Home Care Bulletin

Nov./Dec.'98

American Association for Respiratory Care

Notes from the Chair

by Nicholas Macmillan, RRT

When I first took on the role of Home Care Section Chair, I had no idea of the significant changes that would come about regarding our specialty. Nor was I certain of the skills I had, or would need, to bring some semblance of success to my tenure. Finally, I did not realize just how many people rely on the Home Care Section network. Suffice it to say, I was naïve.

Being naturally retrospective as I write my final "Notes from the Chair," I don't believe being naïve is a negative quality - in this role, or in many others, for that matter. Sure, there's the learning curve thing, but I have found my peers helpful and understanding. Then, there are the toes I've stepped on, as well as those I have found in my mouth. But, again, I am fortunate to be working among a forgiving and understanding lot. What is positive about being naïve, then?

First of all, there's freshness and objectivity, which are necessary to address challenging issues. Secondly, there is energy, which is needed to avoid the fatigue that can be brought on by these unrelenting issues. Finally, there is need for assistance from others, knowing that one person cannot know all the answers.

The freshness, objectivity, and energy I brought willingly to the job. I hope they met your expectations. The assistance was the gift many of you willingly offered. Space will not allow me to list the names of all the guest editors, contributors, consultant panel members, and other volunteers who have assisted me over the last two years. But please know your efforts have contributed to this section's continuing success, and I am very grateful!

Regarding the two years that lie ahead: the section will be left in the able hands of Joe Lewarski, an RRT practicing home care in the Cleveland, OH area. Joe is an avid promoter of respiratory care in the home and steadfast in writing about and supporting the economical justification of respiratory therapists in home care. His section goals will mirror this advocacy, and I look forward to working with him as the section continues to build momentum.

In closing, I expect you may be looking forward to the years ahead too, both personally and professionally. Therefore, I will leave you with a quote that I hope will be as powerful an inspiration for you as it has been for me:

What would you attempt to do if you knew you could not fail? - Robert Shuller ■

Complying with FDA Regulations for Medical Gases

Medical gases such as oxygen are classified by the Food and Drug Administration (FDA) as drug products because they are used to treat medical conditions and must be dispensed under a physician's prescription. The medical gas industry is classified by the FDAas a group of "drug manufacturers." This means we (the industry) start with a raw material (bulk oxygen) that we process, place into consumer-sized containers, label, and deliver to a patient (consumer).

The FDA is charged with ensuring that the medical gas industry complies with laws passed by Congress to protect the public's health. The Food, Drug & Cosmetic Act (FD&C Act), Section 50.1 (a) (2) (B) requires that the methods used in the manufacture,

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processing, packing, or holding of medical gases, and the facilities used for medical gases, conform to current Good Manufacturing Practices (CGMP).

CGMP regulations outline the practices to which the medical gas industry must comply. They represent minimal requirements which, if not followed, will result in violation of the FD&C Act. Compliance assures that the oxygen we "manufacture" meets the required quality and purity characteristics.

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CGMP requirements are outlined in *Fresh Air '98: A Look at FDA's Medical Gas Requirements.* This document can be obtained by calling the FDA at (202) 443-1544 or on the FDA's web site at http://www.fda.gov/cder/compliance/fresh98.htm.

Important FDA/CGMP definitions include:

- **Batch:** A specific quantity of a drug, (i.e., oxygen) that is intended to have a uniform character and quality. The receipt of a shipment of oxygen is referred to as a new batch.
- **Calibration:** The validation of the accuracy of the test results given by the oxygen analyzer. The term "validation" refers to the production of a consistent, known result. In this case, the validation of the accuracy of the test result is achieved by testing the analyzer with a certified known purity oxygen. Specialty gas firms provide these certified purity oxygen cylinders with a letter of certification. The general practice of the industry is to calibrate the analyzer prior to each use.
- **Certificate of Analysis (COA):** A report provided by the supplier of the bulk oxygen. The report must include the purity test result, the date, the bulk supplier's lot number, test method, and the signature of the responsible individual. The COA is routinely received with each new shipment.
- **CGA:** The Compressed Gas Association.
- **Drugs:** Articles that are (1) recognized by the official United States Pharmacopeia and (2) intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man. Medical oxygen must be administered under prescription, generally to treat a medical situation.
- **Device:** An instrument, apparatus, machine, in vitro reagent, or other similar or related article, including any component, part, or accessory, which is (1) recognized in the USP/NF, (2) intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease in man or other animals, (3) intended to affect the structure or any function of the body of man or other animals and does not achieve its primary intended purposes through chemical action within or on the body, and (4) not dependent upon being metabolized.
- **Dewars:** Large cryogenic vessels.
- **Distributor:** A facility that does not manipulate the product or its labeling and sells "as is" from the manufacturer.
- **Documentation:** A written record that shows that a particular function was performed, when it was performed, and by whom. The FDA and the CGMP have a number of requirements for documentation related to the supply of medical gases that should be incorporated into a firm's policies, procedures, and forms. It is imperative for responsible personnel not only to perform their duties accurately and completely, but to document them as required.
- **Lot:** A batch, or a specific identified portion of a batch, having uniform character and quality within specified limits. The terms lot and batch are sometimes used interchangeably; their meanings are very similar.
- **Lot Number:** Any distinctive combination of letters, numbers, and/or symbols from which the complete listing of the manufacturing, processing, packing, holding, and distribution of a lot or batch of oxygen can be determined.
- **Manufacture:** Includes packaging and labeling operations and testing and quality control of drug products (oxygen); a "manufacturer," as the term pertains to the gas industry, is anyone who manipulates (fills from one container to another) the product.
- **Manifold:** A piece of equipment capable of filling multiple cylinders at one time from the same supply.
- **Purity Testing:** The procedure and results (to determine purity level) must meet or exceed the official compendia. Testing records (documentation) must show that the method used is equal or superior to the compendia method in terms of accuracy and reliability. The minimum purity test result specification for medical oxygen, as shown in the United States Pharmacopoeia (USP), is 99.0%. The industry is

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required to use a testing instrument that is sensitive enough to measure the purity of oxygen at not less than 99.0%. Most in the industry use a paramagnetic analyzer.

- **Quality Control Unit (QCU):** Any person or organizational element designated by the firm to be responsible for the duties related to quality control as it relates to the FDA and medical gases.
- **Standard Operating Procedures (SOP):** Detailed, written, step-by-step instructions and procedures for performing and monitoring all aspects of the proper operation of a medical gas operation. The SOPs must be signed and dated, thus indicating review and approval by responsible persons.
- **VGL:** Vertical gas liquid containers. ■

Current Good Manufacturing Practices

Current Good Manufacturing Practices (CGMP) regulations outline the practices to which the medical gas industry must comply. They represent minimal requirements which, if not followed, will result in violation of the Food, Drug & Cosmetic Act. Compliance assures that the oxygen "manufactured" by the industry meets the required quality and purity characteristics. Here are some general guidelines for meeting the objectives of CGMP:

- Each of your locations should designate and document a "Responsible Person" (as well as an alternate in the event of the Responsible Person's absence) to oversee the implementation of your organization's CGMP. These individuals should also be charged with overseeing and supervising overall operations, inspections by the FDA, and Quality Assurance Audits, and reviewing/maintaining all pertinent documentation and attesting to that review and issuing approval by means of a dated signature. If the Responsible/Alternate Person(s) find omissions/errors in documentation, they should determine who made the error or omission and ask that person to properly correct it in accordance with the applicable procedures. When only two people work in a location and one is on vacation, sick, or absent, the filler and/or Responsible Person must critically review the record, then sign and date it as "Reviewed & Approved by" before releasing the product for shipment. Immediately upon return, the second individual must inspect the record(s) and indicate that this was performed by signing and dating below, or in the proximity of, the filler's signature. (The latter should be the exception, not the standard routine.)
- Each location should issue a copy of the company's Medical Gases Policy and Procedure Manual containing all applicable sections. Each location should be responsible for maintaining the Manual and keeping it current. Each Manual should include a copy of the location's current FDA registration, if applicable. FDA registration is required for all locations that manufacture (fill) oxygen.
- Each person engaged in the filling, handling, testing, or release of medical gases should be trained in the operations he/she will be performing and in the corresponding regulations; this training should include periodic refresher training as warranted or, at a minimum, every three years. Training content should include any updates, and documentation of the training should be maintained in the Medical Gases Policy and Procedure Manual. Each location should maintain FDA/LOX records in the Manual as well. Each location should develop and maintain an Emergency Preparedness Plan, which should also be kept in the Manual.
- Each location should be kept clean and in good repair, with adequate space and lighting to assure effective performance of duties, including the prevention of mislabeling or adulteration of medical gases. Adequate space should be available to ensure separation of incoming product, cylinders and vessels, equipment, and the finished product prior to release.
- Each location should be sensitive and responsive to any complaints (expressions of dissatisfaction) regarding the identity, quality, reliability, safety, effectiveness, or performance of oxygen, including related devices and containers. Examples of complaints include empty cylinders, defective valves, wrong labels, etc. Such occurrences should be reported on a Complaints Record Form. All complaints should be investigated and resolved.
- Finally, each location should be capable of assisting, if necessary, with the implementation of a recall related to medical gases. This includes patient contact, product retrieval, and quarantine, as well as providing oxygen for another company location experiencing a recall.

Adhering to these components of the CGMP is paramount to smooth oxygen operations and FDA inspections. ■

How to Handle Inspections by the FDA

The Food and Drug Administration (FDA) may make periodic, unannounced visits to organizations that transfill and supply medical gases to assure that the organization is in compliance with the applicable FDA regulations. The FDA is authorized to inspect all facilities and vehicles in which oxygen is transported. The organization should cooperate with the investigation in accordance with the following guidelines. (Note: These are only guidelines and should be modified according to your organization's local, state, and federal laws.)

1. The inspector should not be refused entry onto the premises, unless extenuating circumstances exist, and you should accompany the

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inspector at all times he/she is on the premises. It is a criminal offense to refuse an inspection.

2. Validate the identity of the inspector and his/her purpose. Ask the inspector for identification. This should consist of a card and a badge. Obtain the name of the FDA office with which the inspector is affiliated. Request and secure a copy of the Notice of Inspection Form (FDA 482), which should include the inspector's name and the office he/she represents.

3. If they are not already on the premises, attempt to contact the Responsible Person(s) and/or alternate as outlined in your policies and procedures manual. If they are not onsite, but can get to the location in a short amount of time (30 minutes or less), it is appropriate to ask the inspector to wait until they have arrived. If they are not available, attempt to reschedule the visit for a time when they will be available. If it is not possible to reschedule, the staff member should assist the investigator with the evaluation. Ask the inspector what he/she plans to inspect. Define and plan the site tour around this objective.

4. Inspections are serious business and occur for several reasons. Some of the most common are:

- A full facility inspection is required by law every two years
- Complaints
- The company has a history of non-compliance

5. The role of the inspector is to determine any lack of compliance. While this relationship may be somewhat adversarial, inspectors should be accorded professional courtesy and respect, and should be assisted throughout the process. Interact in a firm, professional, business-like manner at all times.

6. You should not allow the investigator to take photographs without the approval of management. You should not sign any documents or affidavits. Refer such requests to your manager.

7. Answer operational questions by referring to existing policies whenever possible. If questions arise that are beyond the scope of the Responsible Person, contact a member of your Medical Gas Quality Control Team.

8. You should not offer the inspector a "tour" of the facility or provide extraneous information regarding your operation, unless requested. Do not offer what is not asked for. When appropriate, conduct the inspection in a private office.

9. If requested, allow the inspector to review and copy oxygen transfilling and delivery documentation. Maintain a copy of all items provided. Originals should not be given to an inspector to take from the facility.

10. Refrain from voicing any personal views, opinions, hearsay, or rumors, voluntarily or in response to an investigator's question. You may believe that a comment or discussion is only between you and the investigator, but the investigator is obligated to report all information made available as a means of determining compliance. Any information obtained during an inspection could be used against your organization in determining non-compliance.

11. Make sure each question is understood prior to responding. If you are unclear of the question, ask the inspector to restate it. Answer only what was asked and respond in a concise manner.

12. Record detailed notes regarding the information requested, supplied, and who supplied it, as well as the inspector's findings. The FDA may provide verbal suggestions for improving your operation. Take notes on these suggestions and file them appropriately. Share them with appropriate managerial personnel.

13. You may be provided an FDA Inspection Observations Form (FD 483). You will only be provided a Form FD 483 if the inspector observed evidence of any condition or practice in violation of regulations. It is the obligation of the Responsible Person to clearly understand this report. If you believe it contains an error, attempt to clarify your thoughts with the inspector.

14. The Responsible Person should confirm the organization's commitment to full compliance with all applicable laws and regulations, but as a general rule, not acknowledge or confirm that the observations the investigator thinks are problems actually are violations.

15. It is helpful, after the inspection, to complete a report covering the inspection in as much detail as possible. This should be done even if the investigator has no observations and should include the following:

- Investigator's name
- Describe each question asked and response given
- Describe the investigator's attitude
- Documents reviewed and documents copied
- Labels reviewed and samples taken by investigator
- Copy and attach all forms left by the investigator, i.e., FDA 482 and 483
- Investigator recommendations for correcting efficiencies
- Investigator comments regarding company procedures
- Comments on action already taken or planned (including a timetable) on any deficiencies noted in the report.

Upon review of the report and associated documentation, your organization should arrive at an appropriate response. Respond in writing to the FDA District Office, committing to corrections or deficiency rectification when appropriate and clarifying the company's position regarding observations from the inspection. ■

Home Care Oximetry: a Practice under Scrutiny

by Scott L. Bartow, RRT, MS, vice president VCM, Milwaukee, WI

One area that continues to cause concern for the home care industry and respiratory therapists across the country is the use of oximetry technology in the home care setting and its relation to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) survey process. Our need to comply with regulatory requirements, along with the importance of the accreditation process and its potential ramifications, has made this an area that requires additional attention.

The JCAHO's mission is to improve the quality of care provided

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to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations. As a byproduct of that mission, the Joint Commission is sometimes placed in the position of identifying and surveying practices that are at odds with the preferences of various health care providers (a natural predicament of their role). Home oximetry testing is a prime example of this phenomenon.

The issue, as I understand it, relates primarily to how the JCAHO standards apply to a home care provider that performs an oximetry in the home. The following "Q&A" is an attempt to clarify the questions that have arisen:

Question: Does an organization need a physician's order to obtain an oximetry reading from a home care patient?

Answer: Simply stated, the answer is yes. This is true if you obtain one or one thousand oximetry values, because the Food and Drug Administration (FDA) requires that a physician's order be obtained for the use of an oximeter on a patient. This requirement has been verified by the AARC and JCAHO, and is also included in the JCAHO Lab Accreditation Program. The JCAHO spelled out its position in a 1997 Clarification that stated the following:

- There are several factors in home care that support the involvement of a physician in the use of pulse oximetry. For example, the procedure is not without risk to the patient, the indications and contraindications for use need to be clearly related to the assessment and monitoring needs of the patients, staff need to be trained in the use and interpretation of the findings and need to be available (to the physician), and the results of the oximetry need to be validated to overcome device limitations.
- The Food and Drug Administration has determined that pulse oximeters are prescription devices and should not be utilized without a physician's order. The FDA cannot extend into the practice of medicine but a physician does need to make a determination as to how this device is to be used, hence the need for a physician's order.

It is also important to note that the order requirement is not limited to the accredited home care organization. The rules apply to all providers of oximetry in the home. The difference is simply that accredited organizations have requested an outside organization to come in and observe their activities related to, among other things, compliance with various rules, regulations, and standards. I have no doubt that there are unaccredited organizations that do not follow the rules and thus have a competitive advantage over those that do. This does not, however, relieve the professional health care provider of his or her responsibility to be aware of and follow appropriate practices and laws.

I believe the confusion over the issue can be attributed to the following:

- Since the initiation of the Joint Commission home care accreditation process, there has been a change in the interpretation of the standards as they relate to this issue, and thus a change in onsite survey activities. This means that some organizations and personnel have practical experience that leaves them with the impression that orders are not necessarily required. Remember, the JCAHO states that clarifications of standards are subject to revision at any time and may be superseded, revised, or rescinded.
- Having a physician's order is unpopular, as it adds work for both the provider and the physician. In addition, not everyone follows the rules (or is accredited), and thus compliant organizations are sometimes placed at a competitive disadvantage.
- On the surface, oximetry appears to be a simple procedure, arguably equitable to other activities (i.e., blood pressures or diabetic monitoring) with less demanding requirements.

Question: Does the performance of oximetry automatically subject the JCAHO accredited organization to survey under the *Clinical Respiratory Therapy Standards*?

Answer: The answer is maybe, depending on the circumstances.

No, if the request is a one-time event and the person performing the oximetry is not expected to interpret or react to the value obtained. No, if the person is not expected to perform any function other than the recording/reporting of the patient's saturation. In this instance, it can be considered a part of the equipment management. However, if the physician were to order a second, independent "one time" oximetry it would raise a red flag as to the status of equipment management versus clinical services. If the physician were to order a third, it would be clear that the intent was ongoing monitoring, and the patient would be considered in clinical services.

The performance of the test places the organization under the home health, or clinical respiratory service standards, if the order: (1) requests multiple, ongoing assessment, or (2) requires the person performing the oximetry to evaluate or somehow assess the values obtained. In this situation, all applicable JCAHO standards must be met. The position of the JCAHO was spelled out in the same 1997 Clarification on oximetry, which stated: "The performance of the oximetry makes an organization eligible for the clinical respiratory services and standards compliance."

The rationale behind this position relates to the fact that a professional performs the test, the test is related to the patient's medical condition, and the goal is to improve and measure the patient's condition/therapy. There are expectations from both the patient and the ordering physician related to the test's performance. In short, it becomes part of the patient's plan of care. Recommendations related to noncompliance would be addressed in the JCAHO manual under the standards related to physician's orders (currently TX.2 and TX.2.1).

What is the appropriate organizational response to these requirements? This should be determined by each company. However, there are several acceptable ways to handle the situation:

- You can elect to remove this service from your list of services. (Not recommended, but it does resolve any confusion.)

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- You can provide the service and obtain an order for each oximetry reading performed. In the event that multiple readings are ordered, their frequency or the circumstances requiring their performance should be clearly spelled out. Many organizations routinely request this order at the time of the oxygen setup as part of their intake routine.
- A physician could provide you with an "assessment protocol" listing the expected activities (including oximetry) associated with your services. In the event that the physician orders your services, he or she could write an order requesting that the protocol be implemented. Note: This protocol should indicate the specific circumstances under which an oximetry would be performed, and it should be understood and followed by all appropriate staff members. PRN orders, without an acceptable protocol, would not be acceptable.
- If the home care organization is a Medicare certified hospice, the agency medical director could write standing orders for oximetry (as well as other services) that supersede the patient's doctor's orders.

Question: Who is qualified to perform the oximetry?

Answer: In the case of equipment management only, a "trained" individual (nonprofessional) may perform the test. But I would suggest that a "see one, do one" mentality would not meet the intent of the standards. Further, the individual would need to have documented training by a "qualified health care professional." Finally, remember that the surveyor would be well within his or her area of responsibility to question this individual regarding any technical aspects of oximetry.

In the case of clinical services, the expectations increase, as the individual must be a health care professional. For the purpose of meeting these standards, this could be defined as "a qualified respiratory therapist or other health care professional who has the documented equivalent in education, training, and/or experience; and who meets current legal requirements of licensure or registration."

I would take this opportunity to note that anyone performing the test must be properly trained in the equipment's use. There is great opportunity for disservice to the patient and physician in the inappropriate use of the oximeter. Its perceived simplicity works against it, as there is an impression that "anyone" can use it and obtain accurate results. The utilization of appropriately trained personnel to perform respiratory-related procedures is an ongoing concern of the AARC.

In a related matter, the JCAHO has witnessed an increase in the number of incidents where non-qualified personnel (unlicensed or without the proper scope of practice) have performed tasks requiring specific qualifications. An organization may receive a recommendation regarding a non-qualified staff member (HR.3.1 in the JCAHO accreditation manual) if it is determined that an individual was not appropriately trained. If oximetry were specifically limited to a licensed individual, the identification of these activities (even one occurrence) would place an organization in the state of preliminary non-accreditation. The question of qualifications is often determined by the individual states, and provider organizations must know the requirements within their own states.

Note: The JCAHO is available to answer questions related to their standards. Home Care Accreditation Services may be reached by calling: (630) 792-5754. ■

Just the Facts: Data Tell the Home Care Story

As respiratory therapists who work in the home, we know how valuable our services are to patients who rely on them to stay well enough to avoid hospitalization or admission to a nursing home. But how many of us are really that well-versed on the facts and figures related to this setting? As the home care industry continues to face cuts in reimbursement, a better understanding of the industry as a whole can help us see where we fit into the big picture and why home care is not likely to fade away as the setting of choice in many situations. The following statistics from the National Association of Home Care (NAHC) tell the story:

General information -

- More than 20,000 providers deliver home care services to seven million Americans.
- Annual expenditures in 1997 topped $42 billion.
- The number of providers has mushroomed only in the past decade or so. There were 1,100 home care agencies in 1963; today that number stands at more than 20,000, half of which have been added since 1989.

Payment -

- Hospital-based and freestanding proprietary agencies are growing faster than any other type of provider. They currently comprise 26% and 47%, respectively, of all home care companies.
- Despite the growth in home care over the past thirty years, 1995 spending on home care stood at just four percent of total personal health care expenditures. That compares to 39% for hospitals and 23% for physicians' services.
- From 1988 to 1996, prices for home care services rose at an average annual rate of 1.8%, well below the 3.6% noted for a fixed market basket of goods and services and far under the 5.6% for physician services and 8.2% for hospitals and related services.
- About 3.9 million of the 38.6 million Medicare beneficiaries in 1997 were expected to receive home care services.
- In 1996 and 1997, about nine percent of total Medicare benefit payments were projected to go to home care; by contrast, about half were projected to go to hospitals and about one-fifth to physicians.
- In 1995, home care services made up only 7.8% of total Medicaid payments. However, it is a growing

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benefit. Between 1994 and 1995, expenditures for home care rose from $7 billion to $9.4 billion, up 34%.
- Medicare covers about 48% of home care services. Medicaid picks up about 24% and out-of-pocket expenses for beneficiaries account for around 22%.

Patients -
- A National Center for Health Statistics survey found that almost 30% of patients admitted to home health agencies in 1994 had conditions related to diseases of the circulatory system; those with heart disease comprised 20% of this group. Respiratory patients accounted for six percent of the total.
- The percentage of Medicare patients discharged from the hospital to home care increased in the 1980s as average hospital lengths of stay decreased, up from 9.1% in 1981 to 17.9% in 1985.
- Prospective Payment Assessment Commission Data from 1994 indicated that 13.8% of Medicare hospital patients received home care services within 30 days of discharge.
- The top ten DRGs with discharges to home care in 1994 included DRG 89 - Simple pneumonia and pleurisy age >17 with CC (No. 4) and DRG 88 -chronic obstructive pulmonary disease (No. 5).

Caregivers -
- The Bureau of Labor Statistics estimates that home care employment grew from 344,000 in 1991 to 666,000 in 1996, a 14% annual rate of growth.
- Home care employment has more than doubled since 1988. By contrast, hospital employment has grown by about ten percent and employment in the health care industry as a whole has increased 31%.
- Median compensation for respiratory therapists working in the home in October 1996 was $15 per hour. That compared to $17.80 for registered nurses, $12.51 for licensed practical nurses, $24.25 for physical therapists, and $8.16 for home health aides.

Cost Effectiveness -
- Government statistics comparing hospital, skilled nursing, and home health charges per day for 1994, 1995, and 1996 found that home health charges were just a small fraction of their inpatient counterparts. Hospital charges per day for 1994, 1995, and 1996 were $1, 754, $1,910, and $1, 965, respectively. SNF charges were $356, $402, and $414. Home health charges were $83, $84, and $86.
- A comparison of per patient per month home care and hospital costs for specific diagnoses found a savings of $14,520 for ventilator-dependent adults cared for in the home ($21,570 versus $7,050) and $6,840 for oxygen-dependent children ($12,090 versus $5,250).
- A home care program in Connecticut for COPD patients with a history of frequent hospitalizations found that costs per patient per month dropped from $2,836 per patient prior to the program to $2,508 after the program, for a cost savings of $328 per patient per month. ■

(Source: NAHC web site, http://www.nahc.org)

New Product Suggestions

As you know, new product development is an important component of the services that any association provides its members. But where do these new products originate?

Quite often they originate with you. You and your staff encounter problems and needs everyday. Perhaps you require an educational product on a procedure or disease. Or maybe you need a manual to help you manage certain components of your department.

Tell us what products or services the AARC can develop that will help you perform your job. We will research your suggestion, and if it is viable, produce it and make it available to the profession.

Please provide the following information when submitting your product or service suggestion:
- Brief description of the product
- Describe who will use this product
- Tell why you believe potential users will buy this product
- List your name, member number, and specialty section/committee

Send this information to: New Products, AARC, 11030 Ables Lane, Dallas, TX 75229; email: info@aarc.org; FAX: (972) 484-2720. ■