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# Times

## Racing To Be the Best: AARC Congress in Indianapolis Inspires RTs



Members of the Indiana Society for Respiratory Care welcomed everyone to the AARC Congress in Indianapolis. Attendees got to see a genuine IndyCar up close at their ISRC booth in the Indiana Convention Center. Pictured are: Jeff Scott, Mary Todd, Susan VonTobel, Ross Havens, Jeff Hunsucker, Susan Wynn, and Kathy Stephens.



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1. Frat JP, Thille AW, Mercat A, et al. High-Flow Oxygen through Nasal Cannula in Acute Hypoxemic Respiratory Failure. *The New England Journal of Medicine* 2015; DOI: 10.1056/NEJMoa1503326.
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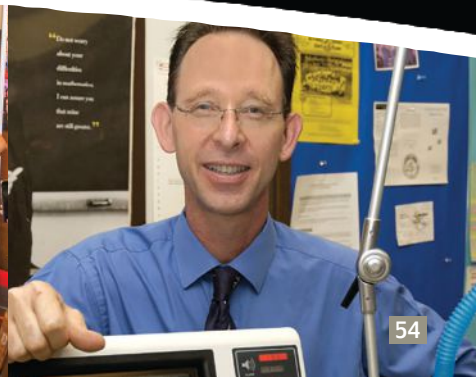
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The Annual AARC Congress is a key part of the never-ending race for better respiratory care. By Debbie Bunch

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Natalie Stavas, MD, told attendees how she ran toward danger instead of away from it in her Closing Ceremony Address. By Debbie Bunch

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

## 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/](http://www.aarc.org/member_services/mission/).



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### Editor

Marsha Cathcart, BA

### Managing Editor

Douglas Laher, MBA, RRT, FAARC

### Contributors

Debbie Bunch, BA  
Sheila Henegar

### Manager of Marketing and Production

Jeanette Chawdhury, MBA

### Graphic Designers

Joyce Havins  
Kelly Piotrowski  
Jennifer Horn

### Director of Business Development

Sarah Vaughn, BS, RRT

### Advertising Rates and Media Information

Contact: [phil.ganz@aarc.org](mailto:phil.ganz@aarc.org)  
Phil Ganz, 48 Abbey Woods Ln.,  
Suite 100, Dallas, TX 75248  
Voice (972) 991-4994  
Fax (888) 206-9006

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Suite 100  
Irving TX 75063  
c/o Advertising Department  
Voice (972) 243-2272  
Fax (972) 484-2720

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Fax (972) 484-2720

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FAARC

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## ► Meet the AARC Staff



**Debbie Bunch**

Writer  
[bunch@aarc.org](mailto:bunch@aarc.org)



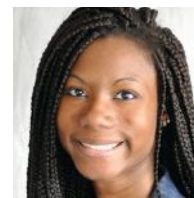
**Timothy Myers**

Chief Business Officer  
[timothy.myers  
@aarc.org](mailto:timothy.myers@aarc.org)



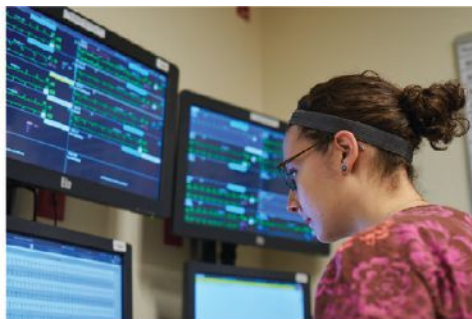
**Crystal Maldonado**

Grants Coordinator  
[crystal.maldonado  
@aarc.org](mailto:crystal.maldonado@aarc.org)



**Ashley Walton**

Customer Service  
[ashley.walton  
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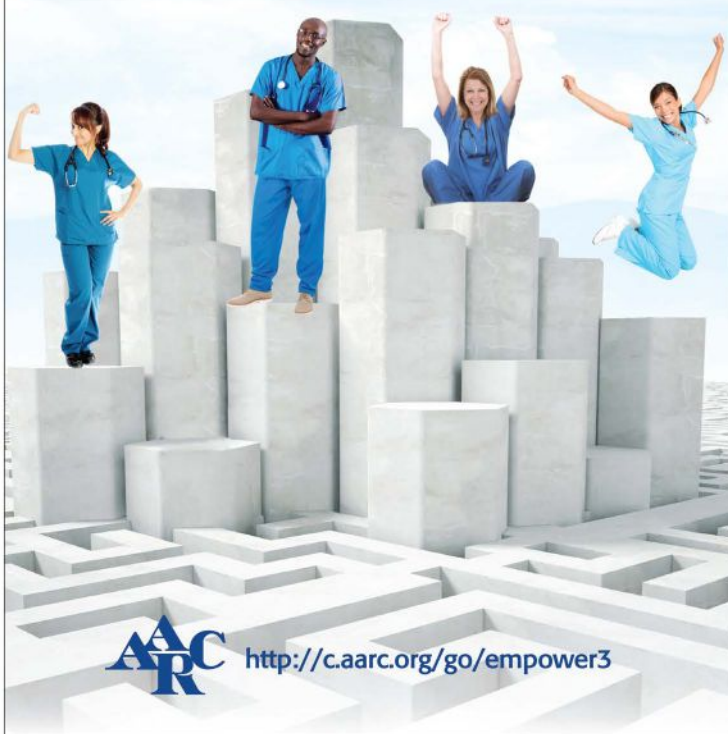
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## Advocacy and Government Affairs Year-End Wrap-Up

by Anne Marie Hummel

This has been a busy year for AARC's Advocacy and Government Affairs staff, as we continue to promote in the legislative, federal, and state arenas the important role respiratory therapists play in the delivery of health care services to those who suffer from chronic respiratory disease.

The AARC weighed in on issues such as the role of respiratory therapists in chronic care management, the benefit to patients of employing RTs in Medicaid-managed care plans, riders to fiscal year (FY) 2017 appropriations bills that would weaken the U.S. Food and Drug Administration's authority to oversee tobacco products, a bill that allows Congress to request the Congressional Budget Office to estimate long-term savings from preventive health initiatives, advocating for respiratory therapy to be a specialized rehabilitation service in long-term care facilities, and many more. Brief highlights of other key activities in 2017 are discussed in this article.

### U.S. Congress

This year has been a rollercoaster ride in dealing with a number of contentious issues in Congress, such as health care reform, tax reform, appropriations, and immigration. Health care reform to repeal and replace the Affordable Care Act (ACA), or "Obamacare," took up the majority of the year's efforts. While the House passed their version of a "repeal and replace" bill, the Senate was not as successful as they drafted their own legislation only to see it fail at the last minute. During the Senate debate, AARC sent a letter to all senators on behalf of respiratory patients opposing

policies that would increase the number of uninsured Americans, weaken essential health benefits, and make health insurance less affordable, while advocating for preventive medicine such as routine newborn screening, wellness visits, smoking cessation, disease management, and pulmonary rehabilitation (PR).

### about the author...



Anne Marie Hummel is an executive associate director of the AARC and specializes in advocacy and government affairs.

### Appropriations

The report language we lobbied for during our Capitol Hill visits was included in the FY 2018 House Labor-Health and Human Services (HHS) report when they passed their appropriations bill, but it was not included in the Senate report. The request was to have the Centers for Medicare & Medicaid Services (CMS) conduct an analysis of COPD claims data in a variety of settings to help demonstrate the value of RTs. An opportunity exists for the language to be included as part of the omnibus reconciliation process, which would deem the separate House and Senate reports as binding and would cover our language included the House report.

### Telehealth

AARC continues to advocate for co-sponsorship of the three telehealth bills introduced in Congress that included RTs as telehealth providers and respiratory care as a telehealth service. They are H.R. 2550, the Medicare Telehealth Parity Act; H.R. 2291, the Helping Expand Access to Rural Telemedicine (HEART) Act; and H.R. 766, Telehealth in Public Housing. Grassroots efforts by our Political Advocacy Contact Team (PACT) representatives to gain co-sponsors while

House leaders were in their home districts during Congressional recess remained a priority. Throughout the year, our lobbyists met with key Congressional committee members to garner support for telehealth vehicles, which include RTs. The AARC also endorsed new procedures established by the American Telemedicine Association to address the needs of the nation's pediatric population when receiving critical services via telehealth. The procedures cover such topics as patient privacy and safety, informed consent, special circumstances and the environment, emergency contingencies, mobile devices, clinical encounters, and provider considerations.

### **Pulmonary rehabilitation**

AARC continued its work throughout the year with other pulmonary organizations to address the low payment rate for PR. The problem remains that hospitals are failing to establish appropriate charges for code G0424, the code assigned to PR, even though an effort was made to educate hospitals through the development of a pulmonary rehabilitation toolkit on services that should be considered as part of the single, bundled code. A campaign launched after Labor Day by the American Association for Cardiovascular and Pulmonary Rehabilitation (AACVPR) and supported by AARC aims to educate hospitals with charges below the national average on services that should be included when establishing appropriate charges for G0424.

AARC and others also submitted comments to CMS recommending a merger of cardiac and pulmonary rehabilitation into a single Ambulatory Classification Grouping under the hospital outpatient prospective payment system. The change would raise the PR payment rate considerably. We are waiting for publication of final rules to see if the suggestion was adopted.

### **Tobacco**

As a member of the Tobacco Partners Coalition, the AARC continues to attend quarterly meetings to discuss tobacco control issues in Congress and the administration. This year we've advocated for restricting smokeless tobacco at major league baseball venues and prohibiting smoking in public housing. The AARC also supported a bill in Congress that would make facilities of the Veteran's Health Administration smoke-free and campaigned against the Disney Company to end its relationship with a media company that helped Phillip Morris International market its products to young people around the world.

### **Competitive bidding**

AARC supported AAHomecare in asking Congressional House leaders to sign on to a letter to the HHS secretary and CMS administrator urging them to use their authority to make needed reforms to current home medical equipment (HME) policies and regulations and to protect beneficiary access from competitive bidding's negative effects. One hundred and fifty-three members signed the letter. Subsequently, AAHomecare developed a survey to determine patient access to HME services under competitive bidding in response to requests from U.S. Congress and regulatory policymakers. Members of the AARC's Home Care, Long-Term Care, and Continuing Care/Rehabilitation Sections participated in the survey.

### **Skilled nursing facilities**

Working with members of the AARC's Long-Term Care Section, the Association submitted comments and recommendations on proposed policies as part of the FY 2018 payment update for skilled nursing facilities (SNFs) to standardize patient assessment data to be reported by post-acute care providers that included oxygen, suctioning, trach care, and mechanical ventilation, and to increase payment for non-therapy ancillary services including respiratory therapy.

For now, CMS has chosen not to finalize several parts of the standardized patient assessment data, including the respiratory grouping, due to concerns of an increased burden and a need for additional resources. After conducting a national field test to determine the time SNFs need to prepare for the reporting requirements, CMS will publish new rule making, which gives AARC a chance to submit additional comments. CMS had not finalized the payment methodology for non-therapy ancillary services at the time of this article's publication.

### **COPD National Action Plan**

The AARC assisted in the development of the first-ever COPD National Action Plan released earlier this year by the National Heart, Lung & Blood Institute. We advocated for RTs to play a significant role in the treatment and care of patients with COPD due to their expertise as disease educators and experts in pulmonary medicine, which can lead to improved outcomes and better lives for those who suffer from COPD.

Our Government Affairs staff also got involved in several state activities this year on behalf of AARC members.

## State activities

### RRT entry level for licensure

Moving the profession forward is a goal of the AARC. Earlier this year, the Association developed a guidance document for state societies interested in moving to an RRT-entry level for licensure (<http://www.aarc.org/wp-content/uploads/2017/03/rrt-entry-to-licensure.pdf>). Three states — Oregon, Georgia, and New Jersey — achieved the goal this year, joining California, Arizona, and Ohio.

### State telehealth laws

This year we saw a number of states enact legislation that would expand telehealth services both under the private insurance market and Medicaid. New Jersey and North Dakota specifically covered respiratory therapists as telehealth providers in its laws. Vermont defined health care professionals who can provide telehealth as being licensed, certified, or otherwise authorized to provide services; Texas included professionals working under the delegation and supervision of a physician acting within their scope of practice. We assume both of these laws would include RTs as telehealth providers. Other states enacting telehealth laws include Hawaii, Maine, and Minnesota.

### Tobacco

New Jersey, Oregon, and Maine passed laws to raise the minimum age to 21 for purchasing tobacco. New Jersey's law became effective Nov. 1, 2017. Oregon's law becomes effective Jan. 1, 2018, and Maine's law kicks in July 2018. That brings the total to five states, California and Hawaii being the other two. Massachusetts is expected to become the sixth.

### Licensure board issues

In 2015, the Supreme Court upheld a ruling by the Federal Trade Commission that the North Carolina Dental Board violated anti-trust laws in trying to restrict non-licensed technicians from providing teeth whitening in shopping malls. The decision has caused states to review their licensing board structures to ensure immunity from anti-trust laws.

As a result of that court decision, Ohio abolished the Ohio Respiratory Care Board (ORCB) and replaced it with an advisory council under the Ohio Medical Board. HME policies previously regulated by the ORCB were transferred to the State Board of Pharmacy. Wisconsin is facing the creation of an Occupational License Review

Council, whose role would be to review currently licensed professions and make recommendations to the legislature on whether less restrictive regulation is available to protect public health, safety, and welfare. Nebraska is battling a bill that would reorganize 172 licensing boards and create a new oversight office to increase competition. Kentucky's licensing board will be housed under the Department of Professional Licensure with oversight by an executive director.

The AARC's state societies should be prepared for encountering an increase in legislation designed to change the structure of licensing boards as evidenced by those states that have experienced changes this year.

### Other state-level activities of interest

South Carolina enacted a law permitting unlicensed persons in community-based programs under the Department of Disabilities and Special Needs to furnish medications, provided they have been trained and supervised by licensed nurses, pharmacists, and physicians and have successfully completed medication training and competency evaluation. Inhalation drugs are among the limited list of medications they can administer.

Tennessee enacted a bill that extends services of emergency medical personnel in an out-of-hospital setting to provide patient evaluation, advice, treatment, or referrals to other community resources.

Washington now permits fire departments to develop a community assistance referral and education program partnering with hospitals to reduce readmissions by hiring or contracting with health care professionals. The professionals include emergency medical technicians and advanced EMTs and paramedics, as long as they perform procedures they are trained and certified to provide and are under the supervision of an approved medical director.

The AARC continues to monitor bills that may remove the term "out-of-hospital" with respect to licensing laws for emergency personnel because it has the potential to infringe on respiratory therapists' services.

### Check out our new AARC advocacy website

You can read more about the policy issues impacting respiratory therapists and the activities of the Advocacy and Government Affairs staff on our new and improved website. Click on the "Advocacy" menu of the AARC website to learn more. ■

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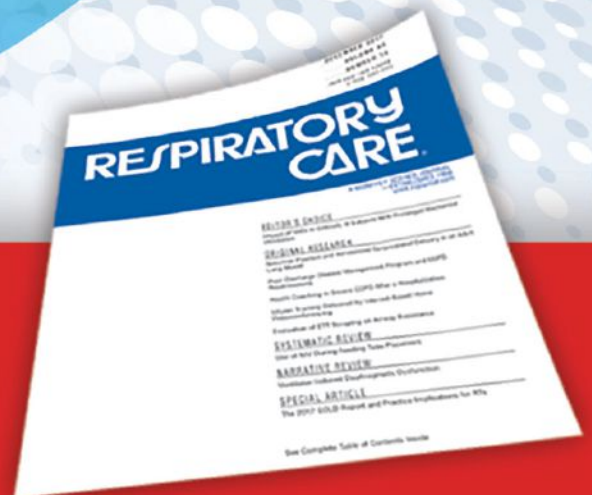
		
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# RESPIRATORY CARE Achievement Marks a Major Milestone



Year 2000 acceptance into *Index Medicus* opened doors for the Journal and the profession by Debbie Bunch



In 1879, John Shaw Billings created a new publication to list medical journals that contained research deemed worthy of use by physicians and other clinicians. His *Index Medicus* was published annually for 125 consecutive years and became the “bible” for researchers seeking to publish their studies in the most highly respected journals.

When the AARC’s science journal, *RESPIRATORY CARE*, was accepted into *Index Medicus* in 2000, then AARC President Garry Kauffman, MPA, RRT, FAARC, predicted a plethora of doors would open. “Acceptance of *RESPIRATORY CARE* into *Index Medicus* is critically important for the profession,” he said at the time. “It will result in increased citations for our Journal... and it will undoubtedly contribute to the promotion of the science of respiratory care by increasing the size of the Journal’s audience.”

David J. Pierson, MD, FAARC, who was then editor-in-chief of the Journal and now serves as editor emeritus, agreed. “Inclusion means that others besides ourselves acknowledge that the profession is science-based and deserving of a place next to physicians and others whose journals are in the *Index*.”

Although the printed version of *Index Medicus* was phased out at the end of 2004, replaced by the online database PubMed, the value of the *Index Medicus* seal of approval persists to this day. For the Journal, inclusion in this distinguished society of some 5,000 journals from around the world has translated into significant growth and development. In the ensuing 16 years, submissions to the Journal have skyrocketed, and the publication is also now included in Web of Science.

Getting to this point, though, required a lot of hard work and dedication by the Journal editors and other leaders in the Association.

### Odds tip in our favor

It all started with a need to overcome a “catch-22” situation. To get into *Index Medicus*, the Journal had to show evidence that it published the most relevant research. But to attract the most relevant research, the Journal needed to be in *Index Medicus*, because many authors were only interested in publishing their papers in an indexed journal. Why? It was all about career advancement.

Dr. Pierson gave a good explanation of the problem back in 2000. “Being in *Index Medicus* means that investigators who are dependent on publication in indexed journals for academic promotion will be more likely to submit their work to us,” said the physician, who went on to serve as Journal editor until 2008. “This applies primarily to physicians, who do most of the research in health care, but also to those RTs

at academic centers who have felt obliged to send their best work to other journals in order to gain points from their universities and their superiors.”

The odds tipped in the Journal’s favor in the late 1990s, when *Index Medicus* more clearly defined the steps non-indexed journals would have to take to be accepted into the prestigious database. Journal editors took those standards to heart, creating a rigorous peer-review system for all of the papers they published, expanding the editorial board, hiring a staff statistician, revising the guidelines for contributors, ensuring their policies were in line with the Vancouver Group guidelines favored by *Index Medicus*, and implementing explicit conflict-of-interest policies.

Charles G. Durbin, Jr., MD, FAARC, a long-time associate editor of the Journal, noted the great value being in *Index Medicus* would bring to the Journal back in 2000. “While the Journal has always been the ‘best’ forum



Scientific research in the respiratory care profession received a significant boost when the AARC’s science journal joined the ranks of the world’s most respected medical publications.

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for respiratory care, now institutional promotional committees will understand the quality of the Journal and see papers published there in a different light.”

### The face of our profession

The passage of time suggests Dr. Durbin was right. In 2011, current Journal Editor-in-Chief Dean R. Hess, PhD, RRT, FAARC, noted in an interview with *AARC Times* that the number of unsolicited submissions had increased several-fold over the past 10 years. “It’s probably fair to say that we now get as many submissions in a month as we published in six months back then,” he said. “That means we can be more selective about what we publish, so the quality of the Journal is increasing.”

The number of international submissions went way up, too, reflecting the growing stature of the Journal among respiratory clinicians around the world. In another *AARC Times* interview conducted in 2014, Dr. Pierson emphasized that the days when “respiratory care” was considered an American invention dominated by Americans were over, in part because of the Journal’s success.

“Respiratory care, the subject area, has now become international, to the extent that the majority of submissions to the Journal come from outside the U.S.,” he said. “I believe two factors are largely responsible — increased recognition of the Journal’s quality in the scientific and publishing communities and an increase in the number of potential authors around the world who are doing good, quality work in this field.”

Dr. Hess emphasized the value this increased recognition was bringing to the profession as a whole. “For people who are not respiratory therapists, the Journal is really the face of the profession. This is particularly true for physicians, physical therapists, and others outside of the United States,” he said. “So the extent to which we do a good job with the Journal reflects very well on the profession and on the AARC.”

### Credibility established

The major milestone reached by the Journal in 2000 with its inclusion in *Index Medicus* set the stage for more than a decade’s worth of explosive growth. Today the AARC’s science journal is a highly respected research publication used and valued not only by respiratory therapists here in the United States, but also by

physicians and other health care colleagues around the world.

As Dr. Hess put it at the time, “Any profession that is worth anything has an academic base — that is the nature of being a profession. It says a lot about us, as respiratory therapists, that our scientific journal is listed in *Index Medicus*. It means that our science, upon which our profession is built, has credibility.” ■

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# WELCOME TO THE 63RD INTERNATIONAL RESPIRATORY CONVENTION & EXHIBITION



# Racing To Be the Best: AARC Congress in Indianapolis Inspires RTs

by Debbie Bunch

AARC President Brian Walsh, PhD, RRT-NPS, FAARC, has put safety, quality, and value at the center of his goals for the Association, and resources for all three were in ready supply during AARC Congress 2017 in Indianapolis. From lectures and symposia devoted to the latest thinking in evidence-based practice to an Exhibit Hall filled with the technology we all need to be able to enhance the care we provide to our patients, this year's AARC Congress delivered.

"We have a wonderful and bright future. There is nothing our profession can't do if we work together to achieve it. I truly believe we are on the cusp of becoming a great profession of the likes no one has seen before," Dr. Walsh said. He stressed that the key to success is to be proactive on all fronts. "Respiratory therapists provide the safest respiratory care. However, medical errors are

the third leading cause of death in the U.S. ... we must take notice and evaluate our practice for opportunities to continue to provide the safest care around, and we have many opportunities to do just that."

Congress attendees participated in a wide range of opportunities and spent plenty of time brainstorming with their colleagues about safe, effective patient care. It all came together to create a rich, collegial environment where RTs could refuel their passion for the profession, boost their careers, and reload their commitment to remaining the lung health experts for patients in need.

On the following pages you'll see firsthand what happened in Indianapolis on October 4-7 and why those four days matter in our mission to improve patient care in 2018 and beyond. ■

Photos by Lennie Sirmopoulos, Convention Photography, Tustin, CA



# Celebrating Excellence

by Debbie Bunch

Respiratory care is full of people who go above and beyond for their profession, their colleagues, and most importantly, their patients. The AARC Congress was the place to acknowledge their efforts.

Photos by Lennie Sirmopoulos,  
Convention Photography, Tustin, CA



# Congratulations, 2017 Award Winners!

Top professionals in respiratory care were honored with a host of awards from the AARC, ARCF, and NBRC during the annual awards ceremony that took place on the first day of Congress and during the annual business meeting on the next day.

- Life Membership: Lynda Goodfellow, EdD, RRT, AE-C, FAARC
- Jimmy A. Young Medal: Robert Chatburn, MHHS, RRT-NPS, FAARC
- Forrest M. Bird Lifetime Scientific Achievement Award: Jim Fink, PhD, RRT, FAARC, FCCP
- Thomas L. Petty MD Invacare Award for Excellence in Home Respiratory Care: Kimberly S. Wiles, BS, RRT, CPFT, FAARC
- Héctor León Garza MD Achievement Award for Excellence in International Respiratory Care: Neil R. MacIntyre, MD, FAARC
- Dr. Charles H. Hudson Award for Cardiopulmonary Public Health: Congressman Gregg Harper
- Mike West MBA RRT Patient Education Achievement Award: David L. Vines, MHS, RRT
- Mitchell A. Baran Achievement Award for Clinical Excellence in Aerosol and Airway Clearance Therapies: Joseph L. Rau Jr., PhD, RRT, FAARC
- Philips Respironics Fellowship in Mechanical Ventilation: Edna Lee Warnecke, MSc, RRT-NPS, RRT-ACCS
- Charles W. Serby COPD Research Fellowship: Daneen Nastars, MSc, RRT-ACCS
- Vyaire Fellowship for Neonatal and Pediatric Therapists: Robert K. Gillette, MD
- Jeri Esierman RRT Professional Education Research Fellowship: Linda C. Schofield, PhD, RN
- William F. Miller MD Postgraduate Education Award: Kevin P. Collins, MS, RRT, RPFT, AE-C
- NBRC/AMP Gareth B. Gish Memorial Award: Marby McKinney, MEd, RRT-NPS, CPFT, AE-C
- Morton B. Duggan Jr. Memorial Education Recognition Award: Nkiruka M. Achionye
- NBRC/AMP William W. Burgin Jr. MD and Robert M. Lawrence MD Education Recognition Award: Nkiruka M. Achionye
- Jimmy A. Young Memorial Education Recognition Award: Melanie C. Walker



The Jimmy A. Young Medal was awarded to Robert Chatburn, MHHS, RRT-NPS, FAARC (right).



Michael Amato of the ARCF (left) presented the Education Recognition Award to: Nkiruka Achionye, Kevin Collins, Melanie Walker, and Marby McKinney.



The Forrest M. Bird Lifetime Scientific Achievement Award went to Jim Fink, PhD, RRT, FAARC, FCCP.



The Thomas L. Petty MD Invacare Award went to Kimberly Wiles, BS, RRT, CPFT, FAARC.



The Mike West MBA RRT Patient Education Achievement Award went to David Vines, MHS, RRT.

## 63rd International Respiratory Convention & Exhibition

- FAARC Designees: Bruce Bray, RRT, FAARC; Dan Conyers, MS, RRT, FAARC; Joseph Goss, MSJ, RRT-NPS, AE-C, FAARC; Jacklyn Grimball, MA, RRT, AE-C, FAARC; Keith D. Lamb, RRT-ACCS, FCCM, FAARC; Steve Mosakowski, MBA, RRT-NPS, CPFT, FAARC; Kathy S. Myers Moss, PhD, RRT-ACCS, FAARC; Harry Román Arroyo, MA, RRT, FAARC; Kimberly S. Wiles, BS, RRT, CPFT, FAARC
- International Fellows: Jinhao Tao, Martha Diaz, Alfred Aidoo
- Specialty Practitioners of the Year: Adult Acute Care, Donna Tanner, MHS, MBA, RRT-ACCS; Continuing Care/Rehabilitation, Mark W. Mangus, Sr., BSRC, RRT, RPFT, FAARC; Education, Monica A. Schibig, MA, RRT-NPS, CPFT; Long-Term Care, Ryan Stiles, BSRT, RRT; Neonatal-Pediatrics, Melissa K. Brown, BS, RRT-NPS, RCP; Respiratory Care Management, Dave Crotwell, BA, RRT-NPS, FAARC; Respiratory Diagnostics, Curt R. Merriman, BA, RRT, CPFT; Surface & Air Transport, Justin S. Misuraca, BS, RRT-NPS
- Honorary Membership: Russell Acevedo, MD, FAARC, FCCP
- Mallinckrodt Best Paper Award by First Author: Robert T. Dailey, MHS, RRT-ACCS
- Draeger Literary Award: Craig R. Wheeler, RRT-NPS
- Ralph Kendall MD Outstanding Site Visitor of the Year Award: Thomas Harding, MS, RRT, RPFT
- NBRC Albert H. Andrews Jr. MD Memorial Award: Sharon S. Ellis, MD
- Summit Award for Outstanding State Society: Respiratory Care Society of Washington
- Outstanding Affiliate Contributor: Hanns Billmeyer, BS, RRT
- Jerry Bridgers Delegate of the Year: Kari Woodruff, BSRC, RRT-NPS, FAARC
- Bill Lamb Award for Community Service: Brenda Basnight, CRT



The Héctor León Garza MD Achievement Award went to Neil MacIntyre, MD, FAARC.



Albert H. Andrews Jr. MD Memorial Award went to Sharon S. Ellis, MD.



Life Membership was awarded to Dr. Lynda Goodfellow, EdD, RRT, AE-C, FAARC.



Robert Daily, MHA, RRT-ACCS, and Craig Wheeler, RRT-NPS received Respiratory Care Literary Awards.



2017 International Fellows: Alfred Aidoo, Martha Diaz, Jinhao Tao.



Fellows of the AARC (FAARC): Kimberly Wiles, Harry Román Arroyo, Kathy Myers Moss, Steve Mosakowski, Keith Lamb, Jacklyn Grimball, Joseph Goss, Dan Conyers, and Bruce Bray.



Outstanding Site Visitor award went to Thomas Harding, MS, RRT, RPFT.



Outstanding Affiliate Contributor went to Hanns Billmeyer, BS, RRT.



Delegate of the Year went to Kari Woodruff, BSRC, RRT-NPS, FAARC.



The Summit Award went to the Respiratory Care Society of Washington.



These companies were awarded the AARC Zenith Award: Aerogen, Philips Healthcare, Vyair Medical, Fischer & Paykel, Tri-anim, and Monaghan.



Specialty Practitioners of the Year: Donna Tanner, MHS, MBA, RRT-ACCS; Mark W. Mangus, Sr., BSRC, RRT, RPFT, FAARC; Monica A. Schibig, MA, RRT-NPS, CPFT; Ryan Stiles, BSRT, RRT; Melissa K. Brown, BS, RRT-NPS, RCP; Dave Crotwell, BA, RRT-NPS, FAARC; Curt R. Merriman, BA, RRT, CPFT; Justin S. Misuraca, BS, RRT-NPS.

## Top Companies Receive AARC Zenith Awards

The AARC's Zenith Awards are presented to the companies that AARC members believe stand out from the crowd based on the quality of their products, accessibility of their sales staff, responsiveness, service record, truth in advertising, and support of the respiratory care profession.

Our 2017 Zenith Awards went to Aerogen, Fisher & Paykel Healthcare Inc., Monaghan Medical Corporation, Philips Healthcare, Tri-anim, and Vyaire Medical.

## Meet the AARC Officials

Newly elected leaders of the Association were installed during the Business Meeting. Karen Schell, DHSc, BSRC, RRT, RRT-NPS, RRT-SDS, RPFT, RPSGT, AE-C, CTTS, was installed as AARC president-elect. Tim Op't Holt, EdD, RRT, FAARC, and Lisa Trujillo, DHS, RRT, were elected directors-at-large. The Transport Section's new chair-elect is Olivia Jenkins, BHS, RRT-NPS.

This year's AARC House of Delegates officers include: speaker, Keith Siegel, MBA, RRT, CPFT; speaker elect, Teri Miller MEd, RRT, CPFT; secretary, Kerry McNiven, RRT; and treasurer, Dana Evans MHA, RRT-NPS. Jacklyn Grimbball, MA, RRT, AE-C, FAARC, is the past speaker.



## Unsung Heroes Receive Some Recognition

Many respiratory therapists do outstanding work for patient advocacy, and they ask nothing in return. Now a new award is recognizing their efforts. Christine Hartling, RRT-NPS, CPFT, of Utah, received the first-ever National

Respiratory Patient Advocacy Award during the Respiratory Patient Advocacy Summit on October 3 for her efforts to advance issues important to her patients.



Mitchell A. Baran Achievement Award went to Joseph Rau Jr., PhD, RRT, FAARC.



The Jeri Eiserman RRT Professional Education Research Fellowship was awarded to Linda C. Schofield, PhD, RN.



The Philips Respiroics Fellowship in Mechanical Ventilation was awarded to Edna Lee Warnecke, MSc, RRT-NPS, RRT-ACCS.



Sharman Lamka presented the new advocacy award to Christine Hartling, RRT-NPS, CPFT.

## Corporate Partners Get a Warm Welcome

The AARC welcomed the 2018 Corporate Partners to the meeting: CareFusion, Masimo, Medtronic, Monaghan, Philips Respironics, Draeger, Maquet, Teleflex, Boehringer Ingelheim Pharmaceuticals, AstraZeneca, Mallinckrodt Pharmaceuticals, ResMed, Fisher & Paykel Healthcare, and Sunovian. All but Sunovian also served as Corporate Partners in 2017.

AARC Corporate Partners comprise best-in-class organizations interested in supporting the goals and work

of the Association. The program provides respiratory care providers with information, insights, and innovative approaches to improve performance and advance the health of all patients.

Each Corporate Partner hosted a booth in the Exhibit Hall in Indianapolis, and attendees took advantage of the opportunity to visit with their representatives and learn more about the passion they have for our profession and our mission to move it forward. ■



Daneen Nastars, MSc, RRT-ACCS, received the Serby COPD Research Fellowship.



Bill Lamb Award for Community Service went to Brenda Basnight, CRT.



Russell Acevedo, MD, FAARC, FCCP, received Honorary Membership.



Hamilton Medical won "Best of Show" among the Exhibit Hall large booths.



Aerogen won "Best of Show" among the Exhibit Hall small booths.

# Extraordinary Events

The lectures and symposia on the program at the 2017 Congress kept everyone busy learning new information in the profession. But Congress is always about a lot more than just the content on the program itself. With an array of special events, attendees had the chance to do everything from advocate for patients to cheer on their favorite teams in the Sputum Bowl.

Photos by Lennie Sirmopoulos, Convention Photography, Tustin, CA





**AARC**  
CONGRESS 2017



## Congress Attendees Turn Out to Support the ARCF

The American Respiratory Care Foundation (ARCF) hosted its fifth annual fundraiser on the eve of the Congress, with people who arrived a day early filling the Lucas Oil Plaza Room at Indy's state-of-the-art sports mecca, the Lucas Oil Stadium, home of the Indianapolis Colts. Guests had the chance to network with colleagues, enjoy some great music and food, and get in the running for a number of fantastic prizes. The big prize winners were:

- David Hollowed, who took home a four-day, three-night getaway to Las Vegas, Williamsburg, Phoenix, or Orlando at a four-star Diamond Resort; and
- Stuart Heatherington, who won a \$100 gift certificate to his choice of the Osteria Pronto or High Velocity (restaurants located in the JW Marriott in Indianapolis).

Attendees were also able to purchase special tickets that included a behind-the-scenes tour of the stadium during the gala.

The event closed with a recognition of ARCF donors and with updates on the role that the ARCF plays in advancing the art and science of the respiratory care profession. The ARCF fundraiser event was sponsored by Vapotherm. ■



David Hollowed won the grand prize.



## Patient Concerns Top the Agenda at Third Annual Respiratory Patient Advocacy Summit

Patients are always front and center at the AARC Congress, and this year was no exception as respiratory therapists and other clinicians gathered with patients and caregivers for the third annual Respiratory Patient Advocacy Summit on October 3. As in the past two years, the event served as a great way to shine a light on the needs of people living with chronic lung disease.

The session began with a lecture by patient advocate Grace Anne Dorney Koppel, who has COPD and serves on the board of directors at the COPD Foundation. This year's Congress keynote speaker, Claire Wineland, followed with a presentation on living with cystic fibrosis and promoting patient advocacy.

Sharman Lamka, president and co-founder of The FACES Foundation, talked about the new National Respiratory Patient Advocacy Award, which is being jointly sponsored by her group and the AARC, then announced this year's winners. Christine Hartling, RRT-NPS, CPFT, of Utah, went home with the top prize. Jeff Cain, RRT, of Michigan and Jamie Causey, BSRT, RRT, AE-C, of North Carolina, were named as runners-up.

A moderated roundtable on patient advocacy led by representatives from the Alpha-1 Foundation, the

Pulmonary Fibrosis Foundation, the American Lung Association of the Midland States, the COPD Foundation, and the Pulmonary Hypertension Association rounded out the Summit.

The Summit was sponsored by Platinum Sponsors Sunovion and Boehringer Ingelheim; Silver Sponsors Gilead, Mylan, and Vertex; and Contributing Sponsor The FACES Foundation. ■



## Early Birds Get a Jump on Learning

AARC Congress 2017 kicked off on Wednesday, October 4, but plenty of attendees rolled into Indy a day early to take part in one of three great pre-courses aimed at delivering targeted information designed to boost their careers.

The day-long "Ultrasound-Guided Peripheral Access Course" covered all the bases for new and experienced

inserters alike. With both didactic and simulation training included, attendees walked away with the confidence they need to assume this role in their facilities. The course was sponsored by Teleflex.

The "RT Leader Workshop: Defining and Communicating the Value" ran during the afternoon and gave managers and other leaders the chance to learn more about the drive to replace volume with value in the respiratory care profession. Through both lecture and interactive sessions, attendees learned why they need to employ patient-focused respiratory care protocols and measure the results of their programs and services. The workshop was sponsored by Monaghan.

The AARC's "Preparing for a Pandemic: The Strategic National Stockpile — Mechanical Ventilation Workshop," which has been supported by a grant from the Centers for Disease Control and Prevention for a number of years now, provided attendees with another chance to get up to speed on the ventilators that will be called into action in the event of a natural or manmade disaster with a major respiratory component. ■



## CF Patient Advocate Claire Wineland Provides Inspiration in Keynote Address

Claire Wineland doesn't remember a time when she didn't have cystic fibrosis. Diagnosed as an infant, she has lived with the condition her whole life, and even though she just turned 20 this year, she's accumulated more insight into what it means to struggle through the adversity of a serious illness than most of us will amass in a lifetime.

In her keynote address on the first day of the Congress, she remarked that she doesn't remember a time when respiratory therapists were not a part of her life, and she told them how much she has appreciated them. "I was raised in hospitals. I have seen respiratory therapists pretty much every single day for years and years. I am incredibly honored to be here."

Claire's "living while dying" story began in earnest when she was 13 years old and had to be placed in a medically induced coma due to a severe infection she suffered after one of her surgeries. She became septic, and the infection attacked the weakest part of her body, her lungs. They put her on a ventilator and it didn't work. They put her on an oscillator, and it did work. As her family and friends surrounded her with prayers and well wishes, doctors gave her only a 1% chance of survival.

When she awoke from the coma three weeks later, she and her parents decided to start a foundation aimed at



Claire's Place Foundation champion Claire Wineland gave the AARC Keynote Address.

helping other families going through similar situations, and Claire's Place Foundation was born. Because it took many months to recover, and people helped her family through that difficult time, she wanted to give back and help give people the resources they need to make life be what they want for themselves. "We have to care about the quality of life. It was important to me that I had a life worth living and was giving something of myself and my experience to other people," she said.

Since then, Claire has dedicated her life to showing the world what it means to live with challenges and why it is so important to embrace them for the ability they have to channel inspiration. She urged the RTs in

the audience to do that in their own lives as well, and to be a guiding light for their patients who may feel too overwhelmed by their conditions to see how adversity can be the gateway to opportunity. She said that patients want to grow and learn and make something of themselves.

"I am here today to help change the conversation of how patients are treated. Please encourage them to make a life for themselves, to have solid ground. If there is a takeaway today, I hope you know that people who suffer most in life actually have the most to give. ■

## "Rally to Congress" Raises Funds for the ARCF

The companies that come to the AARC Congress are, of course, there to sell their wares. But many are there to support our profession, too, and that was in clear evidence in Indy as Draeger sponsored a "Rally to Congress" event that encouraged the motorcycle enthusiasts among us to hop on their bikes and roar into town, all in support of the ARCF. The bikers made a big splash at the Draeger booth in the Exhibit Hall as they donned commemorative t-shirts and gathered for a Harley-Davidson motorcycle photo op on Friday. Among the riders was newly elected AARC President-Elect Karen Schell, DHSc, RRT-NPS, RRT-SDS, RPFT, RPSGT, AE-C, CTTS. ■



## Technology Meets Savings in the Exhibit Hall

Respiratory care runs on technology, and our 2017 Exhibit Hall had all the latest equipment from the top names in the business. Congress-goers got the chance to see the full range of advances available to respiratory care departments and talk to manufacturers' representatives

about how they could best employ those advances in their facilities back home. For many, the Hall delivered big time savings, too, as they took advantage of special deals just for attendees. For some, the price breaks they got were enough to cover all or part of their meeting expenses ■



## Flag-Folding Ceremony Moves Attendees

The AARC has many members who have either served in our country's armed forces in the past or are serving today, and they all received special recognition in a Flag-Folding Ceremony that took place on the third day of the Congress.

This moving ceremony paid witness to the sacrifices these military members have made for all of us as they have protected our freedoms and way of life both here at home and in conflicts around the globe. Thomas Wallsmith, the only respiratory therapist known to have been killed in the line of duty, was among those called out for special recognition. He was featured in the cover story of the May 2017 edition of *AARC Times*. ■



## Plenary Sessions Cover Key Topics

The three biggest lectures during AARC Congress 2017 tackled some of our most pressing issues today.



### Thomas L. Petty Memorial Lecture

## Meeting the Challenge of COPD Care in the U.S.

Meilan K. Han, MD, MS, took the podium to give the Petty Memorial lecture on COPD, recognizing the people living with this chronic lung condition and the clinicians who are charged with their care. In addition to covering the many obstacles that still exist for those with the nation's third largest killer and what can be done to overcome them, she emphasized the role that can be played by RTs, noting they are increasingly central to the care of COPD patients. Dr. Han said, "The burden of COPD in the U.S. continues to grow. However, while progress has been made in diagnostics and therapeutics, improvements in quality of life for patients will depend on the actual implementation of care and an individual patient's access to that care."

Dr. Han is an associate professor in the department of internal medicine and medical director of the Women's Respiratory Health Program at the University of Michigan in Ann Arbor. ■



### Phil Kittredge Memorial Lecture

## Evaluating the Value of the Respiratory Therapist: Where Is the Evidence?

Respiratory therapists like to think of themselves as critical thinkers who can serve as physician extenders and work under therapist-driven protocols. But are we? Marin Kolleyff, MD, delved into those topics during his Kittredge Memorial Lecture, citing recent scientific studies to prove his points.

"Respiratory therapists are in a unique position to influence health care delivery in a number of settings to include acutely ill hospitalized patients and those with chronic conditions in ambulatory settings," noted the physician. He shared a number of clinical studies that have documented the value of RTs in everything from the performance of medical procedures to the application of disease management programs for COPD.

Dr. Kolleyff is a professor of medicine at Washington University in St. Louis and director of both the medical ICU and respiratory care services at Barnes-Jewish Hospital. ■



# REQUEST FOR PROPOSALS

## FOR AARC CONGRESS 2018



The AARC Program Committee invites everyone – members, nonmembers, and groups – to submit proposals for AARC Congress 2018 programs in Las Vegas, Nevada, Dec. 4-7, 2018.

**ALL PROPOSALS MUST BE SUBMITTED ONLINE AT  
AARC.ORG BY DECEMBER 31, 2017**

**Improved submission process – it's easy to submit your ideas!  
VISIT AARC.ORG**

## Donald F. Egan Scientific Memorial Lecture

# Caring for the Mechanically Ventilated Patient — A Patient-Centered Approach

The days when mechanically ventilated patients are always heavily sedated and immobilized are numbered, and Sangeeta Mehta, MD, explained why in the Donald F. Egan Lecture. In addition to covering the new ICU mindset, which calls for patients to be awake, comfortable, and able to mobilize whenever possible, she made the case that this more patient-centered focus results in better short- and long-term outcomes for patients and families alike. “Admission to the ICU and mechanical ventilation are difficult experiences for patients and their family members,” stressed Dr. Mehta. Her presentation highlighted important evidence related to comfort and sedation management, ICU delirium, mobilization, and the patient experience.

Dr. Mehta is an assistant professor of medicine at the University of Toronto and research director at the Mount Sinai Hospital ICU. ■



## Bright New Research Highlights the OPEN FORUM

Original respiratory care research conducted by and for RTs was in ample supply during this year's OPEN FORUM, with 12 poster and discussion sessions and two poster-only sessions that ran during the first three days of the meeting.

The grand finale took place on October 6, as Congress attendees heard from the presenters of the top abstracts submitted to this year's OPEN FORUM during the prestigious Editors' Choice Session. Here are the abstracts and authors included in this year's event —

- A Comparative Analysis of Ideal Body Weight Methods for Pediatric Mechanical Ventilation. Jeffrey R. Bilharz, BS, RRT, Boston, MA
- Evaluation of a Ventilator Bootcamp Improves the Knowledge and Skills Associated with Mechanical Ventilator Use During Inter-Facility Transport of Intubated Pediatric Patients. Teresa A. Volsko, MBA, MHHS, RRT, CMT-E, FAARC, Akron, OH
- Comparison of the RAM Cannula to Conventional Bi-Nasal Prongs in the Delivery of Noninvasive Respiratory Support to Very Low Birth Weight (VLBW) and Extremely Low Birth Weight (ELBW) Infants in the NICU. Cathy W. Hughes, RRT, Washington, DC
- Accuracy of Transcutaneous CO<sub>2</sub> Values Compared to Arterial and Capillary Blood Gases. Randy Willis, MBA, RRT-NPS, Little Rock, AR
- Laboratory Evaluation of Continuous Cuff Pressure Control Systems. Sherry Babic, RRT, Cleveland, OH
- Increasing ARDS Severity by Berlin Definition Reflects Overall Illness Severity. Richard H. Kallet, MS, RRT, FAARC, San Francisco, CA
- Prevalence, Knowledge, Beliefs, and Attitude of Waterpipe (Hookah) Smoking Among Health Care Students at a Southeastern Urban Research University. Mohammed M. Alqahtani, MS, RRT, Atlanta, GA
- Perspectives from COPD Subjects on Long-Term Oxygen Therapy (LTOT) Devices. Constance Mussa, PhD, RRT-NPS, Chicago, IL

The OPEN FORUM was supported by an unrestricted educational grant from Monaghan. Abstracts for the 2018 FORUM at next year's Congress in Las Vegas are due by June 1, 2018, so please send in your abstracts and become a part of this wonderful part of the profession. ■



## International Presence Continues To Grow

International attendees at AARC Congress 2017 shared their expertise with their colleagues from the United States throughout the week. In addition to three international speakers — Thomas Piraino, RRT, from Beamsville, Ontario, Canada; Stefano Nava, MD, from Bologna, Italy; and Sangeeta Mehta, MD, from Toronto, Ontario, Canada — the OPEN FORUM saw participation from 20 international providers, including:

Yuenan Ni, Chengdu, China  
Keisuke Morinishi, Tokushima, Japan  
Tetsuo Miyagawa, PhD, RRT, RPT, RCET,  
Yokohama Kanagawa, Japan  
Kazuto Aishima, Kanagawa, Japan  
Yusuke Chikata, PhD, Tokushima, Japan  
Hui-Ling Lin, MSc, RRT, RN, FAARC, Taoyuan, Taiwan  
Chao Chun Lai, Changhua, Taiwan  
Akira Shobo, PhD, MHSc, Fujimino Saitama, Japan  
Bshayer Ramadan Alhamad, PhD, Al Ahsa, Saudi Arabia  
Heng Lee Tan, MSc, Singapore  
Hsin-Ju Lin, Taoyuan, Taiwan  
Kun Ta Lee, MSRT, New Taipei City, Taiwan  
Hajed M Al-Otaibi, PhD, Dammam, Saudi Arabia  
Tetsuya Hasegawa, Yokosuka Kanagawa, Japan  
Fahad Holil Al Enazi, Riyadh, Saudi Arabia  
Chia-Chen Chu, MSc, CRT, FAARC, Taichung, Taiwan  
Yi-Hao Peng, MSc, Taichung, Taiwan  
Ching-Hua Su, Taichung, Taiwan  
Yalemzewod Assefa Gelaw, MPH, Brisbane, Australia  
Dario Mendoza Rome, MSc, Bogota, Colombia

All of these international colleagues joined our 2017 International Fellows — Jinhao Tao, from China, Martha Diaz, from Colombia, and Alfred Aidoo, from Ghana — at the annual international reception. There the 2017 Toshihiko Koga MD International Medal was presented to Norihiro Kaneko, MD, a longtime supporter from Japan of the International Committee of Respiratory Care and its initiatives. Dr. Kaneko is vice president of the Kameda Kyobashi Clinic in Tokyo and director of the pulmonary department at Kameda Medical Center in Kamogawa. He also serves as vice president of the Japan Respiratory Care Network.

Draeger, Teleflex, the National Board for Respiratory Care, AARC, and the AARC House of Delegates sponsored this year's International Fellowship Program. ■



ICRC Chair Jerome Sullivan presented the Koga Award to Norihiro Kaneko, MD.



The AARC international delegation.

# Sputum Bowl 2017 Was Fun and Exciting

Our annual Sputum Bowl competition is the place where respiratory therapists go to challenge their knowledge in the profession, and this year's competition was fierce as teams faced off during two days of preliminary rounds to see who would make the cut for the exciting Finals Night on Friday evening.

Special features like "Ask the Expert," "Risk/Reward," "Ask the Posse," and "Video Visuals" revved up the excitement during the competition, and the half-time show was a real jaw-dropper as Mark Toland, the top-booked medium in the United States and Canada who has appeared on NBC, WGN, and FOX, wowed the crowd with his combination of comedy, magic, and mind reading. This year's "Roaring '20s" theme, with costumes everywhere, added to the fun. The event was sponsored by Medtronic.

The Missouri practitioner team won the National Sputum Bowl, and the Texas team won the Student Sputum Bowl. Congratulations, Missouri and Texas! ■



Missouri won the National Sputum Bowl!



Medium Mark Toland entertained and amazed the audience (with a little help from an RT).



The Texas team won the Student Sputum Bowl!



# The Next AARC Congress Heads to Las Vegas December 4–7, 2018

AARC Congress 2017 proved to be just what attendees needed to recharge their professional batteries and get ready for the challenges that lie ahead in 2018.

The 2018 Congress be held in Las Vegas, NV. The meeting is set for December 4–7 — that’s Tuesday–Friday — next year, and it’s not too early to make your plans to attend. Like this year’s event in Indianapolis, the AARC be featuring the latest information in respiratory care along with our great Exhibit Hall filled with all the top names in the business and a host of special events aimed at boosting your career and fueling your passion for the profession.

Mark your calendar for December 4–7 and get ready to experience the greatest meeting of the year in Las Vegas. You can register now at [www.AARC.org](http://www.AARC.org).

Do you have an idea for a speaker or topic for the 2018 AARC Congress? Go to [www.AARC.org](http://www.AARC.org) and submit your RFP by December 31.

The Program Committee needs your input to ensure that the 2018 meeting covers the topics that matter most to you and your patients.



The 64th International Respiratory Convention & Exhibition



# See You Next Year!





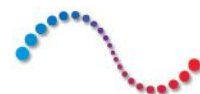
— 2017 —

Since 1947, the AARC has been leading the effort to advance the science and practices of the respiratory care profession while promoting the highest quality of care for our patients. Collaborating with the respiratory communities at-large, we have successfully advocated at the federal, state and local level for patients, their families, the community, the profession and the respiratory therapist.

# The AARC'S CORPORATE PARTNERS

The collaborative efforts between the respiratory care profession and manufacturers in pursuing unique and innovative ways to improve both the quality and outcomes of our patients makes us natural partners in today's ever changing health care continuum.

As health care finances become more strained and patient care becomes increasingly more complex, the mutual challenges become greater for the profession and its industry partners. The inherent synergies of the corporate partner concept are to provide an effective and efficient way to address those needs utilizing our combined skills and resources.





# Running Toward Chaos

by Debbie Bunch

## AARC Congress Closing Ceremony speaker shared her Boston Marathon story

When Natalie Stavas, MD, was a little girl, attention deficit/hyperactivity disorder (ADHD) had yet to be identified. So kids like her who had too much energy to settle down and do their schoolwork were baffling to their parents. Hers decided to conduct a little experiment. “Natalie,” they said, “go run around the block.”

In the Lincoln, NE, neighborhood where she grew up, that “block” was a good four miles in distance, and that little experiment more than did the trick. When she got back to the house, she was calm enough to tackle anything her homework had in store for her. It also turned her into a lifelong runner and inadvertently set her up for what would be a defining moment in her life as she approached the finish line in the 2013 Boston Marathon and heard the first of what would be two deadly bombs go off.

Dr. Stavas shared her story during the Closing Ceremony at AARC Congress 2017 in Indianapolis, leaving her audience awed by her actions and with a better understanding of why some people run toward chaos while others run away. Along the way, she also commended the members of her audience for the vital role they play in the nation’s health care system.

### Her RT connection

The physician’s journey from Lincoln, NE, to Boston, MA, took many twists and turns. She started her career as a critical care nurse and also served as a flight nurse. The latter role put her in direct contact with respiratory therapists on a regular basis, and she told the crowd how much she admires and respects their profession.

“I had the opportunity to work alongside brilliant respiratory therapists,” said Dr. Stavas. “They saved my butt on so many occasions.” She applauded the great program of lectures and symposia offered at the Congress and said she wished she could have attended many of them.

“I truly believe that your profession and your discipline have saved more lives and had more positive impact upon peoples’ lives than any health care professional I’ve ever

Dr. Natalie Stavas  
captivated the audience  
with tales of courage in  
the face of adversity.

come in contact with,” said the physician.

Dr. Stavas eventually decided to build on her nursing skills by enrolling in medical school at the University of Nebraska in Omaha. When it came time to do her residency, she wanted to specialize in pediatrics and she knew the best place to do that was at Harvard Medical School. Despite her advisor’s warning that people from Nebraska didn’t go to Harvard, she applied, and

she became the first from her state to ever be accepted into the pediatric training program at Boston Children’s Hospital, where she now works as a pediatric physician.

### Quick decision

Once she made it to Boston, attempting the Boston Marathon was really a no-brainer for this lifelong runner. Despite the 80-hour workweeks that came with her residency and all the stress that went along with them, she decided she’d run every year of her training. She was on her final residency run when she came up to the iconic “right on Hereford, left on Boylston” final turn at 2:59 p.m. on April 15.

“I heard the explosion, and I had to decide what to do,” said Dr. Stavas. As people streamed toward her yelling things like “bomb” and “sniper” and “attack,” she sprinted toward a public alley that ended at the site of the second bomb blast and was immediately faced with a severely wounded woman. Her only thought: “How am I going to bring this woman back to life?” She sprang into action, staunching wounds and providing CPR. She delivered life-saving care to four people that day, and three of them survived.

In the aftermath of the bombing, Dr. Stavas was interviewed by a number of reporters from news outlets ranging from the Boston Globe to the Los Angeles Times, and she also appeared on Anderson Cooper’s show on CNN. They all had one question she found hard to answer: Why did she run into such a chaotic situation?

She didn't know what to tell them. But the more she thought about it, the more she was sure they were really asking the wrong question. The right question was, "How do we teach society that chaos and challenges are not our enemy, but our opportunity to step up to the plate to make a difference in this world?"

### Finding the answer

In true health care professional fashion, she conducted a little research to find out. She interviewed dozens of first responders and discovered that the answer really lies in the brain. "In our brain we all have an area called the amygdala," explained the physician. One of the most primitive areas of the brain, it lights up like a beacon when people do something kind or courageous — essentially rewarding them for their positive actions through the release of dopamine, the same neurochemical that gives — surprise, surprise — runners the feeling of being high.

The amygdala is connected to the prefrontal cortex, which governs action, and the more people practice taking action in challenging situations, whether that be running a marathon or getting along with the in-laws at Thanksgiving, the more that connection grows. "Our brains are wired to reward us for being kind and selfless," says the physician.

Other research on telomeres — the caps on the ends of DNA — supported her theories as well. In 2009, said Dr. Stavas, Elizabeth Blackburn, MD, became the first investigator to look at the effects of stress on DNA by studying two groups of women: the first was not stressed and the second was extremely stressed. Most of the people in the latter group were caring for loved ones with Alzheimer's disease or other serious conditions. Dr. Blackburn found that most of the women in the extremely stressed group had short telomeres, which meant their DNA was aging at a faster rate. But a small subset of those women had the healthiest DNA of all the women in the study. Why? When questioned about their lives, they said they didn't find them challenging and instead chose to look at the upside of their situations and how grateful they were to be able to be helping to relieve the suffering of another person.

It was the first time, says Dr. Stavas, that research had linked a person's mindset to DNA. "The simple point I take from this is when we are faced with a situation we disagree with or we don't think we can handle, we only have two options — we run toward it and say, 'I'm going to give it everything I got,' or we run the other way."



Congress Closing Ceremony speaker Dr. Natalie Stavas.

### Bring your best self

Dr. Natalie Stavas chose to run toward the chaos on April 15, 2013, and three people lived because of it. A year later, she gathered with survivors of the bombing, her fellow first responders, and a plethora of others who helped out during the aftermath. For Dr. Stavas, who shares her philosophy about the value of helping others through a running program called Sole Train that she started for at-risk youth in the Boston area, the moment was cathartic. "We discovered how important we'd been to each other that day," she told her audience.

She urged the respiratory therapists in attendance to do the same in their everyday lives. "Never forget how important your actions are," she said. "When we commit to being courageous, to bringing our best self to any situation, everyone in this room will be incredibly fit to perform in any circumstance." ■

# Thank You, 2017 AARC *Times* Article Reviewers!

The AARC *Times* staff offers our sincere thanks to the people who took time to review the clinical articles in our publication throughout this year. Your special expertise and dedication

to the respiratory care profession were critical to our ability to publish informative articles for the respiratory care professional. Thank you, reviewers!

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## Executive Office Update

# The AARC Board of Medical Advisors Serves a Vital Role in Our Profession

by Thomas J. Kallstrom, MBA, RRT, FAARC

**T**he AARC has multiple layers that serve our members. You probably are not familiar with the acronym BOMA. BOMA stands for the Board of Medical Advisors, which is the AARC's physician advisory group that has been a part of the AARC leadership structure since the 1950s.

All BOMA members are representatives from medical associations and are physicians very familiar with, or work with, respiratory therapists in their facilities. Several of these physicians, in their early days, started out as respiratory therapists, so there is an intimate level of understanding of the respiratory care profession.

The original legacy representative associations were the American Society of Anesthesiologists (ASA), Society of Thoracic Surgeons, and American College of Chest Physicians (known today as CHEST). Later the American Academy of Pediatrics (AAP), American College of Allergy, Asthma and Immunology (ACAAI), Society of Critical Care Medicine (SCCM), and National Association of Medical Directors of Respiratory Care (NAMDRRC) joined BOMA. The Society of Thoracic Surgeons stepped away in the 1960s, as most of the practice of respiratory care was and still is not in the operating room.

BOMA members advise and support AARC initiatives on clinical matters with an eye toward the respiratory therapist's push for a higher level of professional recognition. Some examples of BOMA's involvement include:

- Promoting formal education. Back in the early days, the profession was made up of mostly men, known as *tank jockeys*, who moved H tanks of oxygen around the hospitals because many lacked piped-in oxygen. The AARC, with BOMA's help, was instrumental in the establishment of formal education programs. As a result, the duties expanded to the clinical arena.

- BOMA stepped up and assisted the Association with scope of practice issues both on the federal and state level, supporting AARC state societies' efforts for RT licensure that had begun in the 1980s. Today, 49 states have licensure. The primary purpose of state licensure is to protect patients by making sure respiratory therapists in that state meet the criteria to practice, as designated by law.

### about the author...



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

- BOMA worked with the AARC in the push for Medicare Part B recognition of the respiratory therapist.
- BOMA was supportive when our Association led the cause to disallow smoking tobacco in commercial aircraft. It was officially banned by law in the 1990s.
- BOMA is supportive in our current efforts to position the respiratory therapist as part of the telehealth team.
- BOMA is supportive of AARC's current efforts to see the current and future workforce move toward holding a bachelor and post-graduate degree.
- BOMA is supportive of our current push to establish the advance practice respiratory therapist.

BOMA continues to be committed to:

- Advising the AARC on any matter of concern to respiratory care brought forth by the AARC, its sponsoring organizations, or both.
- Advising and recommending to the AARC certain matters that its members and their sponsoring organizations consider appropriate.
- Being a primary conduit of information to and from the organizations represented on BOMA and our Association.

- Working with the AARC Board of Directors, its committees, and specialty sections, which are free to consult with BOMA members on any matter. However, BOMA approves all matters regarding medical issues, in accordance with the AARC Bylaws.
- Assisting the appropriate committees and specialty sections of the Association regarding medical programs, publications, and other matters. In fact, each of our specialty sections has a BOMA physician assigned as a liaison.

The current BOMA representatives include:

- **Chair** Lori Conklin, MD (ASA)
- **Chair-Elect** Neil MacIntyre, MD, FAARC (ATA)
- **Past-Chair** Robert Aranson, MD (CHEST)
- **Member** Russell Acevedo, MD, FAARC (CHEST)
- **Member** Steven Boas, MD (AAP)
- **Member** David Bowton, MD (CHEST)
- **Member** Robert Brown, MD (ATS)

- **Member** Ira Cheifetz, MD, FAARC (SCCM)
- **Member** Kent Christopher, MD, FAARC (NAMDRRC)
- **Member** Allen Dozor, MD (ATS)
- **Member** Loreta Grecu, MD (ASA)
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- **Member** Janet Liroy, MD (AAP)
- **Member** Terence Carey, MD (ACAAI)
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- **Member** Kevin Murphy, MD (ACAAI)
- **Member** Peter Papadakos, MD, FAARC (SCCM)
- **Member** Paul Selecky, MD (NAMDRRC)
- **Member** Ravi Tripathi, MD (ASA)
- **Member** Mark Yoder, MD (CHEST)

We appreciate all the efforts made through the BOMA partnership and are happy that we can work collaboratively with other like-minded medical associations. There is much work ahead but together, without silos, we will likely be more successful. ■

## BOMA Members Author Books for the Betterment of Patient Care

One of BOMA's current representatives, Dr. Peter Papadakos, who represents the SCCM, published a book earlier this year titled *Distracted Doctoring: Returning to Patient-Centered Care in the Digital Age*.<sup>1</sup>

Dr. Papadakos is professor of Anesthesiology, Surgery, Neurosurgery, and Neurology at the University of Rochester Medical Center in New York. His book explains that distraction is a diversion of attention as defined by Merriam-Webster. When patients are on the wrong end of a distracted clinician, bad things can and do happen. Sadly, in only the United States, over 400,000 patients die of a preventable death while in the hospital.<sup>2</sup> A distracted clinician certainly must contribute to this alarming number. Cell phones, computers, electronic medical records, and other electronic devices can help make

caregiving easier can also serve as significant distractions.

A few years ago, Dr. Papadakos presented a lecture on this very topic in a plenary session at an AARC Congress. As respiratory therapists, we work in places that are ripe for mistakes that would negatively impact the sickest of patients. We can play a role in identifying potential risks and work to remediate them.

Dr. Papadakos is one of many BOMA representatives for the AARC who have authored books and textbooks. ■



Dr. Papadakos

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2. A New Evidence-based Estimate of Patient Harms. Available at: [http://journals.lww.com/journalpatientsafety/Fulltext/2013/09000/A\\_New\\_Evidence\\_based\\_Estimate\\_of\\_Patient\\_Harms.2.aspx](http://journals.lww.com/journalpatientsafety/Fulltext/2013/09000/A_New_Evidence_based_Estimate_of_Patient_Harms.2.aspx). Accessed October 17, 2017



# RC Currents

IN THE NEWS



Every therapist has a story to tell about a favorite patient that may interest others in the profession. Our “Storytellers” column is the place to share these special moments and memories.

For AARC members who have recently retired, our “Reflections” column gives you the chance to look back at your career or some aspect of it and tell us what it meant to you and why.

So start thinking about how you can tell your colleagues about your experiences; send your story ideas to AARC Times Editor Marsha Cathcart at [cathcart@aac.org](mailto:cathcart@aac.org). ■

## EpiPen Agreement Lowers Price

Patients who rely on the EpiPen for rescue in case of a severe allergic reaction can now purchase the pen at a much lower cost. In an agreement reached with the Department of Health and Human Services (HHS), the manufacturer of the pen, Mylan, has agreed to use the correct reference price from the third quarter of 1990 to calculate inflationary payment rebates under the Medicaid Drug Rebate program. According to HHS, these changes will be effective retroactive to April 1, 2017. ■

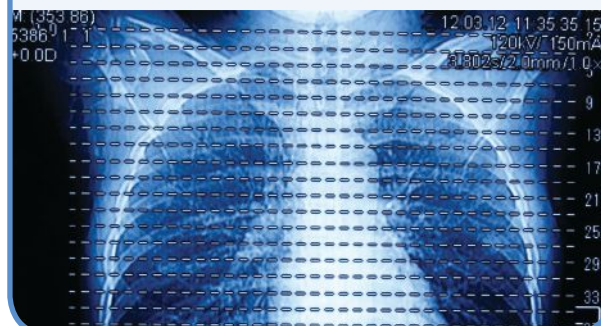


## Age Matters in Mechanical Ventilation

Researchers from the University of Georgia and Virginia Commonwealth University have developed a computer model to help scientists better understand changes in lung function and respiratory mechanics as people age and how they may impact mechanical ventilation.

Using magnetic resonance imaging and computed tomography scan data, the investigators created models of a 50-year-old’s and an 80-year-old’s tracheobronchial tree, bronchioles, and alveolar sacs, then performed computational simulations to estimate lung function of the models under mechanical ventilation. Lung compliance increased by 41% for the 80-year-old model when compared to the 50-year-old model, and the simulation also showed the elderly model was more susceptible to ventilator-induced lung injury due to changes in the mechanical properties of the lung as measured by pressure, wall shear stress, and tissue strain.

The authors believe their findings raise important issues to consider when using mechanical ventilation in elderly patients. “The ultimate goal of our research is to determine the patient-specific optimal settings for mechanical ventilation airflow that support breathing without harming the patient,” noted study author Ramana Pidaparti, from the University of Georgia. The study was published in *PLoS One*. ■





## Telemonitoring Program Improves CPAP Adherence

A telemonitoring program aimed at improving adherence to CPAP outperformed usual care or usual care plus online education in a study conducted among patients with obstructive sleep apnea, report Kaiser Permanente researchers publishing in a recent edition of the *American Journal of Respiratory and Critical Care Medicine*. At the end of the 90-day study, patients in the telemonitoring groups used CPAP 36–60 minutes longer each night than those in the non-telemonitoring groups.

The study involved 1,455 adult patients who were randomly assigned to usual care alone or usual care plus 1) online education, 2) telemonitoring with automated feedback, or 3) both online education and telemonitoring with automated feedback.

Usual care consisted of a one-hour small-group class covering home sleep-apnea testing and sleep apnea and CPAP education, along with a follow-up visit with a respiratory therapist after a one-week CPAP trial to review the data and ask about the patient's experience with the therapy. Those assigned to online education were invited to attend an online interactive program by email.

Patients in the telemonitoring groups received messages encouraging CPAP use by email, text, or phone based on each patient's preference. Messages were sent when CPAP use dropped below four hours on three consecutive nights and when the patient achieved Medicare adherence, which is defined as four hours or more per night on 70% or more nights during a 30-day period in the first three months of use.

The authors note that the telemonitoring strategy improved adherence with no additional provider intervention or staffing resources, making it cost-effective. ■

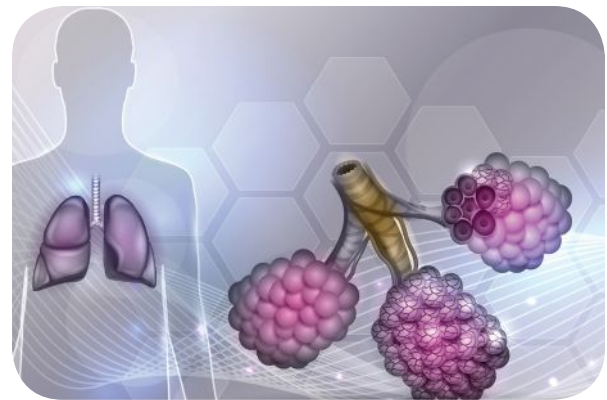
## In Search of More Precise Treatments for COPD and IPF

Researchers from the University of Pennsylvania are zeroing in on lung cell molecular pathways that either promote or inhibit tissue regeneration. The goal: find a more precise way to treat lung diseases like COPD and idiopathic pulmonary fibrosis (IPF).

Working in a mouse model, the team focused on mesenchymal cells, which are generally thought to play a supportive role in maintaining lung structure. They found five distinct cell types based on a suite of genes expressed by each and decided to focus on two, the mesenchymal alveolar niche cell (MANC) and the Axin2<sup>+</sup> myofibrogenic progenitor cell (AMP). MANCs are critical for the regeneration of lung alveoli. AMP cells generate cells called myofibroblasts that form scar tissue after injury and likely contribute to diseases such as IPF.

From there, the investigators determined which molecules are secreted by these two cell types and their surface cell receptors, and then they compared this information to databases of known secreted molecules and receptors on adjacent cells. Results showed MANCs are found in niches or compartments near the alveoli to promote renewal of gas-exchange cells. These cells may play a key role in maintaining the alveoli during the normal life span of the adult, and dysfunction or loss could contribute to diseases such as COPD. They found the main role of the AMPs is to form scar tissue during wound healing, but they can grow out of control, potentially leading to diseases such as IPF.

The researchers now plan to identify these cell types in humans and then find ways to target MANCs for promoting regeneration while inhibiting AMPs to reduce the fibrotic response after injury. They believe a better understanding of the detailed molecular differences between these two cell types may help in the development of the next generation of targeted therapies such as nanomedicine. The analysis was published recently in *Cell*. ■



## Antibody Treatment Cuts Acute Exacerbations by 20% in Some COPD Patients

Two international trials have found that an antibody treatment reduces the rate of acute exacerbations in a subset of patients with treatment-resistant COPD by 20%.

The two Phase III clinical trials evaluated the efficacy of mepolizumab, an antibody treatment that reduces the number of eosinophils in the blood by blocking the pro-inflammatory effects of interleukin-5. Patients included in the trials were still having exacerbations despite being on triple inhaled therapy with bronchodilators and glucocorticoids for a year.

The first trial, termed METREX, was conducted at 117 sites in 15 countries from 2014 to 2017. A total of 837 COPD patients were stratified by blood eosinophil counts and randomized to receive either 100 mg mepolizumab or placebo, delivered under the skin every four weeks for one year.

The patients with high eosinophil counts who received mepolizumab had a statistically significant 18% lower rate of moderate/severe exacerbations than those in the placebo group. The exacerbation rate in the low-eosinophil group treated with the biologic did not differ from placebo. The time to the first exacerbation was

longer with mepolizumab than placebo, but only in the high-eosinophil group.

In a second trial, termed METREO, the team assessed the effect of a higher dose of mepolizumab in 675 patients with elevated eosinophil levels. Patients were randomized to receive 100 or 300 mg mepolizumab or placebo, with the same delivery method and schedule as METREX. The exacerbation rate was reduced by 20% in the high-eosinophil group after 100 mg mepolizumab. The METREO results narrowly missed statistical significance. The 300-mg dose did not provide an advantage over the lower dose.

An analysis of data from both trials found that as baseline blood eosinophil counts increased, so did mepolizumab's reduction in the annual exacerbation rate, suggesting patients with higher initial eosinophil counts benefited more from mepolizumab than those with lower eosinophil counts. The safety profile of mepolizumab did not differ from placebo in either trial.

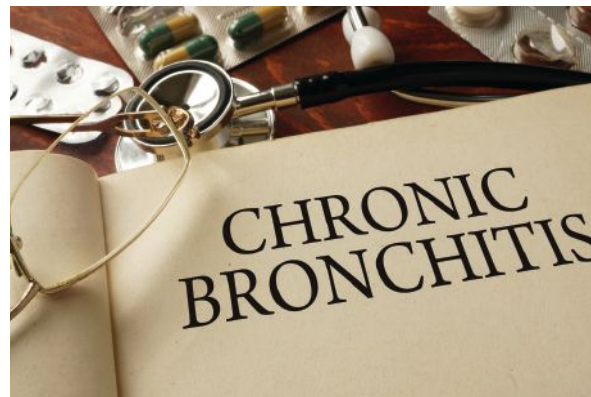
The analysis was published in *The New England Journal of Medicine*. ■

## Diagnosing Chronic Bronchitis

Chronic bronchitis is a common respiratory condition, but until now diagnosis has largely been based on patient symptoms. Researchers from the University of North Carolina believe they are on track to change that situation for the better. In a study published in *The New England Journal of Medicine*, they found that an inability to normally hydrate airway surfaces leads to increased mucin concentrations in people with chronic bronchitis and the accumulation of mucus in the lung. This process is responsible for the phlegm production and chronic airway infections typical of patients with chronic bronchitis.

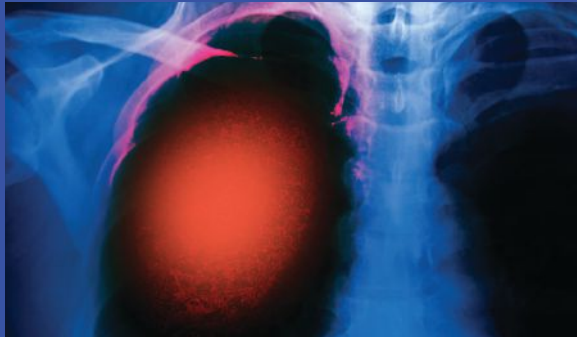
The investigators say their findings could form the basis for the first-ever objective marker of chronic bronchitis and the creation of diagnostic and prognostic tools. The research also raises the possibility that developing new drugs to reduce mucin concentrations could help relieve bronchitis symptoms and prevent disease progression in these patients.

“Until now, we have had little knowledge of what causes the airway mucus accumulation that plagues



chronic bronchitis patients, and the only way we have to diagnose chronic bronchitis is based on what the patient tells us,” says study author Richard Boucher, MD. “This study is a breakthrough in our understanding of this serious condition that affects millions of people in the United States.” ■

## Endobronchial Valve Treatment Improves Emphysema Outcomes



European researchers report good results for the first multicenter, randomized, controlled trial on a minimally invasive procedure for patients with emphysema. The one-way endobronchial valve (EBV) keeps air from entering diseased regions of the lung, allowing healthier regions to expand, improving lung function.

The study was conducted among 97 patients from 17 medical centers who were ex-smokers over the age of 40 diagnosed with severe heterogeneous emphysema. Sixty-five patients were randomly assigned to the EBV arm. On average, they received four valves to cut off diseased portions of their lungs that did not receive collateral ventilation. The other patients received the standard of care based on each medical center's protocols for caring for patients following bronchoscopy. Results showed:

- After three months, 55.4% of the EBV group had a clinically significant  $\geq 12\%$  improvement in FEV<sub>1</sub> vs. 6.5% of controls.
- After six months, 56.3% of those in the EBV group met that minimum FEV<sub>1</sub> improvement vs. 3.2% of controls.
- The average increase in FEV<sub>1</sub> in the EBV group was nearly 30%.
- After six months, secondary endpoints among those in the EBV group were also clinically and statistically significant, including being able to walk nearly 80 meters farther in six minutes, retaining 750 fewer milliliters of air upon maximum expiratory effort, exhibiting less shortness of breath on the modified Medical Research Council Dyspnea Scale, and reporting higher quality of life on the St. George's Respiratory Questionnaire.
- The most common adverse event in the EBV group was a collapsed lung, which occurred in 29.2% of the patients.
- After six months, 30 of the 32 participants in the control arm left the study and received EBV therapy.

The authors plan to continue to follow those who received EBVs for up to two years. The study was published in the *American Journal of Respiratory and Critical Care Medicine*. ■



## Lung Model To Assist with Research

Using an ex vivo lung perfusion system in a rodent, Columbia University researchers have developed a lung scaffold with functional bronchial and vascular architecture they believe will be helpful in research into human diseases of the lung.

In addition to assisting with lung repair, the lung model may help increase the number of donor lungs acceptable for transplant by finding ways to make those lungs more resilient and durable. The model will also be used to develop new targeted therapeutics and new imaging-guided lung evaluation strategies that can be employed in the clinical setting.

The research was supported by a \$8.2 million grant from the National Institutes of Health and published in *Science Advances*. ■

## 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 announce it to the membership and pay tribute. ■

## They Said They Quit, But Did They?

Can you believe what patients who take part in smoking cessation programs say about their tobacco use after the program is over? Maybe not, report University of Kansas researchers who conducted a six-month follow-up on patients who initially received bedside education on quitting smoking while they were in the hospital.

Among the 4,206 patients who completed the follow-up survey, 822 reported they had not smoked in the past seven days and also provided a saliva sample for cotinine testing. More than 40% of those patients tested positive for cotinine at levels very unlikely to have been caused simply by exposure to secondhand smoke.

The finding suggests that patient reports of quitting should always be confirmed by laboratory testing, particularly in scientific studies. "Participants may feel pressure to say they have quit when they have not, so it is essential in studies to verify claims of quitting using an objective test such as cotinine to know true quit rates," study author Taneisha Scheuermann, PhD, was quoted as saying. The study appeared in a recent edition of *Addiction*. ■



## One Night without CPAP

A new study out of Johns Hopkins has taken a look at how obstructive sleep apnea (OSA) affects physiological parameters like blood sugar levels and blood pressure while a person is asleep.

The investigators drew blood samples from 31 patients with moderate to severe OSA and who had a history of regular CPAP use every 20 minutes over a two-night study conducted in their sleep lab. Participants spent one night at the lab with CPAP and then the other after CPAP had been stopped for two nights, in random order. The nights were separated by one to four weeks.

The average age of the participants was 50.8 years old, and the average body mass index indicated obesity. Two thirds of the study group was male, and a quarter had a history of



non-insulin-dependent diabetes. Caucasians made up 64.5% of the participants, African Americans 22.6%, Asians 9.7%, and Hispanics 3.2%.

Results showed CPAP withdrawal caused recurrence of OSA associated with sleep disruption, elevated heart rate, and reduced blood oxygen. CPAP withdrawal also increased levels of free fatty acids, glucose, cortisol, and blood pressure during sleep. The more severe the OSA, the more these parameters increased. Glucose increased the most in patients with diabetes. Blood pressure increased and the arteries showed signs of stiffness the morning after the night without CPAP.

The study was published in the *Journal of Clinical Endocrinology & Metabolism*. ■

## These Factors Affect E-Cigarette Success in Helping Smokers Quit

Georgetown Lombardi Comprehensive Cancer Center researchers who looked at data from the largest national survey of current or recently quit smokers to date have found that e-cigarettes raise quit rates. However, they are more effective in certain people than in others.

Specifically, those who reported never having used e-cigarettes before the current quit attempt, and those who reported using the devices for five days in the past month, were more likely to have quit. The odds of quitting rose by 10% for each additional day of e-cigarette use. The survey was conducted among 24,500 people and was published in *BMJ*. ■



## Return to Flu Shot May Have Kept Kids from Getting Vaccinated

In response to new research showing the nasal spray version of the influenza vaccine may not be as effective in protecting children from the H1N1 strain of the virus, the Centers for Disease Control and Prevention recommended that all kids get the flu shot during last year's flu season. Researchers from Penn State College of Medicine believe that move may have contributed to a lower influenza vaccination rate among children during the 2016–2017 flu season.

Overall, total influenza vaccination rates in Penn State Pediatrics patients were 1.6% lower in 2016–2017 than in 2015–2016. Revaccination rates were even lower in children who had received the nasal spray the year before. If the numbers found in the Penn State study hold true across the nation, it could mean 1.2 million more unvaccinated children, 4,385 additional influenza-related outpatient visits, and 30 additional influenza-related hospitalizations. ■

## Post-Intensive Care Syndrome Common in ARDS

Patients who survive acute respiratory distress syndrome (ARDS) often come out of the experience with post-intensive care syndrome, a collection of debilitating symptoms that can linger for years. Researchers from Intermountain Medical Center, the University of Utah, and Johns Hopkins University who looked at ARDS survivors six months following their ICU treatment found a significant impact.

Overall, 22% of the patients had mildly impaired physical and mental health, 39% had moderately impaired physical and mental health, 15% had severely impaired physical health and moderately impaired mental health, and 24% had severe physical and mental health impairments.

Half of the subjects in the study still weren't living independently at six months, even though 91% had done so prior to contracting ARDS. The worst health status was

seen in Latina smokers. Latino nonsmokers fared the best. Severity of ARDS during the hospital stay did not impact physical or mental health findings. The study was published in *Thorax*. ■

Patient name : \_\_\_\_\_  
Address : \_\_\_\_\_ Phone : \_\_\_\_\_  
Height : \_\_\_\_\_ Weight : \_\_\_\_\_

### Diagnosis

*ARDS (Acute Respiratory Distress Syndrome)*



# Sputum Bowl – Upcoming Changes

Since 1978, the Sputum Bowl has been a key component in our annual AARC Congress meetings. Teams from across the United States compete for the coveted prize, and, best of all, bragging rights. It's fun to play, as well as to watch and cheer on the teams—a highlight for many attendees. In 2004, we made a change to our Sputum Bowl with the addition of the Student Division. While this division has exponentially grown in participation and excitement over the years, the Practitioner Division has seen a significant decline in participation. Therefore, in 2018, we are once again making a change to the Sputum Bowl: the discontinuation of the Practitioner Division.

In an effort to continue to enhance the growing student category, the AARC Sputum Bowl Committee made a recommendation to the AARC Board to discontinue the Practitioner Division. This decision comes after the committee implemented a variety of creative efforts in attempt to increase Practitioner Division participation. As a result, the AARC Board



voted to approve the committee's recommendation at its fall 2017 meeting, effective immediately. Beginning in 2018, the AARC Sputum Bowl will now consist of student teams only.

According to Renee Wunderley, BA, RRT, RRT-NPS, AARC Sputum Bowl committee chair, "This change, while disappointing, allows the committee to focus all of our efforts on building upon the competition which has widespread support from RT students around the country."

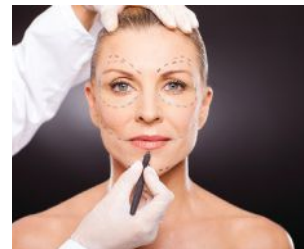
Thomas Lamphere, BS, RRT, RRT-ACCS, RPFT, FAARC, 2018 AARC program committee chair, insists the Sputum Bowl isn't going anywhere. "We look forward to the future as our

Sputum Bowl continues to remain a strong tradition and big part of the AARC Congress, and we are excited to see how the next round of students will perform," Lamphere said.

The Sputum Bowl Committee is already working hard on preparations for the 2018 Sputum Bowl in Las Vegas, NV. More details will be posted as they become available. Monitor the AARC website, newsletters and AARConnect for more information. ■

## Strange but True...

**The fix more than just skin deep:** Cosmetic surgeons generally require their patients to stop smoking for at least two weeks prior to their surgery. A new study finds that may be enough to help some people stop for good. About 40% of patients who took part in a post-surgery survey said they no longer smoked every day and about 25% said they had not smoked at all after their operations. Researchers at the University of British Columbia, Vancouver, weighed in with these uplifting study results.



**Speedy lifesaver:** A new handheld pen-like device developed by scientists at the University of Texas can detect cancerous cells while a patient is still on the operating table, thus helping the surgeon know what to cut away and what to leave intact. In a span of just ten seconds, the pen can sample molecules floating in the fluid found around cells and then analyze them to see if they contain cancer. A pilot study on the effectiveness of the device is planned for 2018. ■

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## My Career in Respiratory Care: It Was All an Accident!

by Stephen F. Wehrman, RRT, RPFT

*To air is human, to respire divine.*  
— Paul Thackara, RRT

### Part One: How I set out to become a nurse and turned into a respiratory therapy technician.

*By Accident.*

I was born in Los Angeles, CA, in 1955, the year Disneyland opened. I always liked science well enough, but when I had a chance to go to college, I decided on an English major. My dream was to become an English teacher. A friendly counselor told me that was foolish. “We have 750 applicants per position. You should go to work for Hallmark.” I dropped out of college, moved to Hawaii, and went to work.

I was washing dishes in a restaurant in Kailua-Kona when a friend of mine came in and said, “I’m going to Hilo to attend nursing school. Do you want to come?” Off I went to become a registered nurse. I did not enjoy nursing or nursing school, even though I learned a lot. I liked listening to this guy who worked at the hospital. He told the most wonderful stories about the emergency room and the ICU. He was a respiratory therapist. I knew I wanted to do that, but there was no respiratory school in Hawaii and I had to move back to Los Angeles.

I went to the community college but was told I had missed the deadline and would have to wait a year. Then I found The Valley College of Medical and Dental Careers. It was a nine-month technician program, and I could start right away! The cost was about \$3,000 and you did not have to pay it back until after you graduated. I was on my way. I thought, “Now I will have a good job so I can go back to school and fulfill my dream

of becoming an English teacher without starving!” I had no intention of doing this for more than a few years.

The moral of the story: Sharing your career and knowledge with others is important. As a respiratory therapist, you matter. People listen!

### Part Two: How I was cleaning equipment one day and became a respiratory therapist.

*By Accident.*

I got a job as an equipment technician at the hospital within a few weeks of starting my clinicals. I was paid \$4.25/hour and thought I was rich! I learned to clean and autoclave glass arterial blood gas syringes, process resuscitation bags, and completely strip and rebuild the MA-1 ventilator. After I reassembled the circuit, humidifier, and spirometer, I tested the ventilator for function. I was the only one in my class who had touched a ventilator!

We humble technicians were not allowed in the ICU or the ER. Nor were we allowed to draw ABGs or attend codes. One day I was standing outside the thoracic surgical ICU doing O<sub>2</sub> rounds when a nurse came flying through the double doors and shouted, “He’s dying, we need respiratory!”

When she saw me, she grabbed me and dragged me into the forbidden unit where I was certain to be fired for even entering. I saw the ventilator patient. He was blue and struggling, the alarms were going crazy, and I knew nothing about this at all! Except that a hose had popped off the Cascade humidifier. I immediately fixed the problem — I had started as an equipment technician after all. Then I ran back to the safety of my oxygen cart and waited to be fired. An hour later, I was sitting in the boss’s office and heard, “You are going to become a Technician II. You will start your classes next week.”

#### about the author...



Steve Wehrman is professor emeritus at the University of Hawaii Kapi’olani Community College in Honolulu, HI.

My teacher at the hospital-based program was the legendary Professor Julius Autry. He proceeded to teach me the advanced skills, but he also taught me how to assess and think critically. He was turning me into a therapist. One day over coffee, he asked me what I saw myself doing in five years. I said, “Teaching English at a college.” He replied, “Why not teach RT?” I asked him how I would do that, and he mapped the whole plan out on a napkin in the cafeteria.

I still have that napkin.

He also talked me into going back to school and getting my AS degree in respiratory therapy. In 1978, I attended the AARC Congress in Las Vegas. The lectures, the exhibits, the leaders — it was like seeing a whole new world . . . but when I saw the Sputum Bowl, I knew this was the profession for me and I joined the AARC. Respiratory therapy was fun!

The moral of the story: Mentoring is the most important thing we do professionally for our young respiratory therapists.

### **Part Three: How I became director of clinical education.** *By Accident.*

I had worked my way up to a technical director position but did not like the city, so in 1981 I moved from Los Angeles to Tacoma, WA, where I worked as a critical care therapist. I love adult emergency, trauma, and critical care medicine.

We had “mandatory” department meetings in those days. One day, I had to drag myself in for this meeting on my day off. During the meeting, the program director for the hospital’s technician program said, “We have to have two teachers from now on — program director and this new director of clinical education. If anyone is interested raise your hand.”

I raised my hand. Suddenly I was director of clinical education and manager of continuing education and quality assurance, two jobs for the price of one! I had never taught at a college before, and it was only an accident that I was there and got the job of a lifetime. Or was it? Remember the napkin? I had spent the last four years doing CPR classes, precepting respiratory students and pulmonary residents, giving in-services to RT and ICU staff, and developing protocols.

I also found another mentor: the amazing Ric Radford, one of the greatest RTs who ever lived! Did you ever use a closed-suction catheter on a patient on ventilation in the ICU? Ric invented that device and others. He also believed that the senior staffers, the leaders, have a duty to mentor the juniors and the new people coming up. I learned to do research and quality assurance, run meet-

ings, and give talks from Ric — this man elevated me to a new level in my profession.

The moral of the story: Prepare yourself for your dream job so you can grab the golden ring when your chance arrives.

### **Part Four: How I was shipwrecked on a small island and became program director.** *By Accident.*

In 1990, I was thrilled to move back to Hawaii as director of clinical education for the RT program in Honolulu. It was the opportunity of a lifetime, except that when I got there the department chair informed me I was now program director. “The other guy quit,” she said. “Oh, and I forgot to mention, the self-study for accreditation is due in one month.”

Lucky me! Once again I was cluelessly venturing into the unknown. But I did know one thing — I wanted to be the best program director I could be. I hit the books! I learned slowly and painfully. I consulted with the leaders in my profession and the AARC. I hired good people to help me and created a team. We worked tirelessly to elevate ourselves as teachers, our students as learners, and the Hawaii Society for Respiratory Care (HSRC). We started a mentoring program for students and one for new faculty at the college.

The moral of the story: Building our profession requires us all to work together.

### **Part Five: How I was given six months to live and reinvented myself instead.** *By Accident.*

After 20 years of being the program director, my arms became weak. My spine had gone to Tahiti without me! I was suddenly the patient, not the guy in the white coat. Neuromuscular and spine disease, fibromyalgia and sepsis — soon I was the person in the wheelchair being told I had six months to live.

I fired my doctor and I’m now 10 years past my expiration date. I had to quit the dream job, but I learned something valuable about myself during this experience. Of course, I learned what it is really like to be a patient, but I also learned that I was still an RT with something to offer, too.

I got a call from the folks at the HSRC. “Could you run for president? We really need you again.” So, I did that, and along the way, I got to learn how we could pass a bill all the way through the legislature and to the governor’s desk, where licensure for RTs became a permanent law! Working together as a team, a bunch of therapists accomplished the impossible.

One day I saw a therapist I knew from the hospital. He said, “Hey, Steve, Rehabilitation Hospital of the Pacific



wants to start a pulmonary rehabilitation program. Do you think you could help them?" This was my new opportunity of a lifetime. I was able to help create a PR program, something that Honolulu desperately needed! Who knew you could accomplish so much after hearing, "It's all over for you"?

My new dream is to start home-based PR so I can go out and help people where they live. I don't know exactly how to do this, but I'm going to figure it out. After all, I'm an RT — that's what we do!

The moral of the story: Every respiratory therapist has the chance to change the world!

**I ka hanu o' ke ola... In breath is life. — Motto of the Kapi'olani Respiratory Program**

So it seems like it was all a happy accident. But not everything in my career was due to chance. Early on, I saw a lot of trauma and death — maybe too much for a 20-year-old. I saw friends and colleagues suffer professional fatigue and burnout. I never burned out because I

vaccinated myself against this insidious condition. I had the antidote for fatigue. People asked me why I spent my weekend at an asthma camp or my day off talking to pink puffers or tutoring. That's easy — it was a no-brainer for me. I volunteered with the American Lung Association in 1975 and I never looked back.

Whenever you feel the burden of the job, or even of life, or when you face impossible challenges, you can make things better by helping others. I still help with my local lung club, not just because it helps others — it helps me, too. ■

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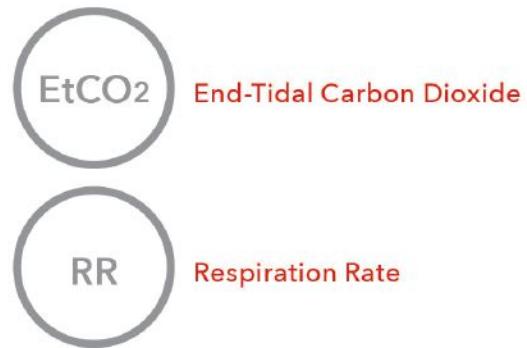
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