NOTES FROM THE CHAIR
by John M. Graybeal, CRTT

Greetings. By the time you receive this issue of the Bulletin, summer should be in full swing. As we enjoy the warm weather, it may seem like the AARC International Respiratory Congress, scheduled for December 6-9 in New Orleans, is still a long time in the future, but it will be here before we know it. I am looking forward to this 50th anniversary meeting of the AARC, and believe that it will be one of the most exciting ever. I hope to see you all there.

Not only is the 1997 Congress approaching, so is the time when the Program Committee will begin working on the program for the 1998 meeting. As you may or may not know, the Program Committee meets during the annual meeting to begin planning for the next annual meeting. As a specialty section, we have the opportunity to provide significant input into the content of the program. In order to maximize that opportunity, I am requesting your input now.

Please take a few minutes out of your day to consider topics that you think might be of interest to you or other respiratory care professionals. And don’t limit yourself—think big. There are considerable regional differences in clinical practice, especially within the Adult Acute Care Section. What may seem commonplace to you may be a very new and exciting topic for clinicians from another region. One of the functions of the annual meeting is to share information between clinicians. Suggesting a topic for the program is your opportunity to do just that. Call me, fax me, or e-mail me with your topic suggestions—just make sure I hear from you with your ideas.

On another note, I would like to thank everyone who submitted nominations for Section Member of the Quarter. As you all know, this is an important award, because our section’s Practitioner of the Year is selected from these nominees. So keep sending in those nominations! However, I do have one point of clarification: please make sure that the nominee is a member of the Adult Acute Care Section. This is a basic requirement for the award, and, unfortunately, several of the people nominated this past quarter were ineligible because they were not section members.

In keeping with the AARC’s 50th anniversary, I would like to feature a special section in the Winter issue of the Bulletin on the past chairs of the Adult Acute Care Section—where are they now and what are they doing (professionally)? Remember Benson, Branson, Hess, Burchfield and Campbell? If you have any current information or interesting stories from the past regarding these pioneers in our section, please share them with your fellow section members by mailing, faxing, or e-mailing them to me at the addresses/number listed on the last page of this issue.

Until the next issue, let’s all hang in there (together) . . .

SECTION MEMBER OF THE QUARTER: MARGARET WEEETER, RRT

Our Section Member of the Quarter for the summer quarter is Margaret Weeter, RRT. Margaret is clinical specialist in the medical ICU at Hershey Medical Center, which is part of the Penn State Geisinger Health Care System. Her responsibilities include staff supervision, patient care, and education (for staff, patients, and families).

Margaret is known throughout the medical center for her very caring attitude and her willingness to go “above and beyond expectations” when dealing with critically ill medical patients and their families. Along with this exceptional level of caring, she is also respected for the depth of her clinical knowledge and her ability to communicate with physicians and other clinicians. As if that was not enough, Margaret has been instrumental in the development and implementation of therapist protocols, including a mechanical ventilation weaning protocol. Way to go Margaret! Keep going that extra mile!

AARC URGES CAUTION AS FDA PROCEEDS TOWARD CFC-FREE METERED DOSE INHALERS

The AARC recently provided comments to the Food and Drug Administration on their Advanced Notice of Proposed Rule Making regarding changes to regulations affecting the

Deadlines for submitting copy for publication in the Bulletin—

Spring Issue: February 1  Summer Issue: May 1
Fall Issue: August 1  Winter Issue: October 1
propellant in metered dose inhalers (MDIs).

The FDA is seeking to implement the Montreal Protocol, a pact that will ultimately result in a worldwide ban on chlorofluorocarbon (CFC) products. CFC ingredients are the propellants that are used to deliver medications to patients suffering from asthma, emphysema and other diseases through an MDI. Respiratory therapists are in the forefront of health care providers who educate and train patients to properly use MDIs.

The FDA is seeking to phase out current CFC products as CFC-free propellants become available. However, in a letter from AARC President Kerry George, the association warned the FDA about not removing current products from the marketplace until appropriate alternate products are widely available. In his letter to the FDA, George says, “We believe patients and the physicians who prescribe the MDIs must have a wide range of options until an equally wide range of CFC-free MDIs are available. Elimination of a particular active ingredient after 12 months of a CFC-free alternative, will not afford this necessary range of options.”

George also stated that Medicare has discontinued large and small volume nebulizers and hand-held ultrasonic nebulizers as covered devices. This policy “has the result of transferring hundreds of thousands of Medicare patients from clinically effective and appropriate MDI alternatives into using MDIs. We believe this will make the FDA’s goal of easing the transition to CFC-free MDIs more difficult, because usage and dependence on current MDIs have now tremendously been increased,” said George.

He also urged the FDA to work with and educate Medicare policymakers on the inappropriateness of this Medicare regulation.

**ARCF “Silent Auction” Offers RC Managers the Chance to Acquire Equipment and Supplies at a Discount**

In an effort to increase the amount of funds available for important research projects and other programs aimed at positioning the RCP for success in the managed care environment, the American Respiratory Care Foundation is planning to conduct its first-ever “Silent Auction” during the AARC’s 43rd International Respiratory Congress, scheduled for December 6-9 in New Orleans, LA. All AARC members and officially registered attendees at the Congress will be eligible to bid onsite or they may participate in the pre-meeting bidding that will take place November 1-30.

While many of the items at the auction will be geared toward individual bidders, much of the inventory will consist of respiratory equipment and supplies designed to appeal to respiratory care managers working under increasingly restrictive budget constraints. Since opening bids for all donated items will be set at approximately 25% of retail value, the Silent Auction offers an outstanding opportunity for managers in all care settings to acquire much-needed equipment at discounted prices.

RC managers or others with purchasing authority are encouraged to take advantage of this opportunity by working with their purchasing departments now to acquire the necessary purchase requisitions. In most cases, auction items will be shipped directly by the donor to the individual or institution with the winning bid.

A preliminary catalog of items will be included in the October issue of AARC Times to assist bidders in planning for the bidding process and to allow those unable to attend the Congress the opportunity to participate in pre-meeting bidding. A final catalog of items will be distributed at the meeting in December.

All funds raised by the auction will go directly into the ARCF’s unrestricted fund supporting educational grants, research projects, practice surveys, consensus conferences, and other philanthropic programs.

The Foundation is currently soliciting items for the auction from a variety of sources and plans to have a wide selection of products in all price ranges available for bidding. The solicitation of items for the auction will continue through September 30. Anyone wishing to donate an item (minimum estimated value of $100) may do so by contacting Brenda DeMayo at the ARCF Executive Office at 11030 Ables Lane, Dallas, TX 75229, (972) 243-2272.

**FYI...**

**Mayo Clinic study looks at lengthening life of CABG grafts**

Nearly 20% of the 300,000 CABG operations performed in the U.S. last year were done to replace aging bypass grafts that had become clogged with the same fatty deposits that necessitated the original procedure. Now researchers from the Mayo Clinic think they may have a solution to the problem.

In a study involving dogs, they have found that “sodding” the inside of a semipermeable coronary artery bypass tube during surgery with a uniform covering of the patient’s own epithelial cells may keep the tubes clearer longer. The epithelial cells, which adhere to the inside of the tube after about a seven minute application of three to five pounds of pressure per square inch, naturally inhibit plaque formation. So far, the dogs who have undergone the procedure have exhibited healthy epithelial linings in the tubes for at least five weeks. (Source: Science News, 4/19/97)

**DOTS program to be implemented worldwide**

World Health Organization officials believe a new tuberculosis program that cut the number of people carrying multiple drug-resistant TB in New York City in half will be able to prevent some ten million TB deaths worldwide over the next ten years.
Indian researchers find pulse oximetry useful in assessing diabetic patients with autonomic neuropathy

Researchers from India have found that pulse oximetry may be an easy and inexpensive way to assess autonomic function in patients with diabetes. Although all of the patients in their study (seven diabetic patients with autonomic neuropathy, eight diabetic patients without autonomic neuropathy, and 12 normal controls) had normal basal percentage oxygen saturation, the fall in percentage oxygen saturation was slower and less intense on exposure to cold in diabetic patients with autonomic neuropathy. That group also failed to exhibit a rebound rise in oxygen saturation. (Source: Reuters Medical News, 3/20/97)

ECG patterns may help in the diagnosis of pulmonary embolism

A study of 80 patients in France has found that an ECG pattern of subepicardial ischemia (inverted T waves) in the precordial leads is the most frequent ECG sign of massive pulmonary embolism. T wave inversion is also best correlated with severity of the embolism, and inverted T wave changes are closely correlated with changes in pulmonary embolism. Researchers from the University Hospital in Nice analyzed the ECG patterns both on admission and during hospitalization to arrive at their findings. The study was published in a recent issue of Chest. (Source: Reuters Medical News, 4/3/97)

Free market approach to hospital closures leaves something to be desired, says report

Taking a market-driven approach to health care is supposed to result in lower costs and greater access to care, but a recent report from Boston University researchers on the effect of the free market on hospital closures in Massachusetts begs to differ. According to the report, titled “Before It’s Too Late: Why Hospital Closings Are Becoming A Problem, Not A Solution”—

- Hospital closings are more likely to take place in under-served areas, thus compounding the access problem.
- Hospital closures may actually lead to increasing costs because, in most service areas, only one hospital remains, creating a geographic monopoly that results in less care for fewer patients at higher costs.
- Hospital closures may also increase costs because, in some cases, outpatient care can actually be more expensive than inpatient care. Specifically, the report cites ambulatory surgical centers, which are becoming mini-hospitals as providers realize that it’s cheaper to care for post-surgical patients onsite than through home care and outpatient follow-up. (Source: Reuters, 5/21/97)

Reusing disposables may be risky business, says FDA

Sterilizing and reusing medical devices manufactured as disposables has become a cost-cutting measure at many hospitals, but the Food and Drug Administration may soon put a damper on the practice. A preliminary study by the FDA has turned up numerous incidents where reusing disposable devices such as cardiac catheters has resulted in infections, chemical injuries, and mechanical failures. Since there aren’t any government regulations controlling the practice of reusing disposable devices, the FDA plans to meet with the Health Care Financing Administration and the CDC to see if such intervention is warranted. The FDA also plans to continue its research into the area to see if stricter controls on sterilization of such devices might solve the problem. (Source: Hospitals & Health Networks, 3/20/97)

Nicotine patch can lead to long-time quitters, says study

When the nicotine patch works, it works well, or so says a new study conducted by researchers from the University of Nebraska Medical Center. They found that patch users who refrained from smoking for one year were highly likely to still be nonsmokers three and four years later.

Researchers reviewed the data from a study done several years ago that analyzed the one-year quit rates of more than 700 smokers who used either a nicotine patch or a placebo patch, then contacted those who had quit successfully for a year to see how they were faring three or four years down the line. They found that long-term quit rates correlated with the dosages of the patch regimens employed in the original study. Among the 28 percent of successful quitters in the original group who had used the 21 milligram patch, 20.2% were still ex-smokers at the four to five year follow-up. In the 18.8% of the original group that had quit successfully for a year using the 14 milligram patch, 10.9% were
smoke-free at the follow-up. The one and 4/5 year quit rates for those using a placebo patch in the original study, however, were just 10.4% and 7%, respectively.

Interestingly, the study also found that older smokers fared better in the study than younger smokers. Across the board figures found that just 3% of smokers under 30 were still refraining from the habit at the four to five year follow-up, compared with 16% of those over 30. The study was presented at the American Lung Association/American Thoracic Society International Conference in May. (Source: Reuters, 5/20/97)

Don’t blame the elderly for America’s health care woes, says report

End-of-life costs for the elderly have been blamed, in part, for our health care system’s continuing fiscal crises, but a new analysis of aging studies conducted by the Alliance for Aging Research (AAR) indicates that they may be getting a bum rap. According to the report, titled “Seven Deadly Myths: Uncovering the Facts About the High Costs of the Last Year of Life”—

- Americans age 85 and older have the lowest average Medicare costs in the last year of life than any other group.
- The amount that Medicare pays in the last year of life drops sharply after age 65.
- Last-year-of-life health care costs for those 85 and older are nearly a third less than for those between 65 and 74.
- Most Medicare costs incurred during the last year of life are for routine hospital and nursing home care, not high tech, high cost futile services.
- Heroic care is provided to just 3.5% of Medicare patients who die in a given year.
- If heroic care was eliminated, the Medicare program would save only about 6% of its total outlay.
- If physicians could predict which patients were destined to die and, thus, which treatments could be eliminated because they were useless, less than 1% of the nation’s trillion dollar annual health care bill would be saved.

Says AAR Director Daniel Perry, “The great unappreciated reality is that we are not taking very old frail people with Alzheimer’s disease and cancer and giving them cardiac bypass operations...the oldest of the old may be the least of our worries in controlling health care.” (Source: Reuters, 5/8/97)

Critical care nurses cling to outdated position

Researchers who surveyed 1,000 randomly selected members of the American Association of Critical-Care Nurses found that about 80% still believe that the Trendelenburg position improves hypotension, even though current literature does not support use of the position. About 500 nurses responded to the survey, which was conducted at the West Virginia University in Morgantown.

According to lead author Dr. C. Lynne Ostrow, most of the nurses reported learning the technique in nursing school, although about a third cited the literature as the source of their information about the position. She believes the current trend in hospitals to have nurses take on responsibility for greater numbers of patients may be partly responsible for the tendency of nurses to rely on traditional care methods rather than updated scientific evidence. “As nurses are encouraged to do more with less in a shorter time, providing support for nurses to remain current with the knowledge base that undergirds their practice is a particular challenge that awaits practical solutions.” The study was published in the American Journal of Critical Care. (Source: Reuters, 5/12/97)

ICUs harbor more antibiotic-resistant bacteria than other settings

Hospital inpatient areas harbor greater numbers of antibiotic-resistant bacteria than outpatient clinics, and ICUs are the worst offenders, says a new report from the Centers for Disease Control and Prevention and Emory University’s Rollins School of Public Health.

While the report notes that patients admitted to ICUs have more complicated medical problems that make them particularly vulnerable to nosocomial infections, it stresses the fact that the treatment of patients with multiple antibiotics is a major part of the problem. “Moreover, antimicrobial resistance in pathogens is more likely encountered in the ICU because of the...effect of treatment with multiple antimicrobials for a single patient, which may result in amplification of antimicrobial resistance in organisms.” The report suggests several methods to curb the spread of such infections in the ICU, including—

- Allocating more resources to stem the problem
- Developing more surveillance activities
- Enforcing scrupulous and stricter infection controls
- Improving use of antibiotics

(Source: Reuters, 4/29/97)

DA issues new standards for cables and leads

New safety standards applying to electrical cables and leads used with medical devices such as breathing, heart, and brain wave monitors have been approved by the Food and Drug Administration. The standards, which are based on international standards, call for these wires to be “protected” so that they cannot be mistakenly plugged into electrical outlets, thus causing death or injury to patients through burning or electrocution.

The new wires must have an electrode at one end that attaches to the patient, with the other end equipped to go into the medical device. The FDA, which says that many manufacturers are already protecting their cables and leads vol-
untarily, plans to phase the new standards in over the next three years. The riskiest medical devices, however, will have to meet the new standards within a year. (Source: Reuter, 5/8/97)

Add your name to the list: RCPs can assist AHCPR by signing up to review grant applications

Since its inception in the late 1980s, the Department of Health and Human Service’s Agency for Health Care Policy and Review (AHCPR) has provided important funding and oversight for a wide range of research efforts aimed at identifying best medical practices. Every year, hundreds of health professionals across the nation assist the agency in that goal by serving as reviewers in the peer review of research grant applications. If you would like to add your name to the list, please forward a current curriculum vitae to: AHCPR, Office of Scientific Affairs, Attention: Bonnie Edwards, 2101 East Jefferson Street, Suite 400, Rockville, MD 20852, or fax your CV to Bonnie Edwards at (301) 594-0154. (Source: Research Activities, 3/97)

AARC Comments On Salary Equivalency Guidelines

The AARC recently provided comments on the proposed Salary Equivalency Guidelines issued by the Health Care Financing Administration (HCFA). The proposed guidelines, which would cover physical therapy, speech language pathology, occupational therapy, and respiratory therapy, were published in the March 28, 1997 Federal Register.

The AARC expressed concerns about three aspects of the proposed rules—
1. The compression of the registered respiratory therapist (RRT) and the certified respiratory therapy technician (CRTT) professionals with non-credentialled workers into one generic category of “respiratory therapy.”
2. The methodology and data sources used to determine the proposed respiratory therapy salary equivalencies.
3. The disregard of added costs imposed by respiratory therapy’s unique Medicare transfer relationship between a hospital and a skilled nursing facility (SNF).

In a letter to Bruce Vladeck, HCFA administrator, from AARC President Kerry George, the AARC went on record as opposing the adoption of the salary equivalency guidelines.

In commenting on the single level respiratory therapy category, George said, “The single category does not account for the higher level of compensation an RRT receives, nor the propensity for SNFs to utilize the advanced RRT practitioner with experience.”

In addition, the methodology used to determine salary equivalency rates for all of the therapy professions does not represent an equitable calculation. “The Medicare transfer agreement requirement limits the efficiency of providers in contracting for respiratory therapy services; a unique set of circumstances not faced by other therapy professions,” said George. “This must be addressed in the regulation.”

AARC Raises Concerns On Conditions of Participation That Restrict Home Respiratory Care Services

The AARC recently provided comments on proposed revisions to the Medicare Home Health Agency Conditions of Participation, applauding the Health Care Financing Administration (HCFA) for the proposal’s flexibility, but admonishing them for allowing only nurses or physical therapists to provide skilled respiratory care as a home health benefit.

“The Conditions continue to ban the one professional who possesses documented competency to deliver such services, the respiratory care practitioner,” said AARC President Kerry George in a letter to HCFA administrator Bruce Vladeck. “This is tantamount to providing a nursing benefit and prohibiting nurses from delivering it, or a physical therapy benefit prohibiting the physical therapist from providing the service.”

According to the Medicare Home Health Manual (the implementing guidelines for the Conditions of Participation), intermittent skilled respiratory therapy visits are a covered service, but only if provided by a nurse or physical therapist.

As part of its comments, the AARC provided Mr. Vladeck with information about the lack of any formal education or competency documentation in respiratory care for any other health providers, and also provided data showing the positive economic and clinical benefit of respiratory care practitioners. Statements from the American Society of Anesthesiologists and the National Association for Medical Direction of Respiratory Care also endorsed the need to use respiratory care practitioners to render respiratory care services.

In addition, the AARC raised the following concerns—
• That the Medicare guidelines are contradictory. The Medicare Hospital Conditions of Participation clearly recognize the critical nature of respiratory care services by establishing a standard of care that requires that there be adequate numbers of respiratory therapists and respiratory therapy technicians to provide these services. Yet Medicare is contradicting itself by not requiring this same standard outside of the hospital.
• That the current Medicare regulations are working against the dynamics of integration of care across all care settings. And at a time when higher acuity patients are being discharged from the hospital, patients must continue to have access to qualified health care providers in the post-acute settings.
• That HCFA is permitting Medicare beneficiaries to receive complex respiratory care by nurses and physical therapists who do not have to demonstrate any respiratory care competency.

The AARC did praise HCFA for turning their focus to providing care in the most appropriate setting, thereby incorporating a flexibility and coordination of services heretofore missing from Medicare standards.
Please check the type of accreditation visit you are reporting:

Pathology & Clinical Laboratory Services ☐
Home Care ☐
Hospitals ☐
Long Term Care ☐

What was the surveyors' focus during your last site visit?

What areas were cited as being exemplary?

What suggestions were made by the surveyors?

What changes have you made to improve compliance with the guidelines?

Please offer any additional comments about the site visit that will be helpful to others. (use additional sheet if necessary)
**OUTSTANDING SECTION MEMBER OF THE QUARTER: NOMINATION FORM**

Don’t forget to make your nominations for the Adult Acute Care Outstanding Section Member of the Quarter award. The winner of each Outstanding Section Member of the Quarter award will be featured in an article in the Bulletin and our Specialty Practitioner of the Year will be chosen from these four winners. The winner of the Specialty Practitioner of the Year award will be honored during the Awards Ceremony at the AARC International Respiratory Congress.

The recipient of this award will be determined by the Section Chair or a selection committee appointed by the chair. Each nominee must be a member of the AARC and a member of the Section.

Use the following form to send in your nominations for this important award—

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Mail or FAX your nomination to the Section Chair at the address/number listed on the last page of this issue.
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