American Association for Respiratory Care's

Continuing Care & Rehabilitation Bulleti

July / August / September 2003

Notes from the Chair

by Mary Hart, RRT, RCP

I recently attended the American Thoracic Society annual meeting, where I had the opportunity to attend the session on the National Emphysema Treatment Trial (NETT) where the results of the study were reviewed and discussed. It was very exciting to sit in the large ballroom, which was packed beyond capacity with physicians and clinicians anxiously waiting to hear the outcomes of the study. The NETT study, which required all participants to attend pulmonary rehabilitation, will have a major impact on our efforts to push forward a National Policy for Pulmonary Rehabilitation. The speaker from the Centers for Medicare and Medicaid Services (CMS) stated during the session that they are considering the development of this policy, and I know several organizations - the AARC included - are working with CMS to write the policy. So, our future looks bright!

Check your calendar! It's time to make plans to attend the AARC International Respiratory Congress in Las Vegas this December 8-11. The Program Committee received more than double the usual number of proposals this year for our section, so we should have another great program. I hope to see you all there - particularly at the section business meeting. This is our best opportunity all year to meet face-to-face and make plans for 2004.

As an Ambassador for the AARC, I have been busy trying to recruit new members to our organization. But I must say that it's been tough, mainly because most of the therapists I know and work with are already members. Despite the challenges, however, I know that working with this new membership program is helping to get the word out about the great benefits of belonging to the AARC, and I encourage all of you to sign up to be Ambassadors as well. (Check out "Benefits of Being an

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Section Connection

GET IT ON THE WEB
Help the AARC increase its efficiency by signing up to receive the *Bulletin* via the section homepage on the AARC web site (www.aarc.org). To change your option to the electronic Bulletin, send an email to: mendoza@aarc.org

SECTION E-MAIL LIST
Start networking with your colleagues via the section e-mail list. Go to the section homepage on www.aarc.org and follow the directions to sign up

Benefits of Being an AARC Ambassador

When the AARC launched the Ambassador program at last year's Internati Respiratory Congress, the intention was to encourage existing members to recruit new m bers for the good of their professional organization. But the AARC believes good d deserve to be rewarded as well, so in addition to that nice, warm feeling you'll get a AARC Ambassador, there are perks. As an Ambassador, you'll receive recognition in *A Times* and invitations to attend special Ambassador events at the AARC Summer Forum International Respiratory Congress. And, you'll also earn points for every new member recruit, and you can redeem for special gifts:

- Recruit a Student Member and earn 2 points.
- Recruit a 3-months-or-more lapsed Member and earn 5 points.
- Recruit a new Regular Member and earn 10 points.
- Recruit a new Plus Member and earn 15 points!

Once you earn at least 30 points, you can begin redeeming them for a variety of th you gifts, such as a simulated-leather portfolio (30 points), a portable CD player (50 poi a digital camera (200 points), or a TV/DVD combo (300 points) - just to name a few. Or your points in for one year of full AARC membership (100 points), one year of Plus m bership (150 points), one-time registration for the Summer Forum (200 points), or one- registration for the International Congress (300 points).

Find out more about becoming an AARC Ambassador on the AARC web (www.aarc.org) or go directly to: http://www.aarc.org/member_services/ambassador/.

Perceived Needs of Respiratory Therapists and Respiratory Care Managers Regarding Geriatric Education Components

by Helen M. Sorenson MA RRT, San Antonio, TX

EDITOR'S NOTE: The following abstract was presented at the AARC Open Forum in 2000.

Background: Respiratory therapists (RTs) are increasingly being called upon to car older patients in a variety of settings. While some respiratory care programs offer gero ogy courses, there is currently no mandate to include geriatrics in respiratory care ed tional programs. The purpose of this study was to determine what aspects of geriatric cation are perceived to be most needed by RTs and respiratory care managers (RCMs).

Method: A multidimensional survey instrument was developed to measure the perce needs of RTs and RCMs for geriatric education. Demographics collected included age, der, length of employment in years, and size of community where employed. Twenty-t variables, in the form of brief statements, were included in the survey, using a 5-point Likert scale, to determine which educational components RTs and RCMs considere being the most and least important. The surveys were mailed to 400 RCPs in Nebraska, domly selected from a list of 1,055 licensed RCPs supplied by the Nebraska State Boa Health, Bureau of Examining Boards. One hundred and forty-one (35%) complete sur were returned. The frequency of responses, means, and standard deviations were calcu on collected data. The Pearson Correlation coefficient was used to describe the relation between the variables.

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NOTES FROM THE CHAIR

AARC Ambassador" to see what's in it for you, then go to www.aarc.org and sign up.) I believe we must, as a profession, build our numbers, become stronger, and have a Louder Voice. The more members we have, the greater our impact will be on clinical practice and reimbursement decisions made by governmental agencies and managed care.

Additional members can also help our section, Remember: we currently have very few members when compared to other sections. And we must maintain at least 350 members to continue our section status. So, please, encourage your fellow continuing care and rehabilitation RTs to join not just the AARC, but the section as well! Membership information is located on the AARC web site to assist you with any questions your "recruits" may have. Application can be made online.

As always, I need your assistance with Bulletin information/articles. Ideas for future articles include:

- Success Stories
- Research Projects
- JCAHO Updates
- Medicare Information
- LMRP - How to make your program work within the standards

Please contact me at maryhar@baylorhealth.edu if you have questions, information to share with members, or Bulletin items. Thank you for your support. ◆

Want to receive this newsletter electronically?

E-mail: mendoza@aarc.org for more information.

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PERCEIVED NEEDS OF RESPIRATORY THERAPISTS AND RESPIRATORY CARE MANAGERS REGARDING GERIATRIC EDUCATION COMPONENTS

Results: Knowing how DNR orders relate to respiratory care, how aging affects the lungs, the importance of patient's rights, and how to administer palliative care ranked highest in the survey. RTs and RCMs ranked fielding questions about sex, discussing patients' nutritional needs, and counseling patients about end-of-life care the lowest. There was a small but statistically significant ($p<0.05$) correlation between age and understanding cultural norms ($r=0.18$), the benefits of physical activity ($r=0.17$), and the importance of patient's rights ($r=0.30$); between length of employment, knowing baseline body temperature, ($r=-0.17$) and understanding drug pharmacokinetics ($r=-0.17$); and between size of the community and understanding cultural norms ($r=0.17$).

Conclusion: This study provides a foundation for determining which geriatric education components are deemed most needed by RTs and RCMs. The data generated from this study may be used as a guide for those electing to insert geriatrics into the curriculum of their respiratory care programs. ◆

GERIATRIC EDUCATION COMPONENTS RANKED BY PERCEIVED NEED
LIKERT SCALE (0-4), N = 23

NEED TO KNOW	MEAN	RANK (SD)
How DNR orders relate to respiratory care	3.73	(0.53)
How aging affects lungs	3.70	(0.47)
The importance of patient's rights	3.38	(0.59)
How to administer palliative care	3.35	(0.74)
Benefits of physical activity	3.33	(0.53)
Relationship of pharmacokinetics to liver/kidney function	3.29	(0.62)
Signs of depression in older adults	3.23	(0.67)
Age-related change in blood pressure	3.19	(0.60)
Age-related change in hearing	3.18	(0.62)
Dynamics of hope vs. hopelessness	3.16	(0.61)
Age-related change in kidney function	3.13	(0.61)
Age-related change in vision	3.11	(0.62)
Age-related change in body temperature	3.08	(0.69)
Discharge planning procedures	3.07	(0.76)
Age-related change in liver function	3.05	(0.65)
Medicare reimbursement guidelines	3.02	(0.80)
The basic concepts of aging	2.98	(0.76)
Availability of social programs for older patients	2.95	(0.77)
The various theories of aging	2.91	(0.82)
Effect of cultural norms on older adult patient care	2.89	(0.80)
Nutritional needs of older adult patients	2.72	(1.13)
How to counsel on end-of-life decisions	2.68	(1.09)
How to field questions about sex	2.07	(0.97)

ROTATED FACTOR MATRIX (PRODUCED ALPHA COEFFICIENT OF 0.92)

FACTOR I (TECHNICAL SKILLS)	
Declining kidney function	0.80
Declining liver function	0.73
Blood pressure changes	0.70
Declining vision	0.66
Declining hearing	0.65
Baseline body temperature	0.63
FACTOR II (COGNITIVE AND CRITICAL-THINKING SKILLS)	
Counseling older adults	0.83
Nutritional needs of older patients	0.65
Questions about sexuality	0.59
Administration of palliative care	0.58
Signs of depression	<0.50
FACTOR III (KNOWLEDGE)	
Theories of aging	0.73
The concept of ageism	0.69
Drug pharmacokinetics in elderly	0.50
FACTOR IV (PSYCHOSOCIAL)	
Benefits of physical activity	0.63
Discharge planning	0.61
Medicare reimbursement	0.58
Social programs	<0.50
FACTOR V (AFFECTIVE CHARACTERISTICS)	
Patient's rights	0.81
Hope vs. hopelessness	0.55
Cultural norms	<0.50
FACTOR VI (OUTLIERS)	
DNR orders	0.79
Effect of aging on lungs	0.67

Resources from the National Lung Health Education Program

One of the AARC's key partners in the fight to improve the outlook for our pulmonary rehab patients is the National Lung Health Education Program (NLHEP), headed up by Tom Petty, MD, FAARC. NLHEP's commitment to working with respiratory therapists to further our collective goals was illustrated last year when the group hired long-time AARC member and our former Continuing Care & Rehabilitation Section chair, Gretchen Lawrence, RRT, FAARC, to serve as a liaison to the AARC.

How can we take better advantage of this important partnership? One way we can all benefit is by using the resources available on the NLHEP web site in our programs. What's on the site? Take a look at the following list, then go directly to **www.nlhep.org** to download these brochures and reports and put them to work in your programs.

BROCHURES

Two informative brochures are available at www.nlhep.org/resources.html to print, but AARC members may also receive preprinted copies - up to 200 each - by sending their full name, complete mailing address, phone number, e-mail address, and number of each brochure they are requesting, along with a brief description of how they are planning to use them to Gretchen at gl-lungs@swbell.net. There is a modest charge to other individuals.

SAVE YOUR BREATH AMERICA!
by Thomas L. Petty, MD, and Dennis E. Doherty, MD
Advice for patients with asthmatic bronchitis, chronic bronchitis, or emphysema, and their families.

PREVENT EMPHYSEMA NOW
by Thomas L. Petty, MD, and Dennis E. Doherty, MD
A companion booklet for physicians.

INFORMATION FOR PATIENTS
- The Second Breath of Life
- Test Your Lungs - Know Your Numbers...You May Just Breath a Little Easier!

PHYSICIANS AND HEALTH PROFESSIONALS
- The Lung Cancer Frontiers web site includes issues of their newsletter dedicated to advancing knowledge about lung cancer and emphasizing early identification and treatment. www.lungcancerfrontiers.org

SLIDE PRESENTATIONS
- NLHEP Physician Slide Presentation I
- NLHEP Physician Slide Presentation II

SERIES OF FRONTLINE BOOKS
- Frontline Treatment of COPD, an electronic book in PDF format
- Frontline Assessment of Common Pulmonary Presentations, by the Snowdrift Pulmonary Conference

COPD
- "The Big Picture: RTs Screen for COPD, Raise Awareness", a reprint of an article by Gretchen Lawrence from *AARC Times*, January 2003
- "COPD Surveillance-United States, 1971-2000", David Mannino, MD, David Homa, PhD, Laura Akinbami, MD, Earl Ford, MD, Stephen Red, MD
- "Epidemiology, Prevalence, Morbidity and Mortality, and Disease Heterogeneity", David M. Mannino, MD, FCCP
- "Definitions, Causes, Course, and Prognosis of Chronic Obstructive Pulmonary Disease", Thomas L. Petty, MD
- "A New National Strategy for COPD
- "COPD: Why 'Test Your Lungs, Know Your Numbers' is the New Battle Cry'
- "Demonstration Project: Hanover Hospital"
- "How to Start a Community Screening Project," Hanover Hospital
- "Test Your Lungs; Know the Numbers"
- "Hanover Area Coalition for Lung Health, A Program Description of 'How To' for Your Community," Michael Ader, MD, and Vicky Shrader, RRT
- "Role of Community Pharmacy in Early Detection of COPD," Tim Buckley, RRT
- "Use FEV_1 as an Early COPD Detection Tool"

GENERAL
- "The Second Breath of Life," Thomas L. Petty, MD

LUNG DISEASE
- "Diagnosis of Roentgenographically Occult Lung Cancer by Sputum Cytology," Thomas L. Petty, MD, Melvyn Tockman, PhD, MD, and Branko Palcic, PhD

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The Modified Borg Dyspnea Scale: Like Pulling Numbers From a Hat?

by Terry S. LeGrand, PhD, RRT; Shana Giles; and David Shelledy, PhD, RRT; University of Texas Health Science Center, San Antonio, TX

Background: The Borg scale is often used during ma, pulmonary, or cardiac education programs to qua patients' progress in learning disease management. Borg scale, designed in 1962, rates perceived exertion ing exercise. It was modified in 1982 to measure perce intensity of dyspnea using a 12-point scale. Conflic results have been reported in studies designed to corr the modified Borg scale with indices of pulmonary physical function. For example, there was no signif difference between Borg scores before and after a monary rehabilitation program in which there were inc es in metabolic and physical function parameters.

Method: To determine whether the modified Borg sca a valid tool to quantify outcomes associated with disease agement education programs. Borg dyspena scores were lected on asthmatics (n=43) who presented to the emerg department during acute asthma exacerbation. Subseque scores corresponding to the Borg scale were assigned blinded fashion to these subjects by randomly selecting from a box. Means were compared using a t-test.

Results: There was no significant difference betw mean dyspnea scores (4.2 + vs. 4.74 + 2.9, p=0.38).

Conclusion: While the modified Borg scale may useful determinant of a patient's subjective level of dis during a given episode of dyspnea, its use as a measu the effectiveness of disease management education is tionable. Respiratory therapists who routinely use the scale should be aware of its limitations, and that it ma fact, be no more significant than "pulling numbers fr hat." In this study, the unreliability of Borg scores co with limitations shown in other studies demonstrates importance of utilizing objective measures of progress measures of health-related quality of life to determin effectiveness of education in disease management. ◆

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RC WEEK
October 19-25, 2003

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