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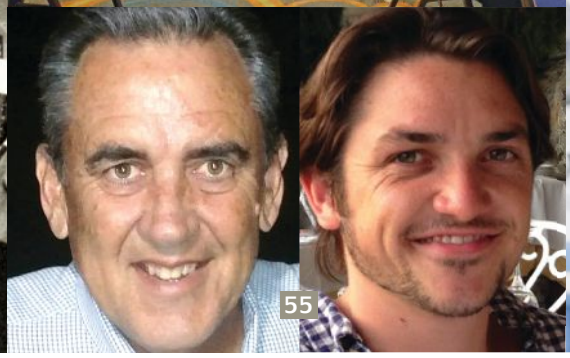
Table of Contents

November 2017
Volume 41, Issue 11



Clinical Perspectives: The COPD Foundation | Page 10

Here's a glimpse of the COPD Foundation's mission, vision, values, accomplishments, and strategic plan. By Jason Moury, MPH, RRT

Chronic Disease Manager: 2017 GOLD Recommendations | Page 14

One of the changes for GOLD 2017 is a clarified definition of COPD — read on for more highlights from this year's update. By Keith Siegel, MBA, RRT, CPFT

Cover Story: Rising to the Apex: The AARC's New Award Program Delivers Much-Needed Recognition for High-Quality Respiratory Care | Page 22

Read about the AARC's new award established to recognize high-quality respiratory care. By Debbie Bunch

Milestones in Respiratory Care: Space-Age Technology Hits Home | Page 26

Relive the AARC's first venture into satellite conferences in 1990 that offered RTs an easier way to get their continuing education. By Debbie Bunch

Elected To Serve | Page 30

In addition to being called to help those in need of respiratory care, these AARC members serve in public office.

Florida Breathes Strong | Page 35

Community groups provide much-needed support for those who fear they will never breathe strong again.

Storytellers: Code Pink, Delivery Room 2! | Page 55

This "day in the life" story has a twist that is sure to make you smile! By Joe Morgan, RRT-NPS, CPFT

General Counsel | Page 6
Executive Office Update | Page 8
NBRC Insight | Page 18
Industry Watch | Page 40
RC Currents | Page 43
Industry Update | Page 50
Advertiser Index | Page 52
Calendar of Events | Page 52
Classified Advertising | Page 52

Cover photo by Melissa Embry.

AARC Strategic Plan

The American Association for Respiratory Care has a 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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PM315

Oh the Humanity!

by Anthony L. DeWitt, JD, RRT, FAARC

Your keys are lost yet again. You search on your bedside table, the kitchen countertop, the TV room, and then back to your bedside table, where you still find that your keys elude you. Cognitively, you know that your keys are not on your bedside table because you already looked there, but when you run out of search options you begin a process that human factors experts call "recycling options." In other words, you try things that have worked in the past, and thus derive comfort from the familiar. Everyone does this. Usually with the same negative results.

Human factors and ergonomics is a scientific discipline that studies how humans interact with various systems. For example, how does a human being interact with a bicycle, a car, or a washing machine? In learning how they interact, and what kinds of hazards that interaction entails, human factors experts try to make products safer for end users.

How humans interact with systems is an important part of analyzing whether systems meet safety goals. The human factors discipline had its start during the Korean War, when the U.S. Air Force was trying to learn why pilots were crashing a new aircraft. Engineers reviewed the aircraft and believed it was designed properly. A cognitive psychologist was hired and he asked one simple question: Are new pilots or old pilots crashing these planes? What the Air Force learned was that the pilots crashing were not the new pilots (as they had falsely attributed the cause), but the old pilots. Only pilots with more experience flying were crashing them. Further investigation showed the reason was because two conflicting controls (one for landing gear, one for flaps) were placed together when previously they had been separate. Identifying the problem allowed the Air Force to solve it. From its beginning, the human factors discipline has been about saving lives.

Human factors experts look at problems from the standpoint of safe design. In looking at systems, they search first for the type of hazard that might be present in a given situation. In an ICU, that might be accidental disconnection of the patient from the ventilator.

After assessing the requirements of the system (in this case, a ventilator that must provide 24-hour life support to patients), they design the system to achieve its primary functional goals while guarding against known hazards like disconnection. They perform tests to validate that the safety measures work, and then they implement the system they have designed and tested. That would surely be the end of the analysis, but human factors experts go one more step. They look at the maintenance and performance of the system and do "usability testing." Here they look to see that the safety measures implemented in the design work in the real world and figure out why they don't work in the outlier cases. Then they re-evaluate and try to eliminate any additional hazards identified by testing.

This last step is perhaps the most important. Early ventilators sometimes had knobs that could be used to adjust the volume of ventilator alarms.[1] This was a feature that no doubt was added to address the situation where a patient required suctioning. Over time, however, the alarm volume knob became a "workaround." It literally allowed people to effectively discon-

about the author...

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

tinue a basic alarm system because alarms that were turned down for suctioning were not always returned to higher volume afterwards. The mitigation response to this was to design alarms that could be muted only for a period of 30 seconds or so. Most modern ventilators cannot mute alarms permanently.

But human factors and ergonomics experts have more impact than simply in the design of medical equipment. They can review systems to determine whether the systems (or policies and procedures) increase or decrease safety in an ICU environment by creating workarounds for policies meant to improve safety. They begin by identifying hazards, and then they apply all the techniques described earlier. What they find is sometimes shocking.

Consider, for example, the automated medication dispensing system in use in one hospital. The hospital had fired a nurse for failure to account for medication taken out of the system. During the disciplinary hearing before the nursing board, the state's witnesses all testified that taking medication out of the system and not recording its use was a serious offense because medication could be taken and used for purposes that were unlawful or unethical.

On cross examination, the director of pharmacy admitted that the system housed medication in different drawers. If you needed Medication A, it would be in drawer 1. But so would Medication B and C. Thus, if you wanted to appropriate Medication B, all you had to do was open the drawer to get Medication A for a patient it was ordered for, and during that time remove the other medication. The director was forced to admit that anyone who wanted to get medication could get it in that manner without leaving a trail. In other words, the system that was designed, supposedly, to improve accountability for drugs in reality did no such thing. It simply allowed users to develop their own workarounds. Not only did this threaten the security of drugs, but it threatened the safety of patients.

It's worth noting that where therapists and other health care practitioners have been found guilty of criminal conduct on the job, it has often occurred in the context of stolen or misplaced drugs.

The nurse at the hearing was able to demonstrate that nothing he did caused any harm, and that the hospital could not account for whether the drugs were even taken out of the drawer due to the flaws in the system and the failure to take inventory of the stock. The nurse learned a hard and expensive lesson: document everything.

For a therapist looking to obtain an advanced degree in something other than a hard science, ergonomic and human factors programs exist at numerous colleges and universities. Applying your background in health care, you could learn how to analyze systems, improve system design, and positively impact patient safety in health care. ■

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COPD National Action Plan

by Thomas J. Kallstrom, MBA, RRT, FAARC

Earlier this year, the National Institutes of Health (NIH) released the first COPD National Action Plan. This was a significant action, as it demonstrated the importance of such a guide. There is a lot of evidence that this action plan was long overdue. Today COPD is the third leading cause of death and the fourth leading cause of disability in the United States. Not only is it important that the 16 million people already diagnosed with COPD, as well as the countless other millions who are undiagnosed, be diagnosed and treated in the most effective way.

The COPD Action plan has five specific goals:

Goal 1: Promote more public awareness and understanding of COPD, especially among patients and their caregivers.

Goal 2: Increase the skills and education of health care providers so they will be better equipped to provide comprehensive care to people with COPD.

Goal 3: Increase data collection, analysis, and sharing to create a better understanding of disease patterns.

Goal 4: Increase and sustain COPD research to improve understanding of the disease and its diagnosis and treatment.

Goal 5: Facilitate collaboration between federal and nonfederal partners to meet the objectives of the action plan and translate its recommendations into research and public health care actions.

So what can respiratory therapists do to make the action plan successful? Several RTs have hit the ground running and are sharing information about their programs in *AARConnect* in COPD Best Practices. If you are not a member of this group, I would encourage you to check it out online. The AARC will continue to share other successful programs our members have contributed to, both on our website and in future issues of *AARC Times*.

Public awareness and patient understanding of COPD as stated in Goal 1 are certainly an area where RTs can make a difference. There are many venues from which patients can glean information, and while many are reliable, some, not so much. There are many high-quality, cost-free educational resources from the NIH, COPD Foundation, AARC, and COPD Coalition.

The second goal is more an introspective in that all caregivers need to be up to date on the best practices of COPD. Again, the above four agencies offer excellent resources. I also encourage you to view several AARC webcasts, available free to our members. They include a discussion on reducing readmissions in which several RTs share their respective programs. There are also archived presentations available, which include a September 2017 presentation by Past President Frank Salvatore, MBA, RRT, FAARC. Frank talks specifically about the National Action Plan. There are educational webcasts available as well. If your interest is in finding a more in-depth education on COPD management, I would direct you to the AARC Pulmonary Disease Educator Course.

Goal 3 is another that RTs can take part in by doing and publishing research pertinent to COPD. To get more insight on how the AARC has embraced this, look at the AARC's science journal, Respiratory Care. Many of our colleagues have published excellent research. In the first nine months of 2017, there were 15 COPD-specific manuscripts in the journal that addressed various components of COPD and its management. There is never

about the author...

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

enough, so I encourage you to consider submitting a manuscript related to COPD.

Goal 4 encourages us to increase the research that is being done now in the diagnosis, treatment, and understanding of COPD. Earlier this year, the AARC partnered with Dr. Jerry Krishnan and his team at Rush University Medical Center in an effort to better understand the role of the RT in discharge and post-discharge.[1] The result was a survey of our members who work with patients with COPD in the hospital. We found that there is a significant opportunity for RTs to be influential in patient understanding of their oxygen system. Sadly, with ever-shrinking reimbursement for appropriate oxygen devices for the patients who need them, much of the Medicare patient education about oxygen management is being presented by a non-clinical delivery driver from the durable medical equipment company. Many hospitals have reduced readmissions by putting in place RT-led programs that reduced readmissions as a result of education given to the patient by the RT.

Finally, Goal 5 asks that we work with other partners to meet the objectives of the COPD National Action Plan so that it will translate into research and public health actions. The AARC has been an active partner with other federal and non-federal agencies and associations for years. Your Association is a long-standing partner with the COPD Foundation. We are currently working with them on a Picori grant that will look at the impact of utilizing the RT as a COPD/obstructive sleep apnea overlap coach. We will share the outcomes of this unique program once the study is completed. RTs are also represented in the COPD Coalition, which is a more wide-ranging group of associations including patient organizations, federal liaisons, and professional health organizations.

The AARC was a significant partner in the development and implementation of the COPD National Action Plan. As a result, multiple RTs answered the call. We are fortunate that we have so many motivated colleagues who are willing to give of their time in an effort to ensure that the patients we serve get the most appropriate and efficacious care possible. We expect to see good things come from the COPD National Action Plan. Will you be a part of its implementation in your practice? ■

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The COPD Foundation

by Jason Moury, MPH, RRT

This month we are taking a moment to focus our attention on those who are affected by chronic obstructive pulmonary disease. COPD is the third leading cause of death in the United States, and affects 16 million Americans which costs us more than $32 billion a year.[1] In the early 2000s, a visionary patient advocate identified a shortfall in the COPD community. This visionary was John W. Walsh. John, who passed away in early 2017, was the founder of the COPD Foundation. John wanted to bring together a community that served patients with COPD in every aspect, with a vision of one day finding a cure for COPD. With this vision and a mission to help those who suffer with COPD, John began a mission that is now in its 13th year.

about the authors...

Jason Moury, MPH, RRT, is vice president of operations management for the COPD Foundation.

The formative years

One of the first major undertakings of the COPD Foundation was to raise awareness of the disease and to focus efforts on increasing COPD research. At the time of the Foundation's inception, COPD was not a well-known disease, and there was minimal funding to promote COPD awareness. Launching the initial edition at the 2004 ATS conference, the Foundation started the *COPD Digest*, the first patient-focused COPD-specific publication. The *COPD Digest* is released quarterly and features articles for COPD patients and caregivers. Additionally, there are frequent articles on new programs and projects, as well as updates in the COPD community.

In 2007, the Foundation focused its efforts on increasing education within the COPD community with the development of the *Big Fat Reference Guide*, the creation of the Call Our Patients Direct (C.O.P.D.) Information Line, and a partnership with the National Heart, Lung, and Blood Institute (NHLBI) on the COPD Learn More Breathe Better® campaign. The C.O.P.D. Information Line was established to fill the unmet need within the COPD community for patient-to-patient interactions. The C.O.P.D. Information Line is staffed by patients as a resource for patients and caregivers of those with COPD. The line handles more than 5,000 interactions per month. Also in 2007, the Foundation started the Mobile Spirometry Unit (MSU). This program was a mobile trailer that traveled across the United States and provided free lung spirometry testing at health fairs, community events, and trade shows. Between 2007 and 2014, the MSU program was successful in testing more than 45,000 individuals' lung volume scores.

In 2009, the Foundation started lobbying for better identification of COPD within each of the states. This effort was to include COPD-related questions in the Behavioral Risk Surveillance System (BRFSS). BRFSS, which is managed by the Centers for Disease Control and Prevention (CDC), allowed the health care community to see what the unknown impact of COPD would be, and it could help serve as a guide to identify trends in COPD. In 2011, the first COPD BRFSS data was released and published, and the data showed that more than 15 million Americans had reported COPD as a diagnosis.[2]

In the late 2000s, the COPDGene® study was funded by the NHLBI. This study was the first of its kind to explore the genetic factors in COPD (www.copdgene.org). COPDGene® has been a partner with the Foundation since its beginning, and the study is still in progress, with more than 10,000 cohorts and 21 clinical sites that cover the United States.[3] The work done by COPDGene® is helping identify the genetic development and progression of COPD.

The DRIVE4COPD years

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Ingelheim. This campaign launched a nationwide effort to identify the 15 million Americans who had COPD and did not know it. With help from the respiratory therapist community and partners like the AARC, more than 3 million people were screened for their risk of COPD. DRIVE4COPD helped identify and start the conversation about COPD with screening events throughout the United States.

Focus and future of COPD

After celebrating a decade of service to the COPD community in 2014, the Foundation focused its efforts on answering the community's needs again. In late 2014, the Foundation launched COPD360social. COPD360social is an online community for people affected by COPD, including patients, family members, caregivers, physicians, and other health care providers. It provides a single online home for these millions of individuals. COPD360social provides our target audience with an engaging and interactive social collaboration environment through which they can have more direct interaction with each other and with the Foundation. COPD360social provides community members with a comfortable venue to share thoughts and ideas, ask questions, start discussions, read and comment on blogs, and communicate with peers, thought leaders, and community managers. This community has been able to help patients talk to one another, seek input from other community members, and improve a social component that the COPD community was lacking.

The most recent project that the Foundation was involved in was the COPD National Action Plan. This plan, which was led by the NHLBI, was released in May 2017 after more than a year in the works. More than 200 members of the COPD community, including AARC members, gathered in February 2016 to set the groundwork for the plan's beginnings. This plan is the first set of blueprints for how COPD should be addressed in the community. Resources for the national action plan are available on the NHLBI's website, and the AARC and Foundation are hosting webinars to introduce the plan to the COPD community.

Another area where the Foundation has focused resources is bedside care, with the development of a *Pocket Consultant Guide* (PCG). The PCG was designed to be a practical tool to assist practicing clinicians in managing the diagnosis and treatment of individuals with COPD at the bedside. The PCG is designed to aid in identifying patients for whom spirometry should be performed, how patients should be classified based on spirometry, what additional assessments should be performed, and when and how these diagnostic evaluations should influence therapy.

Research remains a focus of the COPD Foundation, with several research programs underway.

Hospital readmissions has been another recent focus of the Foundation, which led to the launch of PRAXIS. The COPD Foundation's PRAXIS is an initiative for health care providers, health systems administrators, and policy makers to improve COPD care across the continuum and reduce preventable hospital readmissions. The mission of the PRAXIS is to Prevent and Reduce COPD Admissions through eXpertise and Innovation Sharing. The initiative aims to reduce the heavy burden of COPD exacerbations and hospital readmissions through alignment with CMS Hospital Readmissions Reduction Program (HRRP) goals and the sharing of expertise and resources in ways that enable the proactive identification and elimination of gaps in COPD care.

Research remains a focus of the Foundation, with more than a half dozen focused research programs underway. The Foundation, with funding from the Patient-Centered Outcomes Research Institute (PCORI), has created the COPD PPRN, a research registry with the goal of 75,000 patients. The COPD PPRN, operated and governed by groups of patients and their partners, will collect information that will be kept in a secure database to be used for research — ultimately leading to a deeper understanding of the disease.

The COPD Foundation's mission is to prevent and cure COPD and to improve the lives of all people affected by COPD. With the past, recent, and future efforts of the Foundation, the COPD patient will always have a central voice. ■

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Chronic Disease Manager

2017 GOLD Recommendations

by Keith Siegel, MBA, RRT, CPFT

2017 marks the 20th anniversary of the Global Initiative for Chronic Obstructive Lung Disease (GOLD). Before discussing the 2017 changes in GOLD recommendations, it is worth taking a moment to look back on the origins of GOLD. By the mid- to late-1990s, health care practitioners had developed a "generalized nihilistic attitude" toward chronic obstructive pulmonary disease (COPD).[1] This nihilism was "due to the relatively limited success of primary and secondary prevention, the prevailing view that COPD was largely a self-inflicted disease, and some disappointment with the limited treatment options available at that time."[1]

To counter these prevailing attitudes, COPD experts from around the world, including representatives from the National Institutes of Health and the World Health Organization, met in Belgium in January 1997 to explore ways to standardize the diagnosis, treatment, and prevention of COPD and to significantly reduce its morbidity and mortality. After four years of expert panel meetings, consensus conferences, and review by internationally respected COPD experts and medical societies, the first GOLD Executive Summary report was published in 2001.[2] The GOLD report is updated annually, with major revisions published every five years.[1] Annual updates to GOLD are typically published in November for the upcoming year, so it is important to note that all references to GOLD 2017 in this article are a year old. The 2018 update is expected to be released in November 2017.

about the author...

Keith Siegel, MBA, RRT, CPFT, is president of Siegel Respiratory Consulting, Inc., of Union, ME. He is the speaker of the AARC House of Delegates.

GOLD 2017

The first notable change in GOLD 2017 is in the definition of COPD. The new definition includes the roles of symptoms and airway/parenchymal changes in the development of COPD. The GOLD 2017 definition states that "COPD is a common, preventable, and treatable disease characterized by persistent respiratory symptoms and airflow limitation that is due to airway and/or alveolar abnormalities, usually caused by significant exposure to noxious particles or gases."[3]

To properly guide therapy, a thorough assessment of the patient is critical. GOLD 2017 notes that the following four aspects of COPD must be assessed separately:[4]

- The presence and severity of spirometric abnormality
- Current nature and magnitude of the patient's symptoms
- Exacerbation history and future risk
- Presence of comorbidity

Perhaps the greatest difference between GOLD 2017 and previous iterations of the recommendations is how it treats its classic ABCD assessment tool. While spirometric values are still critically important to establish a diagnosis, they have been removed from the ABCD treatment grid. In previous versions of GOLD strategies, treatment was tied to spirometric values, so a patient with an FEV_1 <50% but minimal symptoms and no exacerbations would be treated more aggressively than a patient with an FEV_1 of 75% with more severe symptoms and multiple exacerbations. Because there are currently no medications that reverse the underlying lung disease, and because there is frequently little correlation between FEV_1 and symptoms, the ABCD grid now focuses its treatment strategies entirely on symptoms and exacerbations.

Unlike past versions, GOLD 2017 now suggests that tools such as the Modified British Medical Research Council (mMRC) questionnaire, which only measures

breathlessness, is inadequate when it comes to classifying the impact of symptoms. The mMRC questionnaire has also shown to be less repeatable for tracking disease state changes over time. GOLD 2017 recommends more comprehensive assessment tools, such as GlaxoSmithKline's COPD Assessment Test (CAT)™ or the COPD Control Questionnaire to better quantify the impact of symptoms.[4]

Spirometry

Spirometry remains a vital tool for the diagnosis and assessment of COPD. A post-bronchodilator FEV_1/FVC of <0.7 is considered diagnostic for COPD. It is important to remember that it is the post-bronchodilator ratio of FEV_1 to FVC that determines the presence or absence of COPD, not the FEV_1 alone. Once a diagnosis of COPD has been made, the FEV_1 helps determine the severity of the obstruction. Rodriguez-Roisin et al note that there is a risk of over-diagnosing COPD in the elderly and under-diagnosing it in younger patients when using a fixed ratio rather than using lower limits of normal values for FEV_1/FVC to make a diagnosis. The authors argue, however, that the risk of misdiagnosis is small because other factors are used in making the diagnosis.[1] GOLD 2017 recommends using a fixed FEV_1/FVC ratio over lower limits of normal because of consistency and ease of diagnosis. The classification of severity of airflow limitation (GOLD I–GOLD IV) remains unchanged from previous versions.

Escalation/de-escalation pharmacological strategies

In previous versions of the GOLD strategy, only initial pharmacological recommendations were made. GOLD 2017 includes recommendations on how and when to escalate and de-escalate medications. It places more emphasis on personalizing therapy based on a patient's ABCD classification and whether the patient is experiencing an exacerbation. "We have extensively revised the pharmacotherapeutic recommendations to include step-up and step-down therapeutic algorithms," notes Dr. Fernando Martinez, a co-author of the GOLD report.

"What we now provide is additional rationale for initial recommended pharmacotherapies and possible alternative options for each of the patient categories (ABCD)."[5]

GOLD 2017 defines acute exacerbations as "an acute worsening of respiratory symptoms that result in additional therapy."[4] Exacerbations are classified as follows:

- Mild: Treat with short-acting bronchodilators (SABDs) only.
- Moderate: Treat with SABDs plus antibiotics and/or oral corticosteroids.
- Severe: Patient requires hospitalization or a visit to the emergency department. This may be associated with acute respiratory failure.[4]

Non-pharmacological strategies for COPD

GOLD 2017 emphasizes the importance of non-pharmacological strategies for managing COPD. These strategies include smoking cessation, vaccinations, oxygen therapy, ventilatory support, interventional bronchoscopy, surgery, nutritional support, and pulmonary rehabilitation. "Patients with high symptom burden and risk of exacerbations (Groups B, C, and D) should be encouraged to take part in a full [pulmonary] rehabilitation program that includes setting patient goals, designed and delivered in a structured manner, taking into account the individual's COPD characteristics and comorbidities."[4]

Comorbidities

COPD rarely exists as a stand-alone disease. According to a study published in the *American Journal of Medicine* in 2009, the median number of comorbid conditions amongst patients with COPD is nine.[6] Common comorbidities include lung cancer, cardiovascular disease, osteoporosis, gastroesophageal reflux disease, cataracts, and depression/anxiety. GOLD 2017 stresses the importance of not altering COPD treatments while treating the comorbid conditions. "When COPD is part of a multimorbidity care plan, attention should be directed to assure simplicity of treatment and to minimize polypharmacy."[4]

Final thoughts on COPD

The National Institutes of Health has recently released its first-of-its-kind COPD National Action Plan.[7] While the release of the action plan is newsworthy, it is only the first step. For it to have a positive impact on the burden of COPD, the plan must be implemented, and that is where RTs can make a difference. "All can contribute to the successful implementation of the COPD National Action Plan. From patients and health care providers to federal partners and advocacy groups, everyone can and must play a role in supporting and moving the COPD National Action Plan forward."[7]

COPD is the third leading cause of death in the United States.[8] While mortality rates for most other chronic conditions have declined, death rates from COPD have doubled since 1969.[9] Respiratory therapists are on the front lines in the fight against COPD and must constantly strive to stay current in their knowledge of COPD. Knowing the 2017 GOLD strategy is an important first step. Working together to implement the National COPD Action Plan is another. With these tools, along with the passion and expertise of respiratory therapists, our COPD patients can live a quality life, and the nihilistic attitude toward COPD that once prevailed can be a thing of the past. ■

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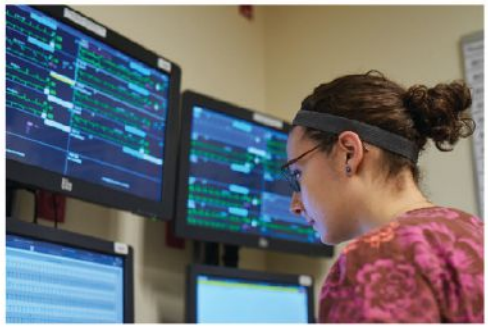

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The 2017 Jimmy A. Young Memorial Lecture

Specialists Reveal Details About Their Practices in Adult Critical Care and Neonatal/Pediatric Care

Introduction

To honor the memory of a remarkable contributor to the respiratory care profession, the National Board for Respiratory Care (NBRC) has presented the Jimmy A. Young Memorial Lecture each year since 1978 during the AARC Summer Forum.

After being introduced by NBRC President Robert L. Joyner, Jr., PhD, RRT, RRT-ACCS, FAARC, presenter and Assistant Executive Director and Psychometrician for the NBRC, Robert C. Shaw, Jr., PhD, RRT, FAARC, began the 2017 lecture by sharing the accomplishments and milestones of Jimmy Young's 15-year career in respiratory care. He grew from being an RT trained on the job to achieving the RRT credential (#263). He then directed an education program in Boston and was the technical director of the respiratory therapy department at Massachusetts General Hospital. After serving as the 22nd president of the AARC in 1973, Jimmy served as a trustee of the NBRC and passed away unexpectedly in 1975.

This year's theme

Dr. Shaw facilitated the 2017 lecture entitled, "Specialists Reveal Details About Their Practices in Adult Critical Care and Neonatal/Pediatric Care." He began with a synopsis of two job analysis studies sponsored by the NBRC in 2016: one for Adult Critical Care and one for Neonatal/Pediatric Care. These studies were conducted to update the content and design of examinations linked to the credentialing of future specialists.

Dr. Shaw noted that it is assumed that a specialist's knowledge base changes over time; therefore, new job analysis studies are necessary every several years. There are also external expectations expressed in testing standards, federal guidelines, legal precedents, and laws that essentially make such studies mandatory.

The NBRC honors former AARC President Jimmy A. Young each year with this memorial lecture.

Methods

As Dr. Shaw explained, these job analysis studies were guided by the Adult Critical Care Specialist (ACCS) Advisory Committee and the Neonatal/Pediatric Specialty (NPS) Advisory Committee, both made up of NBRC board members, as well as consultants appointed by the NBRC and the AARC. Advisory committees met in April 2016 to start the studies before finalizing the surveys during a pilot phase. Using direct emails to individuals and email blasts to AARC members to reach potential respondents, data were collected during the summer months; the advisory committees met again in November to evaluate results of these studies. The NPS study also included members of the Children's Hospital Association.

Because each credentialing examination should focus on critical content, multiple passes were made through each task list while assessing the level of endorsement by survey respondents. Criteria used for identifying critical tasks were:

- Percentage of respondents affirming a task was completed in his or her facility
- Mean importance value from the whole sample
- Mean importance values from sample subsets (e.g., regional groups, bed-size groups, experience groups).

Results

Because the quality of the data was high and the respondents' demographics were not unusual, each committee reached consensus on

confidence to use the summaries of survey data as guides while deciding what content to assess and how to design examinations in the future. Regarding data quality, each committee observed that the amount of measurement error linked to sample sizes was minimized to the point that more respondents would not have helped. Reliability values were high, especially regarding the probabilities that other samples from each population would have given the same ratings. Each committee also observed that almost all respondents concluded that the list of tasks had left no significant content gaps.

Adult Critical Care Specialist Survey

This survey was sent to 5,847 individuals. Among them, 820 individuals (14%) completed the survey. Of the 820 completed ACCS surveys:

- 59% had achieved the RRT-ACCS credential.
- 67% worked at a tertiary referral center.
- 59% worked at a metropolitan urban or suburban hospital.
- 57% were female.
- 36% worked in a facility containing at least 60 ICU beds.
- On average, respondents had 11 years of experience in adult critical care.

A total of 120 tasks were evaluated, all of which survived the 13 passes that could have excluded one of them. Each item on future examinations for this credential will be linked to one of these 120 critical tasks.

Neonatal/Pediatric Specialist Survey

This survey was sent to 14,516 individuals. Among them, 1,419 (10%) completed the survey. Of the completed NPS surveys:

- 91% had achieved the CRT-NPS or RRT-NPS.
- 80% worked where therapists attend high-risk deliveries.
- 73% worked in a teaching or university facility.
- 65% were female.
- 37% worked in a free-standing children's hospital, while 31% worked in a children's division of a general hospital.
- On average, respondents had 15 years of experience in neonatal or pediatric patient care.

A total of 104 tasks were evaluated. One task was excluded after 14 passes through the list, which left 103 tasks. Each item on future examinations will be linked to one of these 103 critical tasks.

Content changes

The advisory committees for both studies created new tasks when they met in April 2016 with the intent to capture new content. After observing the endorsement from survey respondents, new critical tasks will now be included in the examinations as outlined below.

ACCS Examination

- Manage specialty endotracheal tubes.
- Manage ventilation/oxygenation during:
  - Rescue with extracorporeal life support;
  - Exercise and rehab while receiving ventilatory support;
  - Positive end-expiratory pressure management (e.g., mild hypoxemia, severe hypoxemia).
- Optimize aerosol delivery (e.g., during mechanical ventilation, noninvasive ventilation, high-flow nasal cannula).
- Assess patient during therapeutic hypothermia (e.g., targeted temperature management, methods, indications and contraindications, complications).
- Anticipate care based on lab results:
  - Albumin
  - Non-cardiac biomarkers
  - Endocrine assessment
  - Liver function
- Prevent ventilator-associated events by assessing endotracheal/tracheostomy cuff integrity and pressure.
- Perform procedures with an esophageal probe (e.g., transpulmonary pressure, neurally adjusted ventilatory assist [NAVA]).

NPS Examination

- Anticipate care based on toxicology (e.g., drug overdose, neonatal abstinence syndromes).
- Manage ventilation and oxygenation through alternative modes (e.g., volume-targeted, airway pressure release ventilation, NAVA).
- Monitor:
  - Ventilator waveforms (e.g., NAVA catheter positioning)
  - Cerebral oximetry (e.g., near-infrared spectroscopy)
- Facilitate therapeutic hypothermia (e.g., total body/head cooling, passive/active cooling).
- Prevent device-related pressure ulcers.

Summary

Dr. Shaw pointed out that conducting these studies was the right thing to do and something that is expected

to be carried out by external agencies. These studies were guided by therapists and physicians who are board members and consultants. Committees created the surveys in early 2016, collected data during the summer, and made decisions about the content and design of the examinations in the fall. Potential respondents were reached through the combined efforts of the NBRC, the Commission on Accreditation for Respiratory Care, and the AARC.

Task lists for both studies adequately covered each role, and task ratings were sufficiently reliable. In addition, the samples were large, and there were no surprising demographic results. Both the ACCS and NPS examination committees expressed confidence in using the survey results to guide decisions about examination content and design.

After observing data summaries, the ACCS and NPS examination committees agreed to add content that they observed to be critical. Examination design specifications have been revised. Changes will take effect in June 2018 for ACCS and in October 2018 for NPS.

Contact the NBRC

The NBRC is interested in your questions, comments, and concerns. You may contact the NBRC by email at nbrc-info@nbrc.org, by phone at (888) 341-4811, or visit the NBRC website at www.nbrc.org. ■

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RISING TO THE APEX

The AARC's new award program delivers much-needed recognition for high-quality respiratory care

by Debbie Bunch

APEX

Patients know they have a choice in health care facilities. The Apex Award can help them select the best respiratory care providers in their community.

Once upon a time in health care, patients listened to their doctors and did what they were told. If they had to go to the hospital, they went where their doctors directed them to go. They didn't ask too many questions, and if they were unhappy with the care they received, they certainly didn't take to social media to let the whole world know about it.

Those days are long gone and they are not coming back. Today's patients have been empowered by everything from the federal government's patient satisfaction survey to the wealth of information they can find about their medical conditions on the online.

Hospitals and other care providers have had to adjust to this new normal, and they are doing that by seeking out means by which they can set themselves apart from the crowd to both consumers of health care and their internal and external communities of interest. When it comes to their respiratory care departments, the AARC has a new way for them to get the job done. The Apex Recognition Program was launched earlier this year for respiratory care departments in hospitals, long-term care facilities, and home medical equipment companies, and now the first organizations to earn the award have been announced (see the sidebar for a complete list of the groups recognized with this award).

Committed to quality

The first hospital to receive the recognition was Piedmont Healthcare-Atlanta Hospital in Atlanta, GA, a 643-bed facility with an RT department of 116 full-time employees. Department Director Valerie David, MHS, RRT-NPS, AE-C, explains how she came to apply for the new program. "I learned about the award through the American Association for Respiratory Care website while

RTs at Piedmont were thrilled to learn that their hospital was the first to receive the AARC's new Apex Award.

CONGRATULATIONS TO THE 2017–2018 APEX AWARD RECIPIENTS

The AARC created the Apex Recognition Program to provide hospitals, long-term care facilities, and home medical equipment companies with an award they can use to communicate their excellence in delivering respiratory care services to patients, communities, and their colleagues within health care. It recognizes the significant contributions that are made by respiratory therapists and highlights best practices that are aligned with evidence-based medicine.

The program replaces the Association's Quality Respiratory Care Recognition program, which for many years served a similar purpose but did not require organizations to meet all of the standards necessary to acknowledge high-quality care in today's health care environment.

Here are the first organizations to receive the Apex Award, which was given to acute care facilities and long-term care facilities. Congratulations!

Acute Care Facilities

- Boston Children's Hospital, Boston, IL
- Hospital of the University of Pennsylvania, Philadelphia, PA
- Piedmont Healthcare-Atlanta, Atlanta, GA
- Rush University Medical Center, Chicago, IL

Long-Term Care Facilities

- LifeCare Hospitals of Chester County, West Chester, PA

The 2017–2018 recognition is effective through Dec. 31, 2018. Learn more at http://www.aarc.org/resources/programs-projects/apex-recognition-award/. ■

applying to host an International Respiratory Fellow," says the AARC member. As a manager at a hospital that values "exceptional patient care with every patient interaction," she saw the program as a great way to acknowledge the great work being done by RTs every day on the job.

"As health care advances to deliver the highest, safest, quality of care, we believe that our respiratory profession should advance in the same direction," explains David. "Patients and their families have a choice as to where they can receive their health care, and so we want to be the type of department and organization that focuses on the highest quality of care for our patients and their families."

She reviewed the standards required for Apex recognition and realized that her department was already well on its way to meeting them. "I believe that the standards were very appropriate and are appropriate for any team that seeks to be Apex-designated." Gaining approval to apply for the program was easy. David says Piedmont administrators are committed to empowering their frontline staff and recognizing their achievements, and they have devoted both time and resources to shared governance and professional development for staff. With its emphasis on competency testing, quality improvement, around-the-clock staffing of respiratory therapists, and other key factors, the Apex Recognition Program played right into that mindset. "The hospital has an engaged executive team," says David. "We are committed to quality, safety, and service as central to our mission."

Amazing accomplishment

David says the department and hospital will use the new Apex Recognition to promote the high quality of its respiratory care services on its public social media platforms as well as internally to other entities within the hospital. She notes that most of the critical-care nursing units at Piedmont Healthcare-Atlanta have received the Beacon Award from the American Association of Critical-Care Nurses and believes the RC department's new Apex Award is leveling the playing field for RTs. "We as a respiratory care team believed that this recognition will help to solidify our position as high-quality professionals who deliver great care within our organization and community," says David. "Piedmont Atlanta has several quality metrics that set them apart within the industry, and we are so happy to be a part of the care delivery team."

One requirement for Apex recognition is that at least half of the staff be AARC members. David created this "Star Board" to acknowledge new members.

She will also use the award to recruit new RTs to the department — something that will really come in handy now, given plans underway at Piedmont. "The hospital is in the midst of a major facility expansion, with a focus on high-acuity, tertiary/quaternary services," explains the manager. "The Apex award will be important to help us recruit and retain the caliber of talent needed to support these patient populations and service lines."

The award is already boosting the morale of current staff, who are proud of the recognition and what it means for the way those outside of respiratory care view their department. Says AARC member James Pope, BSRT, RRT, "This is an amazing accomplishment for us and the Piedmont family…. It is amazing to be a part of such an outstanding team." ■

Satellite Conferences

Space-Age Technology Hits Home

by Debbie Bunch

The introduction of space-age technology into the everyday lives of average citizens has remarkably changed the way we communicate with each other. As little as 20 years ago, concepts such as working at home through computer link-ups, shopping via cable TV, or leaving phone messages on home answering machines were foreign to all but the most farseeing Americans. Today, they are commonplace and promise to become even more so in the future.

As this technology grows in sophistication, the need for face-to-face communication will undoubtedly decrease further. Communication via technology will increase, giving rise to more ways for people to speak to one another without actually being together. Indeed, in coming years, communication through technology may be the rule rather than the exception in many business and educational situations.

The AARC's satellite conferences, which were begun last April as a joint venture with the Annenberg Center for Health Sciences (ACHS), are a part of this new "mind-set." Through satellite hookup, practitioners across the country can now benefit from continuing education programs that would ordinarily be out of reach for most. The programs are produced at the Annenberg Center located at Eisenhower Medical Center in Rancho Mirage, CA — a facility that handles similar presentations for a wide range of health care groups. "The AARC is the first professional organization we've worked with in this kind of joint venture," says Mark Eppinger, ACHS vice president. "Part of our mission is to facilitate educational communication for the health professions using the latest in communication technologies. We asked the AARC to join us because we felt it would benefit its members by giving them easy access to continuing education," he explains.

Actually, the series concept and the idea to link up the AARC with the ACHS first came from AARC member Phillip D. Pooley, RRT, education coordinator of the respiratory care department at Eisenhower Medical Center. At the time Pooley pitched this innovative idea to AARC leaders early last year, the ACHS had already produced a number of respiratory care teleconferences that were beamed via satellite to various hospitals across the nation. The AARC soon saw the tremendous potential of a joint venture with the ACHS.

Live video teleconferencing necessitates quick direction by the producer The production area is a combination of video and recording electronics.

The first AARC/ACHS program, "The COPD Patient in Trouble, "had Dean and moderator Charles Spearman, BS, RRT, reviewing Dr. Pierson's ten

and director in the production booth.

Hess (left), Dr. David Pierson, commandments of COPD management.

"The live presentations feature some of the leading researchers and experts in respiratory care and pulmonary medicine," says AARC Education Director Robert Czachowski, MBA, PhD. They can be viewed directly in the hospital, home-care site, or school, eliminating the need for costly travel and even more costly time away from the job. "Education can be a financial drain to an institution or to an individual. With the use of satellite communication, travel costs are reduced to nothing, employees don't have to be away from work, and they benefit from high-quality educational programs. It's a win/win situation," he says.

Reaching large numbers

The Association decided to join Annenberg to offer the satellite conferences, says AARC Marketing Director Dale Griffiths, because the AARC saw a real need to provide high-quality continuing education opportunities to a greater number of practitioners. "We are doing it because we can get CEUs (continuing education units) out to the respiratory care community much easier and to many more people than we could with our other programs."

The satellite presentations, says Griffiths, are of the same high quality and feature the same level of speakers as those presenting lectures at the AARC's Annual Convention. They can be broadcast live to any place that has a satellite system. The only difference between these presentations and more traditional ones is that they are viewed in the hospital or school over video equipment instead of in a convention hall. Since the presentations are live and offer practitioners the chance to ask questions via a phone bridge (following the main presentation), those who participate in the teleconference feel that they are only a small step away from attending the event in person.

So far, the AARC and the ACHS have offered two satellite symposiums. The first program in the series (beamed to more than 150 facilities) was "The COPD Patient in Trouble" and featured renowned cardiorespiratory care specialist David J. Pierson, MD, and respiratory care educator and researcher Dean Hess, MEd, RRT, of York Hospital in York, PA. The second program (beamed to 200 facilities) focused on the use of aerosols in respiratory care and featured manager-researcher Robert Chatburn, RRT, of Rainbow Babies and Children's Hospital in Cleveland, OH, as well as Dean Hess.

Two more programs will be offered later this year. The presentation scheduled for Sept. 14 is "Respiratory Problems Following Trauma," featuring Leonard Hudson, MD, of Harborview Medical Center in Seattle, WA, and Michael Benson, RRT, a respiratory therapist at Harborview. Another presentation on Oct. 22 will feature the topic "New Approaches to Asthma."

A lot for the money

What do respiratory care managers who have participated in the first two programs have to say about these teleconferences? So far, the reviews have been great. "We have found them extremely effective and appropriate," says Stuart Moore, RRT, technical director at St. Francis Hospital and Medical Center in Topeka, KS. "Both were practical and applicable topics that apply to respiratory care right now." He signed his department up for all four conferences in the series and says that the broadcasts have met all his expectations, adding that the cost of the programs especially served his department's needs.

The charges to hospitals with fewer than 75 beds is $1 per bed to register for each conference. Hospitals larger than 75 beds and school programs that want to participate pay a flat fee of $75 each. Participating institutions received a discount if they signed up for all four programs in the series. Considering the quality of the programs and the speakers, Moore views the conferences as a real bargain. "You can't get that type of education for that price anywhere else."

Gary Weber, director of the respiratory care department at Calumet Public Hospital in Laurium, MI, also likes the low cost and high quality that the programs provide. "We feel we are getting a lot for our dollars," says Weber. "Some of us, who are members, are also getting our CEUs." Practitioners earn one CEU for each conference they view. "Those are not

In the second program, Spearman, Hess, and Robert Chatburn discussed aerosol delivery techniques.

required in this state yet but they could be soon, so it's good to get started on them," says Weber.

Weber likes the fact that the conferences offer practical information that therapists and technicians can put to use in their everyday practice. "I have a pretty new staff, so I like the basics," he says. Most of his staff members are young and inexperienced. Therefore, after the conferences are over, he and a few other staffers who have been in the profession for a while take the concept one step further by holding a question-and-answer session of their own. By going over the presentation in this way, they are making sure that everyone understands the material presented.

Interaction enhances quality

At Terrebonne General Medical Center in Houma, LA, Troy Troclair, MS, director of staff development and education, had respiratory care staffers fill out an evaluation form after the conferences they viewed. He has been more than pleased with the results, saying, "All the evaluations were favorable." Although he is not a respiratory care practitioner himself, he chose to take the series for his hospital because of the quality of the programs and their low cost. He says he has not been disappointed. "On a scale of one to ten, I'd rate them at a ten," says Troclair.

The fact that the presentations are live and offer the chance for interaction, says Troclair, enhances their value. Although none of the people viewing the conferences at his hospital used the call-in line for questions, he feels that they did benefit from hearing others ask questions and receive answers from the speakers. He also believes that as his staff becomes more familiar and comfortable with the concept of teleconferencing, they will participate more. "Many are new to the concept. It may take awhile before they use it," he adds.

Linda Valentine, RRT, of Magic Valley Regional Medical Center in Twin Falls, ID, agrees that the interactive nature of the conferences is a plus, even for those who don't use it personally. "We didn't ask any questions, but it was nice to hear those of others," she says. Like her colleagues, she also believes the quality of the conferences has been excellent. "It's a good way for people in the department to get inservice, and it's economical because they don't have to leave the hospital."

Program evaluation

The AARC and the ACHS will both review the satellite program after its first year of operation to see if participation in the presentations warrants continuation, according to Dr. Czachowski.

He believes two factors currently keep hospitals and schools from signing up for the programs. First, many still don't have satellite systems, which obviously precludes their participation. Lastly, there is the problem of lack of familiarity to satellite education. Many people, despite technical advantages in this area, are still wary of the concept, says Dr. Czachowski.

"The AARC and Annenberg are working together to make the conferences even better by looking at innovative ways to present the educational material," says Phillip Pooley. For example, in the third conference, which will take place this September, the presentation will follow the format of "professor's rounds." The subject — trauma care — will be handled by a group of presenters who will conduct a case study of an individual patient who goes through trauma care treatment. According to Anne L. Caples, ACHS director of teleconference networks, this type of presentation does a better job of holding the interest of viewers than the more traditional lecture format.

The satellite conferences represent a new era in education that matches high technology with experts in the profession to offer high-quality programs to a greater number of practitioners. While department managers and practitioners in large urban areas have always had access to top-notch continuing education, many people in smaller communities and hospitals have been left out in the cold.

Through this program, most practitioners can now enjoy the type of educational opportunities that time and money previously kept from them. New advances in communication technologies have made life easier and more rewarding for everyone from the traveling salesman who doesn't want to miss any phone calls to those who choose to shop at home. These advances are also helping to ensure a better-informed work force in allied health professions such as respiratory care. •

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Ron Bacon has served in the Indiana House for nearly ten years.

Brian Best enjoys representing Iowa's 12th District.

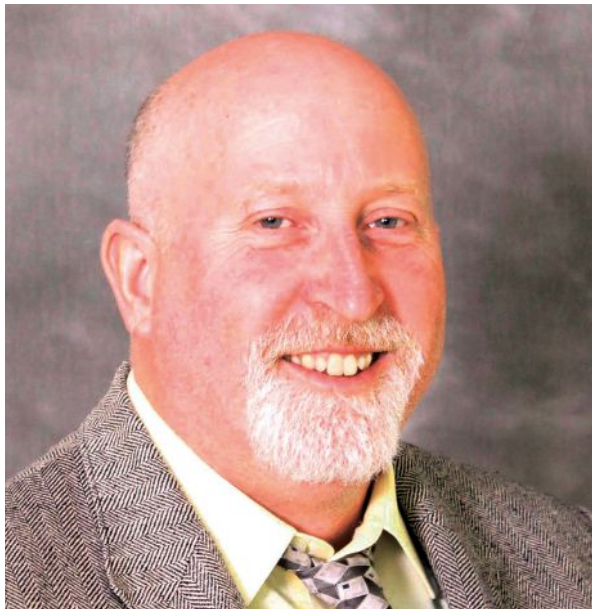
Elected To Serve

It takes courage to run for public office. These AARC members have proven they have what it takes to be leaders.

By Debbie Bunch

Respiratory therapists serve their communities in a multitude of ways. You'll find them volunteering at health fairs, advocating for no-smoking ordinances, working at asthma camps for kids, and doing a host of other things, from coaching little league teams to spearheading fundraisers at their church. Among these volunteer-minded therapists, though, are a select few who have taken the concept of service to new heights. These RTs have stepped up to run for public office, putting themselves out there to be judged for better or for worse by the voters in their towns, counties, and states. We tell four of their stories here.

A former Michigan state representative, Dian Slavens is now serving her community as township treasurer.



Alan Slaydon is in his fifth three-year term on his local electric cooperative board.

Perseverance Pays Off

Who: Ron Bacon, CRT
What: Member of the Indiana House of Representatives
Where: Chandler, IN
AARC member since: 1970

Ron Bacon was living in Boonville, IN, in 1983 and working as director of respiratory care and business development at nearby Warrick Hospital when the idea of running for public office first entered his mind. "I am a fiscal conservative and was not happy with the way our small town was being operated by the current mayor, who had put us a half million in debt," says the representative of Indiana's 75th District and consultant for a durable medical equipment (DME) and nursing home oxygen business he recently sold to Deaconess Health Systems.

He decided to run in the next mayoral race but lost by 600 votes. A bid for city council two years later also ended in disappointment. Lots of people would have thrown in the towel by then, but not Bacon. A year after that, he ran for the at-large seat on the council and won. Four years later, he was up for reelection and again came out on the losing end. Still, he kept his hand in local politics and in 2003 was asked by local physicians to run for county coroner. He won the primary and general election and was reelected in 2007 — the top vote getter in the county that year.

When the 36-year incumbent in District 75 decided to retire in 2008, Bacon realized it was time to step up to a larger stage, and he entered the race. The odds were long. His opponent was a local sports hero and coach. "In order to have a chance, I knocked on over 10,000 doors in 10 months," he says. "I won by 156 votes out of over 17,000 votes cast in the district."

His first thoughts on hearing the news? "OMG, we won. I was not supposed to. Now what do I do?" Turns out, quite a lot. Over the past nine years, he has continued to work toward a balanced budget and legislation aimed at making Indiana "the best state to work, raise a family, and start a business." He is currently vice chair of the Public Health Committee and serves as the House representative to the Medicaid Advisory Committee, two appointments that are served well by the years he has spent in the respiratory care profession.

"My 50 years of experience as an RT, with a working relationship and understanding of most aspects of health care, have made me the go-to guy for health care bills," says Bacon. ■

Winning the First Time Out

Who: Brian Best, CRT
What: Member of the Iowa House of Representatives
Where: Carroll, IA
AARC member since: 2005

Brian Best became a self-described "political nerd" in his 30s. The owner and operator of a small DME company in Carroll, IA, enjoyed watching politics on TV and he developed a great interest in foreign policy and national issues alike.

"In the 2010 and 2012 elections, I would go to local events like parades and other celebrations and see the local state representatives, and I mentioned to my wife, Sharon, that I thought it would be fun to try it," recalls the first-term representative from Iowa's 12th District. "But I had a lot of doubt and never got serious about it until Sharon told me to go for it."

It was a big stretch for the business owner, whose previous experience in public service was limited to an appointed position on the planning and zoning commission in his hometown of Glidden, IA (population: 1,200). "We met twice a year, if we needed to or not," quips Best.

With no previous campaign experience and facing a two-term opponent, Best never really thought he would win. But hard work, lots of loyal friends, and community engagement made the difference. While he made it a point to show up at local parades and other events with his supporters in tow, all wearing "Best 4 House" t-shirts, his

opponent and his supporters rarely attended, giving Best the opportunity to build a solid foundation of grassroots support.

As the election neared, things were looking good. "They do polling in Iowa for state house and senate seats," explains the representative. "I got a call from the Speaker of the House the night before the election. He told me that he was very sure that I would win, but I never really believed it until the official count was taken."

The polls were proved true the next day, when Best took the seat. "I was totally ecstatic," he says. "It was one of the greatest nights of my life."

Best says he came to the state capital to make a difference. His top priority is economic development, and he currently serves as chair of the Economic Development Budget Committee. He also believes strongly in the community colleges in his state and is committed to keeping them strong, noting they support an array of vital programs that provide the state of Iowa with the skilled people it needs in the workforce. He supports the legalization of medical marijuana to treat conditions like seizures, multiple sclerosis, Crohn's disease, ALS, and many others as well.

A member of the Health and Human Services Committee, he believes his respiratory care background gives him a perspective on health issues that many of his colleagues simply don't have. He's also thrown his support behind his fellow RTs, most recently standing up for his colleagues in the profession when they successfully faced a de-licensing challenge in the state.

Best hopes to continue his service in state government and is looking forward to the next election. "I do plan to run again next year when my office comes up for election again," he says. "I am enjoying my service to the district and feel it is a tremendous honor to represent over 30,000 constituents at the state capital." ■

From State Government to Local Office

Who: Dian Slavens, RRT
What: Canton Township Treasurer
Where: Canton, MI
AARC member since: 2006

Dian Slavens has always enjoyed serving her community, whether that be as a Girl Scout leader, Sunday school teacher, or volunteer at her local school. Today she is continuing the tradition by serving as treasurer of her township, an office she ran for and won after she became disillusioned with the current representative, whom she felt was "not in touch with our residents."

But the treasurer office isn't the first to be held by this long-time therapist. She also served three terms in the Michigan House of Representatives. "In 2008 I decided to run for Michigan State representative for District 21," says Slavens. "I had been frustrated and complaining about the lack of voice that I felt our community had with regard to school funding, health care issues, along with many other issues." She won in 2008 and then again in 2010 and 2014. Term limits in the state kept her from another round of service in the House, but she's proud of the things she was able to help accomplish during her time in the state capital. And she believes her background as an RT often came into play.

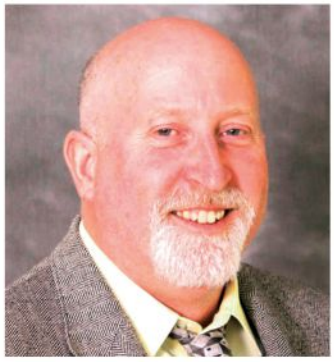
"The smoking ban in restaurants and buildings was one of the first bills that I helped pass," she says. "I believe as a health care professional my voice made a big difference." As the legislation was making its way through the state government, she invited her colleagues in the legislature to visit her hospital. She also helped bring cardiologists, pulmonologists, and neonatologists from Henry Ford Hospital to speak with senators and representatives about the dangers inherent in secondhand smoke.

Slavens worked tirelessly to pass autism legislation, which opened the door to insurance coverage for the condition in Michigan. "I found having a voice from someone with a medical background really made a difference when bills are being introduced and passed," says Slavens.

She explains that campaigning for local office was really no different than campaigning for state office. "I went door to door, talking to residents and listening to what was important to them." She plans to run for Canton Township treasurer again and says she enjoys being able to effect change in her community. ■

Keeping the Lights On

Who: Alan Slaydon, RRT
What: Director, Beauregard Electric Cooperative, Inc.
Where: Deridder, LA
AARC member since: 1997



Alan Slaydon's interest in running for a seat on the Beauregard Electric Cooperative, Inc. (BECI), board of directors came naturally — his father had long served the organization, too. "I became interested in the board position in early 2000," he says. "My father had retired from BECI, and it was a great organization that I wanted to be part of," says Slaydon. So he went for it.

But that family connection didn't translate to immediate success. Slaydon, who serves as director of cardiopulmonary services at Beauregard Memorial Hospital in Deridder, lost his bid for a seat in 2000. He did well enough to consider a second attempt in 2003, though, and that time he won.

He campaigned for the seat by going door to door, mailing out fliers, and engaging the community in his ideas for BECI whenever he could. "I felt it was time for my generation to begin to take an active leadership role," he says.

Winning was exciting for this newbie to politics, but he also knew he had a lot to learn about the cooperative, which serves the electrical energy needs of residential, commercial, and industrial members in a seven-parish area of southwest Louisiana. "Electricity is something we take for granted till we turn on the switch and the light does not come on," says Slaydon. His goals are to improve reliability while maintaining the lowest possible rate for members.

Now serving his fifth three-year term, Slaydon says his background as an RT manager has definitely helped him deal with the issues he faces as a member of the BECI board. "Having been a director prior to the elected position, I was comfortable with budgets and governmental regulations," he says. ■

Editor's Note: The AARC is looking for story ideas and tips from you, our members, to continue to feature the multiple talents of RTs everywhere, much like those in this story. If you have a story to tell, an interesting side job, or an exciting hobby you believe your fellow AARC members would enjoy reading about, let us know by contacting AARC Times at cathcart@aarc.org.

New coalition brings information and support to COPD patients and their families

by Debbie Bunch

Too many people with COPD think they will never breathe strong again. Respiratory therapists in Florida are engaged in a new organization designed to turn around that thinking.

People with COPD used to exist in the shadows. Despite their large numbers, neither the general public nor the media nor even their own physicians devoted much time or attention to the condition. Sure, they received whatever treatments were available, and they were ordered supplemental oxygen to help with their breathlessness, and, if they were lucky, they were offered the opportunity to participate in a pulmonary rehabilitation program. But few people other than the respiratory therapists charged with their bedside care during acute exacerbations and sometimes in the home rose up to advocate for their ongoing needs.

Things have certainly changed. Now there are daily medications for COPD that are regularly advertised in the media, informing patients about the options available to them and the general public about the disease and how it is treated. Patient organizations aimed at supporting people with COPD have proliferated. And COPD coalitions have sprung up all across the country to bring the various COPD communities of interest together for the good of all.

The COPD Foundation has been a key partner in — and, indeed, driver of — many of the new initiatives involving COPD, and now the organization is helping state coalitions deliver even more support and information to patients, families, and clinicians at the grassroots level through a program called BREATHE STRONG COPD. Nowhere is that more true than in Florida, where the effort is being led in part by members of the Florida Society for Respiratory Care (FSRC).

Finding their niche

"The Florida Society has been a partner of the Florida COPD Coalition since 2010, and Community Workshops have been a 'niche' for the Florida COPD Coalition, with over 16 workshops in 12 Florida communities over the past 7 years," says Bob Sobkowiak, RRT, who serves as the Florida COPD Coalition coordinator and is the Florida state captain for the COPD Foundation and the BREATHE STRONG program. "The BREATHE STRONG COPD Coalition developed in 2016 as an initiative to include respiratory industry sponsors, with the goal of increasing the effectiveness of the COPD Community Workshops."

Charter members of BREATHE STRONG FLORIDA include the FSRC, the COPD Foundation, the Florida Cardiovascular and Pulmonary Rehabilitation Association, the American Lung Association of Florida,

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BREATHE STRONG participants enjoy the camaraderie the group provides.

This 2016 seminar was well attended.

RT students helped out during this session last July.

and the Alpha-1 Foundation. Since its inception in the fall of 2016, the group has increased its meetings to include monthly sessions aimed at connecting, engaging, and empowering providers and patient caregivers at both small and large venues around the state.

"Groups range from 6 to 25 in Support Groups to 50 to 100 in Workshop Meetings," says Sobkowiak. He estimates that about 500 patients and caregivers have taken advantage of the sessions so far, a fact he believes shows that the organization is meeting its goal of helping patients and families become more active and gain the confidence they need to become partners in their self-management and advocates for their care.

The group has been dedicated to two long-time supporters of COPD in Florida who have passed away over the past few years: COPD Foundation founder John Walsh and Nick Jones, a national champion COPD patient and advocate as well as the founder of the Airheads of The Villages COPD Support Group.

Making connections

Thanks to the COPD Foundation's COPD360social online community and various other platforms, BREATHE STRONG participants are making connections through social media as well, and they are sharing best practices related to Alpha-1 testing methods, pulmonary rehabilitation mentoring, and physician research. The bond between respiratory therapists and patients is being solidified, and both providers and patients are sharing COPD Foundation, Alpha-1 Foundation, and BREATHE STRONG self-management tools that range from a COPD Action Plan to handouts designed to help patients reach their personal goals for health and wellness. "Regional and community BREATHE STRONG teams of RTs, as well as RT students, patients, and physician champions, are becoming more engaged in their communities," explains Sobkowiak. Those connections are leading to some new and revived programs in some parts of the state.

Blowing on pinwheels is great exercise for the lungs.

Attendees at a workshop last April.

Participants study their handouts.

A small group works on key issues.

In one community in the Panhandle of Florida, patients had been lacking a COPD Support Group for a number of years. Thanks to BREATHE STRONG, a fledgling Alpha-1 Support Group was able to connect with the champion of a strong local pulmonary rehabilitation program to restart the COPD Support Group. "Prior to BREATHE STRONG introduction, neither key partner was aware of each other's presence, needs, and goals to serve this large underserved COPD community," says Sobkowiak.

2017 BREATHE STRONG goals have included:

- Achieve Alpha-1 COPD patient goals
- Increase Alpha-1 Testing
- Increase CME/education programs
- Achieve COPD community goals
- Increase patients enrolled in the Power Patient Research Network
- Increase patients/providers engaged in COPD360social
- Increase education days
- Increase social media connection, engagement, and empowerment

Staying strong

Bob Sobkowiak and his colleagues will be building on those goals through a number of activities scheduled for National COPD Awareness Month in November, and he believes the success Florida has had with the program can be duplicated by AARC members in other parts of the country. "I believe that other state societies could benefit from the connection, engagement, and empowerment of their grassroots for both sustainability and innovation for professional growth and post-acute influence on COPD health."

By working with a range of groups and individuals interested in improving the outlook for people with the disease, BREATHE STRONG FLORIDA is helping patients increase their self-management abilities, raise community awareness, find support resources, overcome limitations posed by the condition, and live healthier, happier, and more hopeful lives.

For more information about starting a BREATHE STRONG COPD group in your state, contact Bob Sobkowiak at (877) 396-8161 or bobs@copdbreathestrong.org. ■

Industry Watch

Vertex Pharmaceuticals announces positive results for CF treatment

Vertex Pharmaceuticals, Inc., has announced positive data from Phase 1 and Phase 2 studies of three different triple-combination regimens in people with cystic fibrosis who have one F508del mutation and one minimal function mutation (F508del/Min). These are the first data to demonstrate the potential to treat the underlying cause of CF in these patients, who have a severe and difficult-to-treat type of the disease. "These safety and efficacy data are clear and compelling," noted Vertex Executive VP and Chief Medical Officer Jeffrey Chodakewitz, MD. "We will be collecting and evaluating additional data from these and other studies and will make a decision on which regimen(s) to take forward into pivotal program(s), which we expect to begin in the first half of 2018."

Mount Sinai partners with Contessa Health on hospital at-home initiative

The Mount Sinai Health System has partnered with Contessa Health, an innovative health care company that manages acute care services at home through prospective bundled payment arrangements, to extend Mount Sinai's existing hospital-level care at home program, known as the Mobile Acute Care Team, to new markets. Mount Sinai initially launched the program in 2014 with the support of a multi-year innovation award from the Centers for Medicare and Medicaid Services. Through the program, eligible patients receive hospital-level care for selected conditions from Mount Sinai providers in their homes in lieu of a hospital stay.

RADICAVA receives FDA approval to treat ALS

According to Mitsubishi Tanabe Pharma America, Inc., RADICAVA™ (edaravone), an intravenous therapy indicated for all adult patients diagnosed with amyotrophic lateral sclerosis (ALS), is now available in the United States. The first ALS treatment option approved by the U.S. Food and Drug Administration in more than 20 years, RADICAVA has been shown to slow the decline in the loss of physical function in ALS patients by 33%. "After 13 years of clinical research and investment, we have reached a seminal moment, which may shift the treatment paradigm for this terrible disease," says Tom Larson, chief commercial officer. "We are all extremely proud and excited to be a part of bringing RADICAVA and new hope to patients in the U.S."

Aridis Pharmaceuticals launches study on pneumonia antibody

Aridis Pharmaceuticals, Inc., is actively enrolling patients in a global study of Aerucin®, the company's broadly reactive monoclonal antibody being developed to treat acute pneumonia caused by the Gram-negative bacteria *Pseudomonas aeruginosa*. The randomized, double-blinded, placebo-controlled trial is ongoing in 14 countries worldwide. "Propelled by positive safety data in humans and preclinical evidence that Aerucin is effective against a broad range of *P. aeruginosa* clinical isolates, including antibiotic-resistant strains, we look forward to evaluating its ability to improve clinical outcomes compared to standard of care antibiotics alone in a diverse, global patient population," says Aridis founder and CEO Vu Truong, PhD. The company expects to complete the study in the second half of 2018.

Regeneron Pharmaceuticals halts work on RSV antibody

According to Regeneron Pharmaceuticals, Inc., the Phase 3 study evaluating suptavumab, an antibody to respiratory syncytial virus (RSV), did not meet its primary endpoint of preventing medically attended RSV infections in infants. The company plans to discontinue further clinical development of the antibody. Chief Scientific Officer George D. Yancopoulos, MD, PhD, was quoted as saying, "We are disappointed in these results, as we had hoped suptavumab

might offer a new option for the thousands of infants impacted by serious RSV infections every year."

Akonni Biosystems receives NIAID grant for research

Akonni Biosystems has received a Phase 1 Small Business Innovation Research contract from the National Institute of Allergy and Infectious Diseases, which will help the company accelerate the advancement of its proprietary technologies to address the unmet need for simple, effective, and affordable tools to diagnose lower respiratory diseases in children. "Akonni's unique solutions for diagnosing respiratory infections from noninvasive samples offer the potential to reduce the morbidity, mortality, and cost of treatment for the millions of affected children each year," said Michael Reinemann, MPH, director of business development.

LUNGevity Foundation names new advisor

LUNGevity Foundation has named Drew Moghanaki, MD, MPH, to its Scientific Advisory Board. Dr. Moghanaki leads the clinical research program at Hunter Holmes McGuire Veterans Affairs Medical Center in Richmond, VA, and has been instrumental in bringing more than $34 million in funding to improve outcomes for lung cancer patients through a Phase 3 lung cancer trial for veterans and a key Veterans Administration partnership to increase access to lung cancer screening.

CVS Health looks at who gets the flu vaccine and why

A new survey conducted by Harris Poll on behalf of CVS Health found that 61% of Americans plan to get a flu vaccine every year, or plan to get one this year, resulting in a 2% increase from last year's survey findings. Of those who get a flu vaccine every year and plan to get one this year, 67% believe it's the best way to prevent themselves from getting the flu. Nearly two in three employed Americans say they would still go to work even if they were feeling ill with flu-like symptoms.

Windtree Therapeutics undergoes financial restructuring

Windtree Therapeutics, Inc., has initiated a financial restructuring program intended to improve its capital structure, better enabling the company to raise the additional capital it needs to fund its AEROSURF® respiratory distress syndrome program and further develop its pipeline of surfactant products utilizing its proprietary KL4 and aerosol device technologies. "We are excited about the prospect of improving our capital structure and eliminating the financial overhang of long-term debt," Senior VP and CFO John Tattory was quoted as saying.

Pieris Pharmaceuticals appoints new senior VP and COO

Pieris Pharmaceuticals, Inc., has appointed Allan Reine as senior vice president and CFO. "It's a pleasure to welcome Allan to the Pieris team at this exciting phase," Pieris President and CEO Stephen Yoder was quoted as saying. "His medical background, industry network, and successful track record as a growth-focused health care investor bring unprecedented strategic value to the company from a corporate finance perspective." Pieris is engaged in advancing novel biotherapeutics through its proprietary Anticalin® technology platform for cancer, respiratory conditions, and other diseases.

REMSleep introduces a new nasal pillow interface

REMSleep Holdings, Inc., announced it has introduced a new nasal pillow interface designed to dramatically improve treatment compliance for those suffering from sleep apnea. The patent-pending pillows are designed to allow adequate air flow at a slower air velocity, among other features. CEO Tom Wood reports the company spent five years designing a pillow to combat CPAP noncompliance. They note that Deltawave's proprietary design allows patients to breathe normally while on CPAP. ■

Brief submissions and photos for this column may be sent to *AARC Times* Editor Marsha Cathcart at cathcart@aarc.org.

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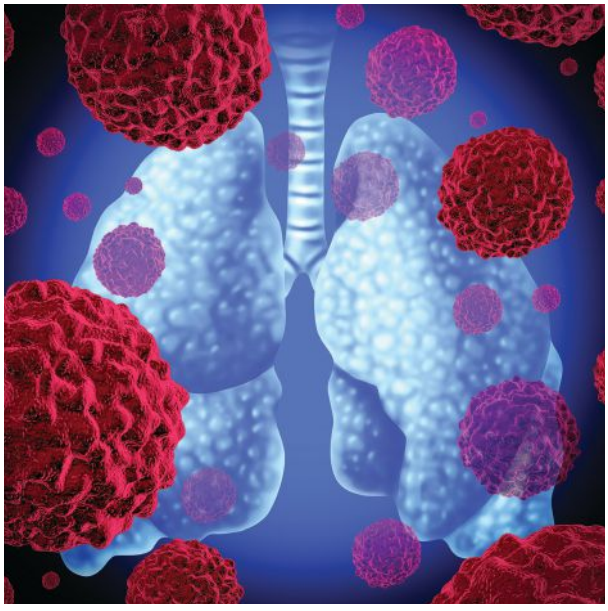
RC Currents

IN THE NEWS

Stem Cell Therapy on the Horizon



North Carolina researchers are working on stem cell therapy that may one day be used to treat lung diseases ranging from idiopathic pulmonary fibrosis (IPF) and chronic obstructive pulmonary disease to cystic fibrosis.

The investigators outlined their work in two recent papers. In the first, published in *Respiratory Research*, they demonstrated that they could harvest lung stem cells from people using a relatively noninvasive technique in the doctor's office. They were then able to multiply the harvested lung cells in the lab to yield enough cells for human therapy.

In the second study, published in *Stem Cells Translational Medicine*, they showed they could use the same type of lung cell to successfully treat IPF in a rodent model. The researchers are now in discussions with the U.S. Food and Drug Administration (FDA) and are working on an application for an initial clinical trial in patients with IPF. ■

Now Seeking Your Ideas for Congress 2018

We know it seems early, but we're already gearing up to plan Congress 2018. The requests for proposal (RFPs) for our next AARC Congress, set for Las Vegas, opened up on August 1 and will run through the end of December. If you have a topic or speaker to suggest for next year's meeting, please use our new and improved "RFP 2.0" application process on our website at www.AARC.org to make your request. The AARC's Program Committee will begin culling through all the suggestions early next year.

There will be no deadline extensions this year, so be sure to get your RFPs in by December 31, 2017. Your input is important to help the committee ensure the 2018 meeting covers the topics that matter most to you. ■

Tell Your Story

Every therapist has a story to tell about a favorite or most memorable patient that would interest others in the profession. Maybe it was an "aha moment" when you knew you had made the right professional decision for that patient. Maybe it was when you first realized how much difference you were making in the lives of that patient and his family. Or maybe it was just something the patient said or did that made you laugh or cry or just be inspired to be a better RT. Our "Storytellers" column is the place to share them. Send your story to *AARC Times* Editor Marsha Cathcart at cathcart@aarc.org. ■

Transitions

In the lives of AARC members

David A. Sazama, RRT, passed away earlier this year at the age of 70. His respiratory care career spanned 45 years and he was an active member of the Wisconsin Society, where he served as president in 1975.

Sequana J. Cooke Harris, MBA, RRT, RPSGT, lost her life while serving as a stunt driver on the set of the upcoming movie, Deadpool 2. She earned her respiratory therapist degree from Long Island University and her MBA from Dowling College. The first black woman to compete in motorcycle race competitions, this had been her first opportunity to serve as a stunt driver in a major motion picture. ■

Contribute to Our "Transitions" Column

The AARC "Transitions" column is devoted to sharing news about the passing of AARC members. You can submit news about your colleagues' recent passing by going to http:c.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. ■

Nocturnal Oximetry Could Diagnose More Kids with OSA

Nocturnal oximetry measured at home may be a simple and effective way to assess more children for sleep apnea, report investigators from the University of Chicago. They compared their oximeter-based automated system to polysomnography, analyzing more than 4,000 studies performed on children aged 2–18 years who were referred to one of 13 leading pediatric sleep laboratories around the world for frequent snoring or other signs of obstructive sleep apnea (OSA).

Results showed the accuracy of oximetry alone increased as disease severity increased, detecting about 75% of children with mild apnea, 82% of those with moderate disease, and 90% of those with severe sleep apnea.

The authors estimate this strategy could reduce costs of diagnosing these children by up to 95%. "Access to an accurate and easily implemented diagnostic tool, such as overnight oximetry for OSA, could increase the frequency and lower the cost of screening, providing a simple, robust way to detect children at high risk and get them into treatment," study author David Gozal, MD, MBA, was quoted as saying. The study was published in a recent edition of the *American Journal of Respiratory and Critical Care Medicine*. ■

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New Biological Markers of Cystic Fibrosis

Two new biological markers identified by researchers from McMaster University may help in the diagnosis of cystic fibrosis (CF).

Using a specialized technique, the investigators collected and analyzed sweat samples from infants in CF clinics at the McMaster Children's Hospital and the Hospital for Sick Children in Toronto, identifying several previously unknown chemicals that were consistently associated with babies who had CF. Those chemicals were secreted in sweat at much lower concentration levels than chloride.

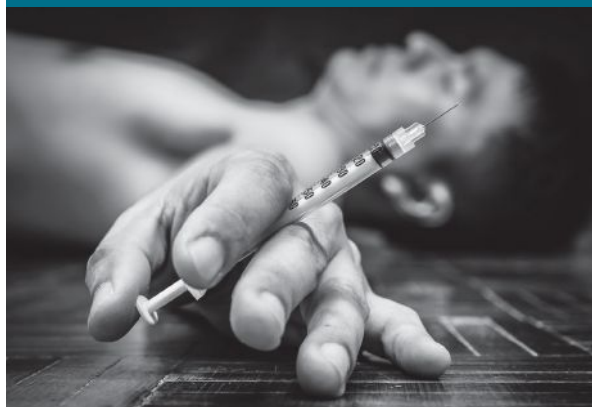
The researchers believe testing for these biomarkers could be useful in cases where the chloride sweat test result is unclear. The biomarkers also point to other underlying mechanisms that contribute to the progression of CF and could lead to better therapeutic interventions earlier in life.

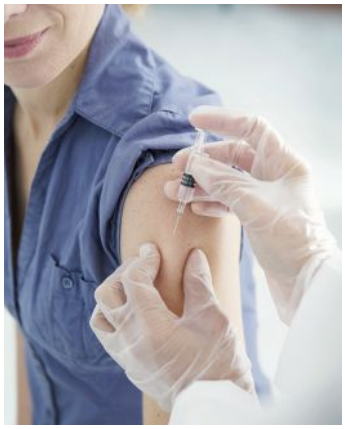
"The easier it is to detect CF, the earlier it can be diagnosed, and the better people's chances are at living a longer, healthier life," Joanna Valsamis, from Cystic Fibrosis Canada, was quoted as saying. The study appeared in *ACS Central Science* earlier this year. ■

How the Opioid Crisis Impacts the ICU

The opioid crisis is top of mind these days, and now researchers from Harvard Medical School shed some light on how it is impacting ICUs across America. The investigation began with a look at 4,145,068 patients requiring ICU care at 162 hospitals in 44 states over seven years. Of those, 21,705 overdosed on opioids, most commonly heroin.

Among the opioid overdose patients, 25% experienced aspiration pneumonia, 15% rhabdomyolosis, 8% anoxic brain injury, and 6% septic shock. Ten percent of patients who overdosed required mechanical ventilation. Overall, admission to the ICU increased by 34% during the study period. Deaths from opioid overdoses averaged 7%, but rose to 10% by 2015. The study appeared in a recent edition of the *Annals of the American Thoracic Society*. ■





Microneedle Patch Boosts Flu Vaccine

Boosting traditional flu vaccination with a biodegradable microneedle patch and protein constructed from sequences of influenza virus subtypes could improve the effectiveness of conventional influenza vaccines. That's the take-home message from Georgia State University researchers who tested the strategy in mice.

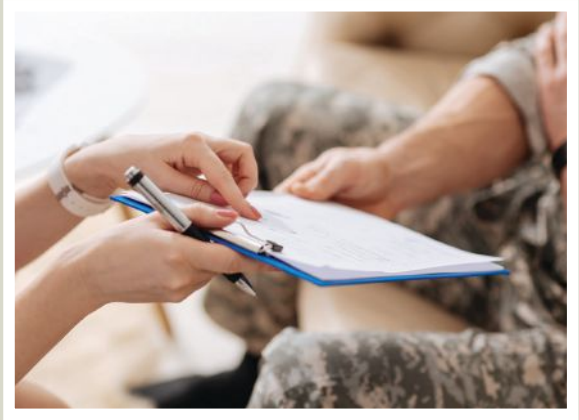
Mice who received the microneedle patch four weeks after vaccination with the standard flu shot were better able to maintain the humoral immunity antibody response against influenza virus infection than those that received the conventional vaccine alone. The study was published in a recent edition of the *Journal of Controlled Release*. ■

FDA Changes Course on Nicotine Addiction

A comprehensive new plan from the FDA designed to serve as a multi-year roadmap to better protect kids and significantly reduce tobacco-related disease and death is placing nicotine, and the issue of addiction, at the center of the agency's tobacco regulation efforts. The overriding goal is to ensure that the FDA has the proper scientific and regulatory foundation to efficiently and effectively implement the Family Smoking Prevention and Tobacco Control Act.

"The overwhelming amount of death and disease attributable to tobacco is caused by addiction to cigarettes — the only legal consumer product that, when used as intended, will kill half of all long-term users," says FDA Commissioner Scott Gottlieb, MD. "Unless we change course, 5.6 million young people alive today will die prematurely later in life from tobacco use."

The FDA plans to begin a public dialogue about lowering nicotine levels in combustible cigarettes to non-addictive levels through achievable product standards, and it will issue an advance notice of proposed rulemaking to seek input on the potential public health benefits and any possible adverse effects of lowering nicotine in cigarettes. It will also develop product standards to protect against known public health risks such as battery issues related to electronic nicotine delivery systems and concerns about children's exposure to liquid nicotine. ■

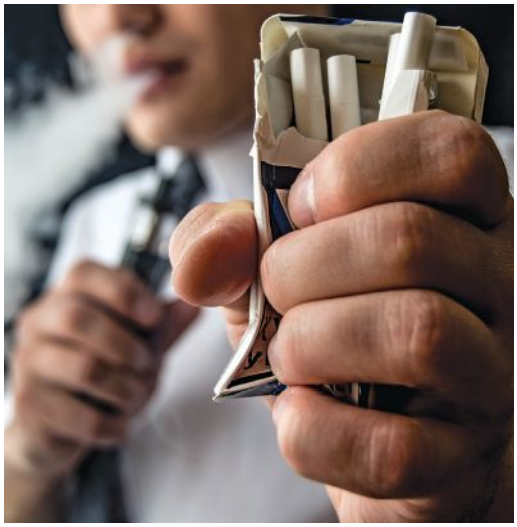


LCI May Diagnose Deployment-Related Lung Disease

The lung clearance index (LCI) might be a better way to diagnose lung disease related to military deployment than the standard lung tissue biopsy.

Researchers from National Jewish Health compared the LCI with standard biopsies in 17 patients with definite deployment-related lung disease and 11 with probable deployment-related lung disease. The average LCI score was higher for patients with symptoms of deployment-related lung disease when compared to a non-deployed control group, although the difference narrowed and became insignificant upon adjustment for age, body mass index, and smoking. Still, an abnormal LCI score was more sensitive for identifying patients with deployment-related lung disease than standard lung function tests or CT scans.

An elevated LCI score was also a better indicator of abnormal results on lung biopsy. The study was published in a recent edition of the *Journal of Occupational and Environmental Medicine*. ■



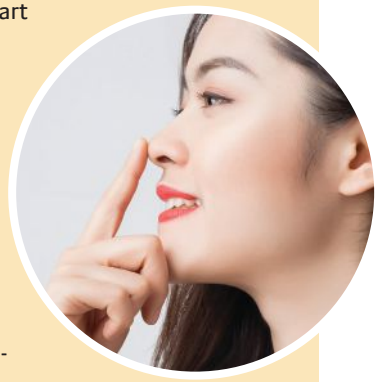
Study Suggests E-cigarettes Help Smokers Quit

A new study out of the University of California San Diego suggests e-cigarettes are, indeed, helping people kick the habit. Researchers examined the relationship between e-cigarette use and smoking cessation using data collected by the U.S. Census CPS-TUS, a national survey of adults 18 years or older conducted to obtain information about changes in the country's use of tobacco products. It is based on the largest representative sample of smokers and e-cigarette users available, although it is not a randomized trial.

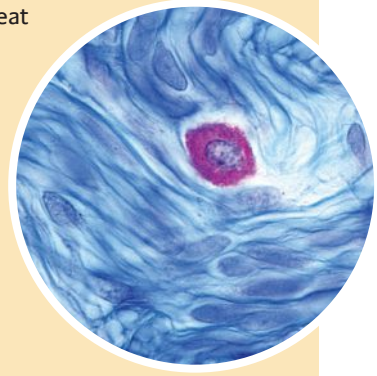
Survey participants were asked about their use of traditional cigarettes and e-cigarettes over a 12-month period. Researchers found that 65% of smokers who used e-cigarettes within the previous 12 months had attempted to quit smoking traditional cigarettes, compared to 40% of smokers who did not use e-cigarettes. Overall, 8.2% of smokers who used e-cigarettes successfully quit smoking traditional cigarettes, while 4.8% of smokers who did not use e-cigarettes were successful. The study appeared in the *British Medical Journal*. ■

Strange But True...

Heart healthy: Even low doses of radiation during breast cancer treatment can damage the heart, but researchers from Valley-Mount Sinai Comprehensive Cancer Care think they have found a good way to protect it: just take a deep breath and hold it. When they had breast cancer patients undergoing radiation hold their breath during the application of radiation, the average dose of radiation to the heart dropped by 26.2–75%. Why? Expanding the lungs moved the heart away from the breast and thus the heart got a lower dose.



Smell restored: Chronic kidney disease patients often suffer from a loss of smell, which can lead to poor nutrition. Researchers from Harvard Medical School find the asthma drug theophylline can help. Sense of smell was improved in five out of seven patients who tried it for six weeks.



New indication? Mast cell inhibitors already on the market to treat allergic conditions such as hay fever and asthma may one day be used to prevent deep vein thrombosis as well. British researchers studied the concept in mice by "turning off" the gene that produces mast cells. Results showed mast cell–deficient mice were protected from developing the dangerous blood clots. ■

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October 24–October 25, 2017
Worchester, MA
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November 13, 2017
Roanoke, VA
VSRC 36th Annual Mountain Air Symposium
Contact: sharitoomey@yahoo.com

Other Meetings

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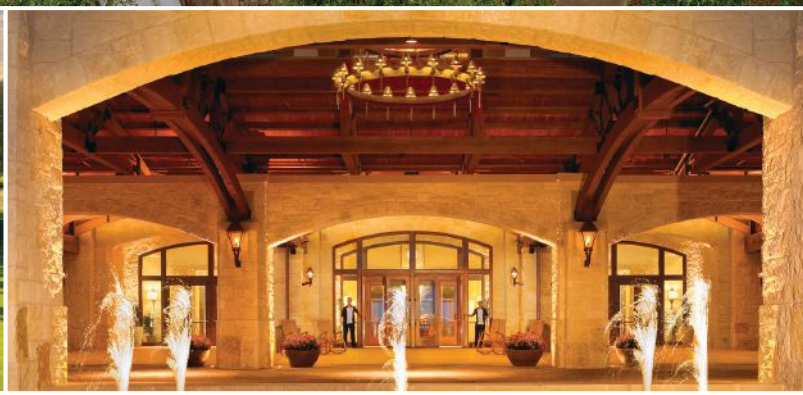


Code Pink, Delivery Room 2!

by Joe Morgan, RRT-NPS, CPFT

Happiness and fulfillment is essentially a state of going somewhere wholeheartedly.
— W.H. Sheldon

With a title like the one you see for this article, you are sure to expect a story about an infant resuscitation, so I will not disappoint. However, this story has an unexpected twist. First, though, I would like you to join me in considering the word "re-sus-ci-tate." I feel it is important to examine its meaning. The value of this exercise will hopefully become apparent as the story progresses.

From a clinical perspective, we define "resuscitate" as the steps taken to revive from unconscious or apparent death. In a wider view of the word, we find it can be defined thus: to restore or breathe new life into. I like that rendering, especially since I'm a respiratory therapist. This latter definition is the message I hope to bring forward.

One of those days

Let me set the stage for my story: I was having one of those difficult respiratory days. You know those, I'm sure. I was falling behind on my treatment schedule. I had spent way too long in the ER, with all those unsavory smells like alcohol, tobacco, and a chronic GI bleeder. Adding to the stress of the day were repeated pages for blood gas draws and one new ventilator set-up.

I finally got a break in the early afternoon and was looking forward to a cup of joe (that's coffee, Joe-style) and some de-stress time. As it usually goes, the STAT beeper went off with a Code Pink in Delivery Room 2. I jumped from my seat in the cafeteria with that all too familiar adrenaline rush and sped down the hallway to labor and delivery. Almost crashing into Sharon, the RN, I flew through the door of Delivery Room 2. The OB doctor was holding a blue, slimy, limp baby boy who, at first glance, looked like a sundried raisin.

I took the baby and placed him on the recovery bed in the back corner of the delivery room and went to work. Sharon and I had the drill down after working together for so many years. I immediately grabbed a bulb syringe to clear the airway while she started tactile stimulation. We were both desperate to see some sign of life in this boy.

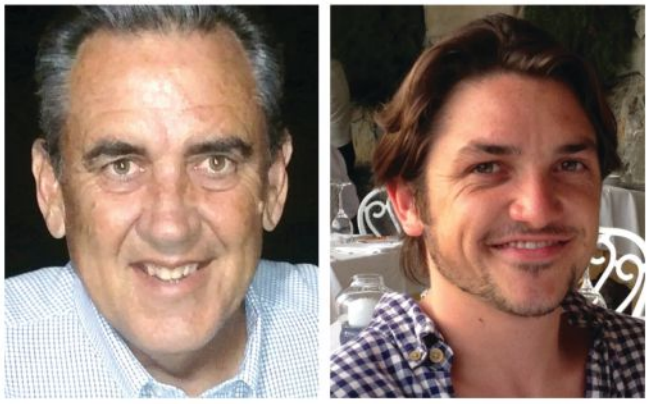
Expelling the bulb syringe revealed a small but evident bit of meconium mixed with the amniotic fluid. So I grabbed the laryngoscope and a suction catheter to evacuate any further signs of meconium, then began to bag the baby with O_2 as we continued to rub, slap, and stimulate him, waiting for some sign of life.

Then, wonderfully, a reaction began: a gasp, another, and then a cry. His color changed from blue to blue gray, and then to a beautiful pink, like the evening sunset against a marvelous sky.

What a RUSH! Using all the skills Sharon and I had developed over the years, we restored an apparent death into a breath of new life.

about the author...

Joe Morgan is an AARC member from California who currently serves as a quality assurance specialist for Radiometer America, Inc.



Joe Morgan and his nephew Miles have a special connection that began minutes after Miles was born.

Is Miles okay?

As I conclude my story, I'm sure you are thinking, "He is going to say something like, 'not only did we resuscitate this baby, but the event actually revived and breathed new life into my day.'" Actually, that's not a bad thought. As respiratory therapists, we can breathe new life into any situation with our skills—an act of kindness, a smile, or a word of encouragement. So get out there and resuscitate someone every day, and you will also be resuscitating yourself. Breathe new life every day!

But like I said at the outset, there is a twist to this story, and I wonder if you will be as surprised as I was in its conclusion. After cleaning and wrapping up this blue-to-pink, flaccid-to-lively, silent-to-crying baby boy, I heard a fatigued and desperate voice from behind me on the delivery table say, "Joe, is Miles okay?" I turned to look, and the person lying on the table was my sister-in-law, Julie.

I almost had a code myself! Yes, indeed, my day was resuscitated! At that moment, I was "SUPER Joe Therapist!" Miles—24 years old now—still thanks me whenever we meet. ■

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