three-letter acronym taught to him by former AARC president John Hiser, MEd, RRT, FAARC, will guide his presidency — Promote, Advance, and Advocate. He'll tackle the first part of that equation by promoting public awareness of respiratory therapists to what he calls the one person to whom RT services really matter — the consumer. "Nothing speaks advocacy more than the patient, caregiver, or another provider standing up for us," he said. Gaining that recognition, however, will require the profession to move forward on a couple of key fronts.

"Listen, the time has come to advance our education once again," he emphasized to his audience. "I'm not saying that it's the end of the associate degree programs, but let's work together to find ways to bring students into the profession and advance them to what I agree should be the entry degree of the profession — the bachelor's degree." Reaching that goal won't happen overnight, he warned attendees; but with small and careful steps, it can be reached. "If we want it done right, we need to take a proactive stepwise approach."

Part of that stepwise approach may require rethinking the way the Association has advocated for respiratory care in the legislative arena. "We've been fighting for recognition for many years," he said. "We need to continue the fight."

Advanced Practice Respiratory Therapist

Salvatore plans to increase patient access to RTs by advocating for a new category of respiratory therapist as well — the Advanced Practice Respiratory Therapist, or APRT. With the advent of health care reform, non-physician providers are going to be essential to meet increasing demands for health care services; and he believes it's time for the AARC, National Board for Respiratory Care, and the Commission on Accreditation for Respiratory

Care to come together to develop the proper education and testing necessary to position RTs to fulfill roles similar to those filled by advanced practice nurses and other providers.

"RTs with proper education and competency testing are well suited to be mid-level providers in hospitals and possibly alternative care locations," he told his audience. "The three organizations must work in concert with each other to develop this track."

None of these goals or the others he has set for his term in office (see sidebar for a complete list) will come to fruition, however, without strong support from grassroots RTs; and Salvatore emphasized that means growing the AARC — something he will work hard to accomplish during his tenure. "It is time for respiratory therapists who are not members to step up and realize the importance of membership," he said. "Membership in the AARC equals strength both at the state and national level."

Supporting the profession means supporting the profession's philanthropic arm as well. Salvatore called

PRESIDENT SALVATORE'S 2015–2016 GOALS:

- Continue to develop and execute strategies that will increase membership beyond 50,000 active members and participation in the AARC both nationally and internationally.
- Promote activities to increase public awareness of respiratory therapists and their role in the diagnosis and treatment of respiratory disorders.
- Advance the concepts and initiatives brought about by the "Respiratory Therapist for 2015 and Beyond" conferences. Develop a toolkit to ensure the existing educational programs are able to move in a direction that will allow them to continue to develop our future students at a level that is consistent with them obtaining a bachelor's degree, which will eventually become the entry into our profession.
- Promote and advocate for appropriate patient and caregiver access to respiratory therapists in all care settings through local, state, and national legislation; regulation and/or policies including, but not limited to, recognizing respiratory therapists outside the traditional health care venues; and recognizing the credential of Registered Respiratory Therapist (RRT) as the minimum requirement for licensure.
- Continue to advance our international respiratory community presence through activities designed to address issues affecting educational, medical, and professional trends in the global respiratory care community and to advance advocacy for the patient.
- Promote the access of high-quality continuing education for development and enhancement of the skill base of today's practitioners to meet the current and future needs of our profession.
- Encourage the development of programs, accreditation, and credentialing of the Advanced Practice Respiratory Therapist (APRT) as a level of practice that will further improve the care given to our patients and advance the career track of our profession.
- Maintain and expand relevant communication and alliances with key allies and organizations within our communities of interest.
- Expand efforts to obtain research funding and develop the next generation of respiratory therapy researchers. The American Respiratory Care Foundation (ARCF) is an integral part of the funding/fundraising related to research; we will increase participation by our membership in ARCF fundraising activities through an educational effort that will increase awareness in the importance of the ARCF. ■

on everyone in the audience to contribute to the American Respiratory Care Foundation (ARCF), emphasizing it is the ARCF that supports many of the research projects aimed at solidifying the scientific basis of respiratory care.

Building a stronger profession

Salvatore closed out his speech with a tribute to his friend and colleague, Jerry Bridgers, CRT, who passed away last year. A long-time AARC member, Bridgers was known far and wide as a therapist who was always willing to give back to his profession.

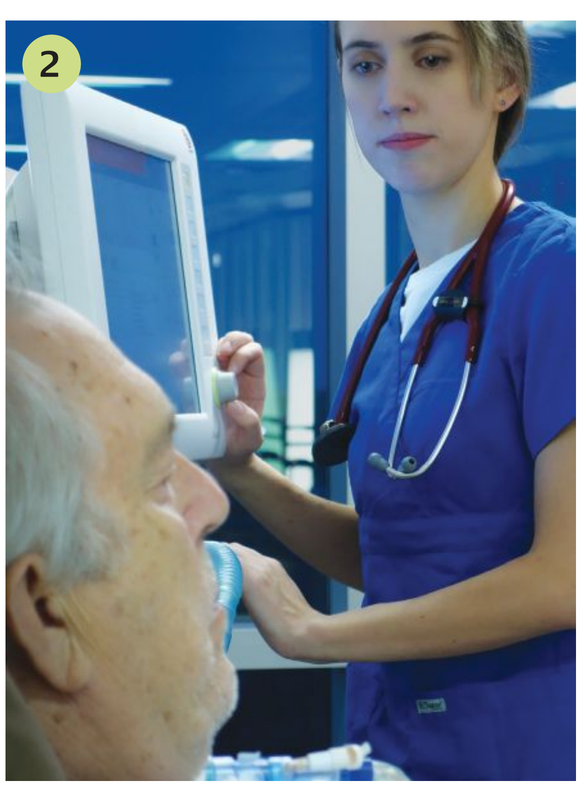
"I pledge to you beginning today and for the next 683 days that my work for this profession will be done with the same love that Jerry had and has instilled in many of us who are in this room," he said. "We will have our ups and downs over the next two years. I only ask that you keep in mind the three words that will be the basis of our growth — promote, advance, and advocate. Together, we can build a stronger profession." ■

Choose the Cover of *AARC Times* Magazine

The AARC has been collecting photos from Association members this year for our photo contest. Now it's time to select the winning photo for our April *AARC Times* cover.

Congratulations to this year's Photo Contest finalists, who each received a free annual AARC membership renewal!

Go to www.aarc.org now and click on the "Photo Contest" button to cast your vote for the winning photo. ■



1. Diane DeClerck, RRT, Ortonville, MI
2. Stephen Olsen, BA, Casper, WY
3. Roy Spierer, BS, RRT, Morristown, NJ
4. Mohammed AlAhmari, PhD, RRT, AlKhobar, Saudi Arabia

Start looking for respiratory care "photo ops" for the AARC's 2015 Photo-of-the-Year Contest!

Be Our Guest!

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.

The **International Fellowship Program** is a sponsored activity of the American Respiratory Care Foundation (ARCF). Since 1990, health professionals from more than 63 countries have shared experiences, knowledge and developed 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 the AARC's International Respiratory Congress. Learn more at: www.arcfoundation.org/international/fellows/

For more information contact:
April Lynch
Email: lynch@aarc.org
Phone: 972-243-2272

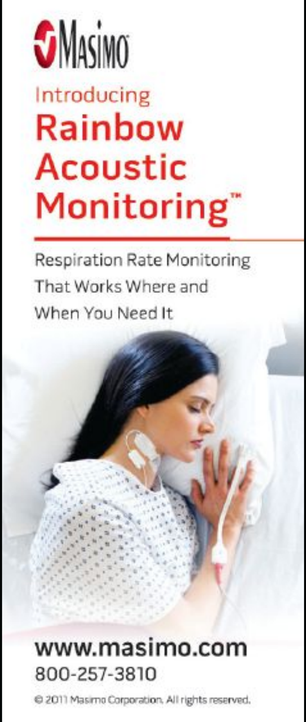
APPLICATIONS ACCEPTED THROUGH JUNE 1

APPLY AT: www.arcfoundation.org/international/fellows/

Special Advertising Section

Industry Update

Featuring information on products and equipment from manufacturers



Business Transformation Process

The ANSWER, from Philips Respironics, is a comprehensive business transformation process that connects product, technology, and workflow innovations for both sleep and respiratory care management. The three-phase process addresses the key aspects in the sleep patient's journey from patient set-up, to compliance, through ongoing resupply. The ANSWER provides a customer-focused solution that enables a home care provider to integrate data source solutions, automate via the SleepMapper mobile and Web-based application, and differentiate by sharing conclusive patient outcomes data. www.philips.com

Ebola Intervention Kit

OxySure Systems Inc., along with Estill Medical Technologies, has introduced an Ebola Intervention Kit designed to provide caregivers with two critical tools for the early treatment of Ebola patients or anyone showing possible Ebola symptoms. The kit consists of the Thermal Angel Blood and IV Fluid Warmer® and the OxySure 615 Portable Emergency Oxygen System. By combining the fluid warmer and the emergency oxygen solution, caregivers now have access to a kit that requires no AC power and is portable, includes disposables that can be discarded, and is easy to use with simple instructions. www.oxysure.com, www.thermalangel.com

Anesthesia Workstation

The Perseus A500 anesthesia workstation from Draeger offers unprecedented configurability, high-performance ventilation, enhanced ergonomics, and automation to support the workflow of the operating room. It is the first and only anesthesia machine in the U.S. to offer airway pressure release ventilation, which supports continuity of care between the ICU and OR. The workstation can also be combined with the Infinity Acute Care System for greater monitoring, ventilation, and networking power. www.draeger.com

Maintenance Bronchodilator

Boehringer Ingelheim's Striverdi®Respimat® (olodaterol) Inhalation Spray 5 µg is a long-term, once-daily maintenance bronchodilator treatment of airflow obstruction in patients with COPD, including chronic bronchitis and/or emphysema. It is not indicated to treat asthma or acute deteriorations of COPD. The long-acting beta agonist is delivered via the Respimat inhaler, which provides a pre-measured amount of medicine in a slow-moving mist that helps patients inhale the medicine. The Respimat inhaler was developed to actively deliver medication in a way that does not depend on how fast air is breathed in from the inhaler. www.boehringer-ingelheim.

PAP Travel Briefcase

Philips Respironics' PAP travel briefcase helps sleep apnea users travel with ease when carrying their sleep therapy system. It is the only customized, all-in-one luggage option that organizes PAP equipment, a laptop, and small carry-on items neatly, securely, and discreetly. Two separate bags (one for PAP equipment and one for a laptop) combine into a single carry-on. The two bags zip and unzip easily from one another so either bag can be carried separately. The briefcase accommodates Philips Respironics' System One sleep therapy equipment or other PAP systems. www.philips.com

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

RC Currents

IN THE NEWS

EDUCATORS: Help Recognize and Reward 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. Awards include registration and airfare to attend AARC Congress 2015, to be held Nov. 7–10 in Tampa, FL.

To see all of the awards bestowed by the ARCF every year, go to the Foundation's Grants, Awards and Fellowships page at www.arcfoundation.org/awards/. For more information, contact April Lynch at lynch@aarc.org. ■

Check Out Our New Members List 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. ■

Respiratory Care Education Annual Call for Papers

The AARC will publish Volume 24 of the *Respiratory Care Education Annual* (ISSN 2372-0735) in the fall of 2015. 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*, and in *Ulrich's Periodical Database*.

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 as established by RESPIRATORY CARE. Abstracts should not exceed 250 words. General guidelines for the manuscript as well as guidelines for preparing the manuscript, text formatting, and reference formatting may be found at http://rc.rcjournal.com/site/includefiles/author_information.xhtml.

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 edu@aarc.org. Deadline is **Feb. 16, 2015**. ■

Respiratory Care Education Annual

The American Association for Respiratory Care

Original Contributions

Let's Get Beyond Tobacco: A Needs Assessment of Tobacco Use Among Lesbian, Gay, Bisexual, and Transgender (LGBT) Young Adults in Columbus, OH

COPD Outreach Through Service Learning in Respiratory Therapy: Student and Community Perceptions

The Effectiveness of Patient Educational Handouts on How to Use Dry Powder Inhalers with Patients with Chronic Obstructive Lung Disease and the Patient's Ability to Generate Adequate Inspiratory Flow Rates

Predictors of Success in a Baccalaureate Respiratory Therapy Program

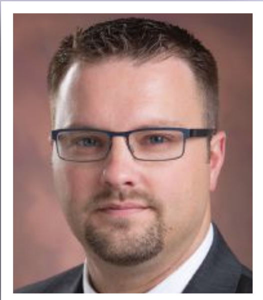
A Needs Assessment for the Delivery of Asthma Education to Parents of Young Children

Interprofessional Collaboration between Two Rural Institutions: A Simulated Teaching Laboratory Paradigm

How Will Published Programmatic Outcomes Affect Credentialing Success in Respiratory Therapy Education?

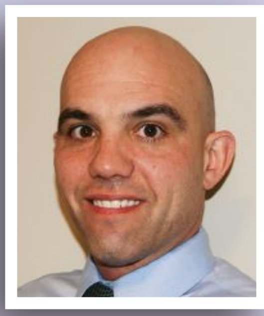
Moving on Up

George Garcia, MBA, RRT-ACCS, RRT-SDS, has joined Victor Valley Global Medical Center in Victorville, CA, as director of cardiopulmonary and rehabilitation services. He previously served as regional director of cardiopulmonary services at Prime Health Care hospitals in Garden Grove and Huntington Beach, CA.



J. Brady Scott, MSc, RRT-ACCS, is now director of clinical education at Rush University Medical Center in Chicago, IL.

David L. Ellwanger, BSRT, RRT-NPS, has retired from his position as a full-time respiratory therapy director at Southern Regional Medical Center in Riverdale, GA. An RT and AARC member since 1971, Ellwanger plans to become a clinical instructor in the Georgia State University cardiopulmonary care program and remain active with the Georgia Society for Respiratory Care.



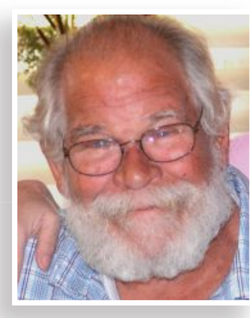
Michael Dougherty, BS, RRT-NPS, has been promoted to the position of key application field manager for neonatal and respiratory care with Draeger's marketing team. Dougherty will oversee and execute the marketing and product management of Draeger's neonatal product portfolio, including jaundice management, warming therapy, and transport devices. He previously served as a local respiratory sales executive with the company.

You can submit news about AARC members "moving on up" by sending to cathcart@aarc.org. ■

Call for Open Forum Abstracts for AARC Congress 2015

The AARC invites you to submit abstracts for the Open Forum at AARC Congress 2015. 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. We now have three different ways you can present your poster at AARC. See https://aarc2015.abstractcentral.com for more details. The deadline to submit abstracts for the Open Forum is **May 1, 2015**. ■

Transitions



Tom Gable, RRT, passed away last fall. He began his career in respiratory care in the early 1970s, working in the pulmonary function laboratory setting and also teaching pulmonary function testing to students at Boise State University in Idaho. He created and built the Samuel Bloom Pulmonary Function Laboratory at St. Luke's Regional Medical Center in Boise, supervised the Idaho Sleep Disorders Center, and administered esophageal pH probe testing for the hospital's endoscopy lab. Gable was a member of the winning team of the first AARC Sputum Bowl, which continued to win it three years in a row. He later took on an organizational role in the event and was an avid supporter of it for many years. A scholarship for respiratory care students at Boise State University is being developed to honor his memory. ■

Hand Hygiene Suffers as the Shift Wears on

Bedside caregivers may be more likely to wash their hands at the beginning of their shifts than at the end, report U.S. researchers who looked at hand-washing data on 4,157 caregivers at 35 U.S. hospitals over three years.

Their study found hand-washing compliance rates dropped an average of 8.7% from the beginning of a typical 12-hour shift to the end. Higher work intensity led to lower hand-washing rates while longer times off in between shifts increased compliance.

"Demanding jobs have the potential to energize employees, but the pressure may make them focus more on maintaining performance on their primary tasks, particularly when they are fatigued," study author Hengchen Dai from the University of Pennsylvania was quoted as saying. "For hospital caregivers, hand washing may be viewed as a lower priority task; and thus it appears compliance with hand hygiene guidelines suffers as the workday progresses." The study was published in a recent edition of the *Journal of Applied Psychology*. ■

Round 2: Smoking-related Cancer Risks Multiply

Having one smoking-related cancer increases the odds of developing another, separate smoking-related cancer in smokers, report National Cancer Institute researchers who combined the results of five large, prospective cohort studies. Overall, current smoking at the time of a first cancer diagnosis conferred a 5.41-fold increased risk of a second cancer diagnosis when compared to the second cancer risk seen in people who had never smoked. Current smoking also increased the mortality rate from all forms of cancer.

Former smokers had an increased risk of developing a second smoking-related cancer as well, but the risk decreased with the number of years since smoking cessation. "Our study demonstrates that health care providers should emphasize the importance of smoking cessation to all their patients, including cancer survivors," study author Meredith S. Shiels, PhD, MHs, was quoted as saying. The study was published in a recent issue of the *Journal of Clinical Oncology*. ■

RT Department Steps Up to Research

by Keith D. Lamb, BS, RRT-ACCS

The importance of research related to respiratory care has never been more apparent. As our seasoned researchers grow closer to retirement, there are few replacements and few respiratory care practitioners who are committed to picking up where they leave off.

In August of 2013, staff of the respiratory care department at Iowa Methodist Medical Center in Des Moines, IA, decided to get serious about understanding the scientific evidence pertaining to their chosen profession and their responsibility to help contribute. Part of UnityPoint Health Des Moines, the department also staffs Lutheran Hospital in Des Moines and Methodist West Hospital in West Des Moines. We began by gathering our clinical leadership team together to develop a long-term plan.

First step: Start a journal club. What began as an online project where clinically relevant articles were chosen and sent to staff by email soon developed into an in-person club held in various locations, including the occasional off-site meeting at a staff member's residence. "Our Journal Club is mobile," says AARC member Julie Jackson, BAS, RRT-ACCS, department manager at the hospital. "One month the meeting will be held in a classroom at our education center, and then the next month we will have it at someone's home." Each approach has its advantages. Some like the convenience of being able to participate while at work, while others like the more relaxed atmosphere of having the meeting off campus.

Overall, our journal club has been a resounding success. Each meeting, we have a couple more people show up and have recently hosted 25 therapists in one sitting. Staff members and students and faculty from the Des Moines Area Community College (DMACC) respiratory therapy program are all invited, and one hour of continuing education credit is awarded to those who attend. We are also planning to offer remote access to outlying facilities that may not have the resources to organize such an endeavor.

Second step: Develop a research committee. "We wanted good, solid research ideas," says committee member Sejla Hall, RRT. The committee very quickly had 15 members who initially met every other week. They were asked to take over the journal club, which they just as quickly made their own. It didn't take long before the committee had a couple of projects underway to answer issues that existed within the department. Performance improvement was the mission; and as of this writing, the department has almost a dozen research projects on its plate.

The committee is primarily made up of staff respiratory therapists but has also invited participation from students. Nicole Benhart, a first-year respiratory therapy student from DMACC took the challenge. "I am really excited to take part in what I think is an incredibly important responsibility of all professional RTs," she says. Benhart has been an energetic addition to our team who, in addition to contributing to the committee, has also presented at our journal club. If she is any indication of our profession's students, our future is bright.

Step three: Hire a data collection coordinator. "With so many projects" says Jackson, "we needed somebody to help with the daily grind and to keep things organized." AARC member Trevor Oetting, BA, RRT, stepped up

(continued on next page)

to the plate. Previously a shift supervisor, he has been instrumental in the department's rapid shift toward practicing according to the evidence and contributing to the literature. He and I meet almost daily to discuss how to bring all of these projects to fruition. "It's ambitious," says Jackson, "but we have the right leaders in place to make it all happen. We have really grown over the last year."

Step four (final step) of the plan: Develop a collaboration with other thought leaders and educators in the area. We worked with educators from DMACC to develop a curriculum where students could do an elective rotation working with us on research projects. Students rotate through our department in five-week increments. AARC members Kerry George, MEd, RRT-ACCS, FAARC, director of education for the RT program at DMACC, and Larry Barrett, MEd, RRT, director of clinical education, are enthusiastic about the enhanced relationship between their program and UnityPoint Health. "Research is clearly an important component of our profession, and we are delighted that our students are a part of this vital process," says George, also a former president of the AARC and the National Board for Respiratory Care.

"We had such a positive response by our students when this was offered as a possible collaboration," says Barrett. "We had at least a dozen interested students for 10 open slots. It was incredibly well perceived." The addition of students to our research team has been a fantastic move. They get the opportunity to develop a project and publish their work, and we get highly motivated students who provide invaluable perspective and energy helping us with our efforts.

Now all of the above efforts are starting to pay off. We are generating a better understanding of the science pertaining to our profession and are using this understanding to change local practice and contribute to the literature so others may benefit. Thanks to our ability to better manage our internal data, we have embarked on several other initiatives as well. One of the most significant involves the development of an adult extracorporeal membrane oxygenation (ECMO) program. We were able to collect and analyze internal data pertaining to our severely hypoxemic patient population, and this enabled us to get a better perspective on just how many of our patients could benefit from ECMO.

Other protocols have been developed using this same approach. "Several protocols are being used to help guide and direct our efforts to better manage our patients on the general floors too," says Jackson. "There is no doubt that the use of our local data and the implementation of evidence-based and therapist-driven protocols and guidelines has improved the way we take care of patients." ■

Keith Lamb, BS, RRT-ACCS, heads up adult critical care and critical care research for respiratory care services at UnityPoint Health Des Moines in Des Moines, IA, and also chairs the AARC's Adult Acute Care Specialty Section.

Active Asthma Increases Heart Attack Risk

Mayo Clinic researchers presenting at the American Heart Association's Scientific Sessions 2014 last fall found that active asthma may increase the risk of a heart attack. The study was conducted among 543 patients who had heart attacks and 543 non-heart attack patients of the same age and gender. Within the heart attack group, 81 patients had asthma and 44 of those patients had active asthma, defined as any use of asthma medications and unscheduled office or emergency visits for asthma.

After controlling for traditional heart attack risk factors, patients with inactive asthma were not at an increased risk of heart attack; but those with active asthma had a two-fold higher risk. The authors believe these results suggest patients with active asthma and a history of symptoms such as chest discomfort or shortness of breath should be evaluated for potential heart disease.

"Lifesaving medications for acute heart attack and asthma attack are different; treatment for one potentially can make conditions worse or life threatening for the other," senior author Young Juhn, MD, was quoted as saying. "Our study shows use of asthma medications to control asthma may not seem to be related to the risk of heart attack, so clinicians should make an effort to better control asthma of patients with active asthma using therapeutic and preventive interventions." ■

Financial Incentives Boost Quit Rates

Could a money reward encourage economically disadvantaged smokers enrolled in a quit-smoking program to continue abstaining from cigarettes? Yes, report UTHealth researchers publishing in a recent issue of the *American Journal of Public Health*.

The investigators randomly assigned smoking-cessation program participants to either usual clinic care consisting of an educational orientation session, weekly support group meetings, physician visits, and pharmacological treatment, or the intervention group, which received usual care plus the opportunity to earn a $20 gift card for abstinence on the quit date. Patients continued to be eligible for gift cards throughout the study, with the dollar amount increased by $5 each week, which meant participants could earn quite a lot of money over the four weeks. Progress was monitored for 12 weeks following the quit date.

Results showed 49% of the patients in the intervention group were abstinent at four weeks versus 25% of the usual care patients. Twelve weeks after the quit date and eight weeks after incentives were discontinued, 33% of the financial incentives patients were abstinent versus 14% of those in the usual care group. Women in the intervention group had the highest abstinence rates. ■

PEER TRAINERS IMPROVE ASTHMA CARE FOR KIDS

The best person to encourage parents of children with asthma to follow their child's asthma management plan may be another parent of a child with asthma. That's the take-home message from Washington University School of Medicine investigators who looked at outcomes from a peer-coaching program over a two-year period.

The study involved 948 families with children ages 3–12 who had asthma. The families were randomly assigned to either usual asthma care from their pediatricians or usual asthma care in addition to regular phone calls from peer trainers in which they were taught how to give medications effectively, encouraged to take their children to primary care physician appointments, and provided with support to help them better manage their children's asthma. Families received an average of 18 calls over one year.

When compared with children in the usual care group, kids in the intervention group experienced an additional three weeks without asthma symptoms at the one-year follow up, according to their parents. A similar reduction in asthma symptoms was seen in children with Medicaid insurance; these children also had 42% fewer emergency department visits and 62% fewer hospitalizations. These reductions were maintained throughout the second year of follow-up without any further contact with the peer trainers. ■

Strange But True...

Mask couture: Could the face masks you don at work to protect yourself and your patients from aerosolized infections make a fashion statement? According to CNN, they did at a recent fashion show in Beijing, where air pollution has been reported as out of control. Models sported everything from crystal-studded masks to masks that were incorporated into the overall design of their outfits.

Ferreting out clues: U.S. researchers working on a project funded by the National Institutes of Health have sequenced the ferret genome, an advance they say could one day lead to new treatments for a range of respiratory diseases, including influenza. Why? Respiratory infections in people are much the same as those in ferrets and are transmitted in a similar manner.

Catch me if you can: Cancer and other conditions may one day be diagnosed by a tiny pill that a person swallows, reports *Time Magazine*. The pill is being engineered in the Google X research facility and would work by unleashing tiny magnetic particles into a person's bloodstream, where they would pick up the presence of chemicals or cells associated with certain diseases.

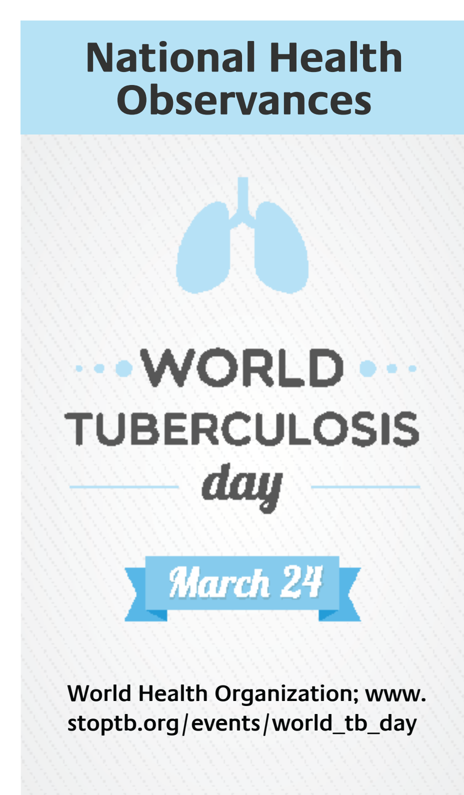
Bird breath: Scientists have long believed the one-way air flow seen in bird lungs resulted from the high energy demands of flight. Now it appears an unknown forerunner may be to blame instead. The same one-way air flow pattern was recently discovered in the green iguana, a reptile not known for high-capacity aerobic fitness. The University of Utah researchers believe this suggests the pattern first arose some 300 million years ago in a common ancestor of lizards, snakes, crocodiles, and the dinosaurs from which birds emerged. ■

Contribute to Our "Transitions" Column

The AARC "Transitions" column will now be devoted to sharing news about the passing of AARC members.

You can submit news about your colleagues' recent passing by going to www.AARC.org/transitions. Please provide any information about the member's recent obituary so that we can share it with the membership and pay tribute. ■

National Health Observances



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

RT Student Members: Send Us Your Stories

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.

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, and a brief description of the story subject. Then attach a Word document of the story. We hope to hear from you soon! ■

More Patients Are Surviving ARDS

U.S. researchers presenting at CHEST 2014 last fall offer some good news for anyone caring for patients with acute respiratory distress syndrome (ARDS). According to their analysis of over 174,000 patients in the National Inpatient Sample database, mortality rates for the condition have declined by 14.6% over the past decade, going from 46.8% in 1996 to 32.2% in 2011. An 8.9% absolute reduction in mortality rates was seen from the years 2000 to 2005 alone.

The investigators attribute the decline in ARDS mortality to improvements in critical care medicine — specifically, greater use of low tidal volume ventilation. "While we cannot prove causation for the decreased mortality, we believe that collaborative advances in critical care medicine contributed to the overall decline," study author Jared Radbel, MD, was quoted as saying. "We assert that the sudden and sharp decrease in mortality from 2000–2005 can be attributed to the practice of low tidal volume ventilation." ■

Hand-off Tool Decreases Medical Errors

A new hand-off tool developed by military researchers who collaborated with nine civilian hospitals is helping to keep patients safe. A recent study found that the tool reduced injuries due to medical errors by 30% across all nine institutions. The I-PASS hand-off bundle includes:

- Training in team communication skills
- A verbal hand-off process organized around the verbal mnemonic "I-PASS" (**I**llness severity, **P**atient summary, **A**ction list, **S**ituational awareness and contingency planning, and **S**ynthesis by receiver)
- A written or computerized hand-off tool that reflects the verbal mnemonic
- A faculty development and observation program
- An institutional dissemination campaign.

"Patients are at the center of everything we do," Brig. Gen. Jeffrey B. Clark, director of the Walter Reed National Military Medical Center, was quoted as saying. "By quickly adopting the I-PASS transitions of care principles for all health care teams, we simultaneously bring state-of-the-art health care to our patients and teach the next generation of health care team members what right looks like." He and his colleagues published their findings in the Nov. 6 edition of the *New England Journal of Medicine*. ■

Adenotonsillectomy May Improve Asthma Outcomes

Children with asthma who have their tonsils and adenoids removed end up with better asthma outcomes, according to University of Chicago researchers publishing in a recent issue of *PLOS Medicine*. They looked at data on more than 40,000 children between the ages of 3–17 who underwent removal of their adenoids and tonsils as a treatment for obstructive sleep apnea. Asthma symptoms among these children were compared pre- and post-surgery and were also compared to 27,012 children with asthma who did not have their tonsils and adenoids removed.

Episodes of acute status asthmaticus fell 38% in the year after the surgery in the adenotonsillectomy patients versus just 7% in children with asthma who did not have the surgery. Acute asthma exacerbations dropped by 30% and 2%, respectively. Acute bronchospasm and wheezing decreased significantly for those who had surgery as well but remained unchanged for those who did not. Prescription refills followed the same pattern.

Perhaps most significantly, asthma-related hospitalizations declined 36% in the surgical patients, and a 26% drop was seen in asthma-related ED visits. No significant reductions in hospitalizations or ED visits were seen in the children who did not have the surgery. ■

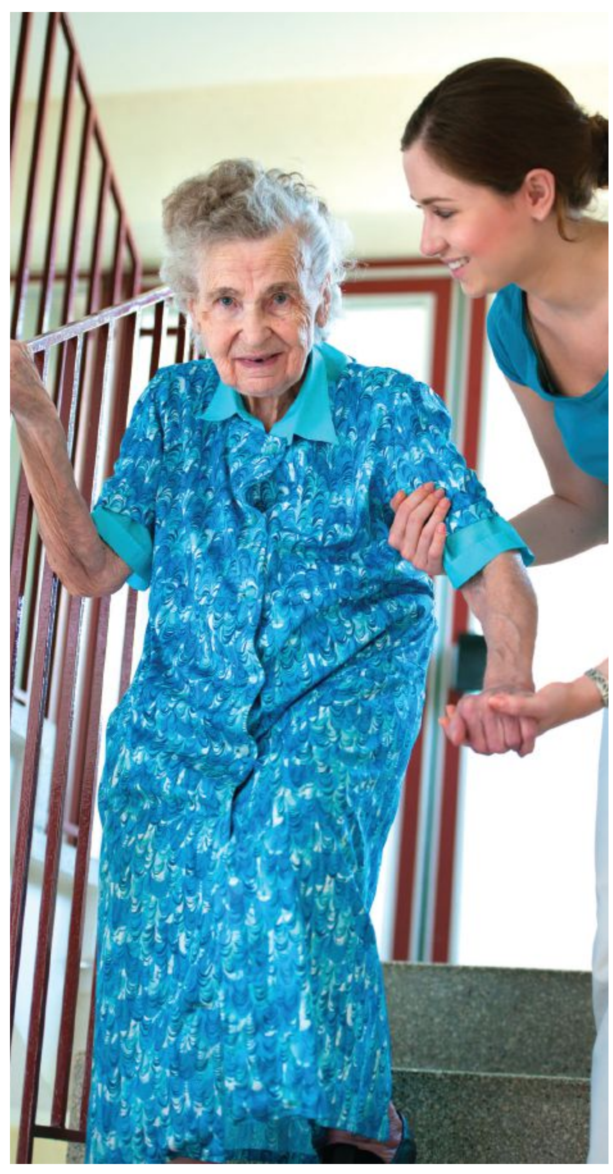
(continued from page 11)

The RT's role in the continuum of care for lung disease patients

Some hospitals are already beginning to see the impact RTs have on managing patients with COPD and other lung diseases. Discharge planning is beginning earlier in the hospital visit, incorporating RTs to manage respiratory care as part of the inter-professional care team. Programs are utilizing RTs as asthma and COPD navigators or educators. In one program, Lung Partners,[9] RTs are a part of the primary care model. They function as transition coaches who provide COPD patients with their treatments, assessment for COPD-related issues, and education. The coach helps facilitate the discharge plan and visits the patient at home after discharge.

With the growing number of elderly COPD patients and health care reform challenges, there is a great need for RTs to focus on skills that will provide value to the patient in the hospital, clinic, and home. Developing excellent assessment and communication skills will help future RTs excel as a valued member of the health care team.

New roles are already emerging for RTs, such as care coordination. RTs can have a great impact on patient safety, reducing hospital readmissions and length of stay, and improving patient satisfaction and quality of life. While some of these certainly can have a positive financial impact for health care institutions, keeping our patients safe should be top priority. ■



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Calendar of Events

AARC & State Society Programs

January 22–23, 2015

Ruidoso, New Mexico

New Mexico Society for Respiratory Care Conference

Contact: www.nmsrc.org

February 5–6, 2015

Davis, West Virginia

West Virginia Society for Respiratory Care's annual Winter Conference

Contact: www.wvsrc.org

Other Meetings

April 30 – May 1

Columbus, Ohio

6th Annual Pediatric Asthma Conference

Contact: Nationwide Children's Hospital, (614) 355-0676 or www.NationwideChildrens.org/conferences

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May 15–20

Denver, Colorado

ATS 2015: Pulmonary, Critical Care, and Sleep Medicine

Contact: http://conference.thoracic.org/2015/

Submissions for the next available issue are due Feb. 2.

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

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— 2015 —

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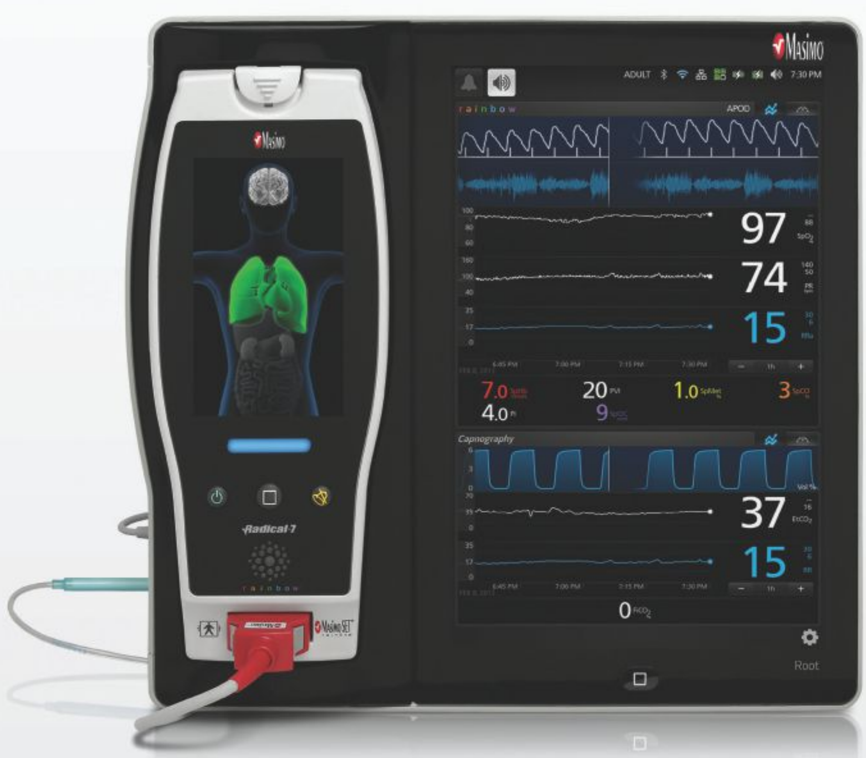

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