AARC Approves Updated Pulmonary Rehabilitation Position Statement

The AARC Board of Directors approved an updated Pulmonary Rehabilitation Position Statement late last year, demonstrating its renewed commitment to our specialty area.

“The AARC had a pulmonary rehabilitation position statement in the past,” says Linda Van Scoder, EdD, RRT, chair of the AARC’s Position Statement Committee. “We felt that a revised statement would better communicate the AARC’s position and the important role respiratory therapists play in restoring patients to their highest level of independent function and to improve their quality of life.”

The statement reads:

A program of pulmonary rehabilitation is a multifaceted continuum of services designed for persons with pulmonary disease and their families. As a component of respiratory disease management, the goals of pulmonary rehabilitation are to restore patients to their highest possible level of independent function and to improve their quality of life. Pulmonary rehabilitation, generally conducted by a multi-disciplinary team of specialists, should be included in the overall management of patients with respiratory disease to assist in alleviating symptoms and optimizing health. The respiratory therapist, by virtue of specialized education and interest in the individual’s respiratory care, is a key partner in a successful rehabilitation program.

Notes from the Chair

by Mary Hart, RRT, RCP

It’s almost Christmas as I sit writing this column, and I am thinking of the New Year and what it might bring. Will I ever figure out all there is to know about getting reimbursed for our programs? How many pulmonary rehabilitation programs will close their doors because of reimbursement problems? How many people with chronic lung disease will miss out on the benefit of such wonderful rehab programs?

I am asking these questions because it could happen - if programs are without motivated, innovative, and dedicated staff and administrators. One purpose of our section Bulletin is to share information about effective strategies used in pulmonary rehab programs across the country. The only way to do this is for more of you, our section members, to write articles about your programs, new equipment, techniques, outcomes, presentations, or research updates. Now that the Bulletin is being published only four times a year, we will be sending via e-mail short news items to you in a more timely manner, thus leaving more space in the printed Bulletin for articles from members. We need you to step up to the plate and deliver!

I would also like to propose that we all share documentation forms, policies, and procedures via our section home page, www.aarc.org/sections/rehab_section/rehab.asp. What do you think? Please contact me with any information that you would like to see on the web site or in the Bulletin. Let’s make this the best year ever!

It’s Official

RTs working in pulmonary rehab programs would hardly bat an eye at new findings from a government study on smoking in people with chronic health conditions, but it’s nice to get confirmation of what we’ve known all along: smokers with diagnosed chronic conditions continue to smoke despite their health problems.

According to the Agency for Healthcare Research and Quality (AHRQ), about 38% of those with emphysema, 25% of those with asthma, 20% of those with hypertension or cardiovascular disease, and 19% of those with diabetes reported being current smokers in 2000.

Three out of five of this group also said their doctors had advised them to quit smoking in the past year.

The new data come from a self-administered questionnaire added to the AHRQ’s Medical Expenditure Panel Survey (MEPS) in late 2000/early 2001 to collect information on health care quality and satisfaction with health care. The data on smoking in the United States were derived by combining the results of the new questionnaire with demographic, chronic condition, and preventive care information collected by MEPS’s nationally representative survey of people over the age of 18 who are not in the military or living in institutions. More than 15,600 people responded to the survey questions.

Lung Profiler to Assist COPDers

The American Lung Association has launched a “COPD Lung Profiler” on its web site to help COPD patients learn more about their disease and the specific treatments which may help them live healthier lives. The Internet-based support tool is being billed as a user-friendly activity that “confidentially matches an individual’s clinical information to a carefully selected group of peer-reviewed clinical studies.” From this information, the tool provides patients with “personalized information about treatment options and side effects relevant to their condition, along with helpful questions to discuss with their doctors.”

You can check out the profiler by visiting www.lungusa.org and clicking on the COPD Lung Profiler icon.
Another Reason They Should Quit

A new study finds postmenopausal women who quit smoking or significantly reduce the number of cigarettes smoked can lower levels of two proteins involved in bone loss. A hormone-binding protein called SHBG and a marker of bone loss called NTx dropped by 8% and 5%, respectively, in women who quit or cut back on their cigarette intake over a six week period. By contrast, SHBG and NTx levels rose within a control group of women who maintained their smoking habits during the same time period.

“This may partly explain how smoking contributes to osteoporosis in postmenopausal women,” says Cheryl Oncken, MD, MPH, who authored the study in Nicotine & Tobacco Research along with colleagues from the University of Connecticut School of Medicine. They believe future research should focus on whether longer periods of reduction or abstinence might produce more significant declines in these or other bone loss proteins, and whether these changes result in stronger bones and less fractures over time.

Want to receive this newsletter electronically? E-mail: mendoza@aarc.org for more information.

### Pulmonary Rehabilitation: The Year in Review

Brain W. Carlin, MD, FCCP, FAACVPR, medical director of cardiac and pulmonary rehabilitation at Allegheny General Hospital in Pittsburgh, PA, presented an interesting review of the scientific literature pertaining to pulmonary rehab at last year’s CHEST 2002 conference in San Diego, CA. Dr. Carlin has graciously agreed to share the information with us:

**GENERAL - REHABILITATION**


**CHRONIC OBSTRUCTIVE PULMONARY DISEASE**

- T Nishimura, T Izumi, M Tsukino, T Oga. Dyspnea is a better predictor of 5-year survival than airway obstruction in patients with COPD. *Chest* 2002;121:1434-1440.

**PHYSIOLOGY - COPD**


**EXERCISE TESTING**


**REHABILITATION**


---

**Continuing Care and Rehab Bulletin**

Published by the American Association for Respiratory Care 11030 Ables Lane Dallas, Texas 75229-4593

(972) 243-2272 • (972) 484-2720 FAX e-mail: info@aarc.org

**Chair**

Mary Hart, RRT, RCP Baylor Asthma and Pulmonary Rehab Center 4004 Worth St., Suite 300 Dallas, TX 75246 (214) 820-3500 (214) 841-9799 FAX maryhar@baylorhealth.edu

**E-mail:** mendoza@aarc.org
Nasal Spray Flu Vaccine Not for the Elderly

Elderly people most at risk for complications due to influenza aren't likely to be good candidates for the newly developed FluMist vaccine. Food and Drug Administration (FDA) advisors have endorsed the nasal spray vaccine only for healthy people between the ages of five and 49.

According to the advisors, there is currently not enough medical evidence showing the vaccine protects older people - particularly those with chronic diseases such as asthma or COPD - from the flu. Given the restrictions, health officials question whether the vaccine will be available for anyone in time for this fall's flu season, noting the FDA may balk at approving a vaccine with such limited use.

The vaccine was originally developed to provide an easier vaccination route to toddlers but won't be used in that age group because studies have shown it increases the risk of asthma attacks. Health officials also note the vaccine, which is made from a weakened but live flu virus, hasn't been adequately compared for efficacy with standard flu shots, made from killed viruses.

OUTCOME MEASURES


Music Means Miles

Ohio State University researchers believe listening to music while exercising may help people with severe respiratory disease increase their fitness levels. In their study, subjects with serious lung disease who listened to music while walking covered an average of about 19 miles over the course of an eight-week exercise intervention study. A control group that didn't listen to music only walked an average of about 15 total miles. That four-mile difference is significant, says study author Gene Bauldoff, an assistant professor of nursing at Ohio State, suggesting that participants in the music group may have felt less hindered by shortness of breath.

Study participants were divided into two groups of 12 patients. Each patient had already completed a six- to eight-week pulmonary rehabilitation program in the three months prior to the study. During the eight-week study, subjects kept journals of how often they walked and for how long. Participants were encouraged to walk for at least 20 minutes two to five times a week.

Subjects in the music group were given a portable audio-cassette player and two tapes containing country/western, classical, pop/Motown, and big band music. All the participants received an electronic pedometer to wear while walking. The pedometer measured walking distance to 0.01 mile. Each also performed two six-minute walks three times during the trial: at the beginning of the study and at weeks four and eight. At each visit, the researchers recorded the greater of the two distances the participant covered. They also asked participants how tired or out of breath they felt at the end of each walk, and the subjects filled out questionnaires on anxiety, depression, and quality of life during each visit.

By the end of the study, the total walking distance covered by the music group was 24 percent higher than that walked by the non-music group (19.1 vs. 15.4 total miles). This translated into an average increase of 445 total feet walked per workout in the music group, from 1,022 feet to 1,467 feet covered. The average distance covered by the non-music group decreased by about 170 feet, from 1,129 feet to 960 feet.

“That’s pretty dramatic, considering that something as simple and cost-effective as music helped improve these patients’ fitness levels,” Bauldoff says.

She and her colleagues aren’t certain why there was such a large difference in distance walked between the groups, but they believe music may have helped subjects walk at a greater velocity.

“Increased velocity may enhance the effects of training, leading to physical differences in a relatively short time,” she says. The greater walking capacity in the music group also may have spilled over into other aspects of their lives. Bauldoff notes participants in the music group reported less trouble with shortness of breath during routine activities, such as bathing, combing their hair, and cooking meals. Participants in the non-music group didn’t report any change in breathing.

The research was supported by a grant from the National Institute of Nursing Research and published in a recent issue of *CHEST*.  

---

**NUTRITION AND COPD**


---

**FDA**

AARC Membership: 
Join as a Group and Save! 
The Bigger the Group, the Bigger the Savings!

Single membership in the AARC is $90 per year. Through the discounted group program, you can save on bulk membership purchases:

- 10-19 memberships: $85 per membership
- 20-39 memberships: $80 per membership
- 40-99 memberships: $75 per membership
- 100 or more memberships: Call the AARC for an even bigger savings

HELP OUR SECTION GROW

With numbers comes strength; we need practicing respiratory therapists to be active members in their professional organization and their speciality section.

Contact Pat Lee at (972) 243-2272 or lee@aarc.org for more information. ♦