

President's Message Laurie Tomaszewski



The AARC has an annual award called the Summit Award. The Summit Award is the recognition by the American Association of Respiratory Care for the society that has attained the highest level of activism. Each state society, that chooses to submit an entry, has a chance to be awarded this prestigious honor. Every year it is the first duty of our President-Elect to collect and submit our information to the AARC. Each year we struggle to obtain the information. I would love for this year to be different...what does that mean to you? I'm asking every one of you, who does anything to promote our profession, to let us know about it. We want to brag about you!

Have you or your department:

- Held an educational offering to the public?
- Gone to health fairs or community events and promoted our profession?
- Represented our state on a national level? (It is amazing how many there are of you out there!)

President's Message
continued on page 5.

Walking in My Oxygen Patients Shoes by Robert McCoy, BS, RRT, FAARC

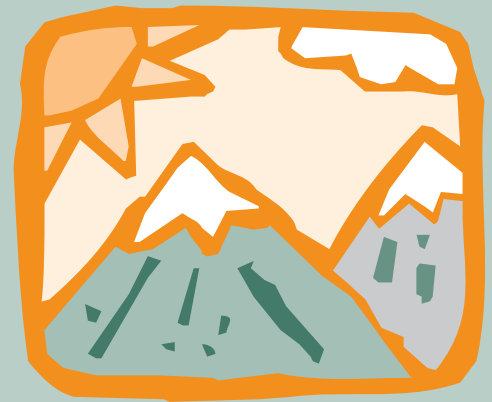
There is an old saying that you should not judge a man until you have walked in his shoes for a mile.

As Respiratory Therapists we are trained to diagnose and treat lung disease, yet quite often our limited knowledge of what it is like to have lung disease limits our ability to understand the patient's perspective. We preach and teach, yet many times do not reach the patients with therapy to improve their quality of life. In home care, we provide oxygen equipment, yet don't know what it is like to live with oxygen 24/7.

I recently had the opportunity to climb Pikes Peak in Colorado to raise money for a charity. The altitude at the top is 14,100 feet where even resting oxygen saturations are around 80%. At first I declined as my age and conditioning would limit my ability to complete the climb. On further consideration, I realized I'm a respiratory therapist that works with oxygen technology and conducts research. I decided to do the trip and make this an adventure. I would take a walk in my patient's shoes to see what it is like to need and wear oxygen while doing physical activity.

The trip was well planned and we would begin our walk at a base station that was at 10,000 ft and follow a trail for 6 miles up the mountain to the summit at 14,100 ft. The estimate time required to

complete the climb was 6 hours. The trail they described turned into a mountain side that had steep inclines and large boulders. It was good they did not go into too much detail as I might have reconsidered my decision.



First step, get oxygen

Just like our patients, I wanted the lightest weight, longest lasting oxygen system. Since I work in the business I thought I could convince manufacturers to support the trip with products. I was able to get two m6 composite cylinders that would be the lightest compressed gas systems. I was able to use an oxygen conserving device that was part of my inventory from doing comparative testing of OCDs. I chose a silicone type cannula as they seem to be the softest and my experience with the asthma walk proved

Article continued on page 12.

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R E I N V E N T I N G L I V E S

Editor's Note

WINTER ISSUE DEADLINE
NOVEMBER 12, 2007



I was so hoping that I found some help for *The Bronchus* committee but I'm sad to say my new committee member fell through. So I would like to put a call out to anyone who is interested to please contact me at meganterveen@hotmail.com if you'd like to join our committee.

In this issue is a great story from Bob McCoy about his recent experience where he got a chance to put himself in the shoes of our patients. I was so impressed with his article and other recent articles that we've received about respiratory therapists learning from their own hands-on experiences. These days I spend more time with sleep patients than asthmatics or COPDers. I've tried wearing a CPAP at home before attempting to put myself in my patient's shoes and I openly admit that it was a difficult experience. I threw in the towel easily after a week

hoping that it was my lack of real motivation to treat a true sleep disorder as the reason for failure though I'm not sure if that is just the story I told myself. I learned from my feeble attempt how very different my patients can be. What's right for one person is certainly not always right for someone else.

I congratulate all RTs out there who practice patience every day and remember that no two people are exactly the same. Don't forget to stretch daily to stay flexible!

Megan Schultz



The Bronchus is the official newsletter of the Minnesota Society for Respiratory Care, and an affiliate of the AARC. Published in Minneapolis, Minnesota. *The Bronchus* welcomes articles from respiratory therapists, physicians, nurses, and other health care personnel interested in pulmonary care.

Editorial Guidelines:

The Bronchus welcomes contributions from readers, whether in the form of editorials, counterpoints, or commentaries. The editors of *The Bronchus* make the final decision on what letters are published. All letters must include the writer's name, address, telephone number, and email address if available. This information will be included in the letter if it is published. Any reader responses to a submitted letter will be referred back to the author. Letters must also include the writer's signature. We reserve the right to edit all letters. Letters should be kept brief. By submitting a letter to the editor, a counterpoint letter or a commentary article to the MSRC you are agreeing to give the MSRC permission to publish the letter or article in any format and in any medium. All letters submitted become the property of the MSRC.

Disclaimer: All articles published, including editorials, counterpoints, and commentary, represent the opinions of the authors and do not reflect the official policy of the Minnesota Society of Respiratory Care or the institution with which the author is affiliated, unless this is clearly specified.

Editor _____ Megan Schultz
Circulation Coordinator _____ Jeff Anderson
Advertising Manager _____ Nick Kuhnley

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Megan Schultz: meganterveen@hotmail.com

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If you change your address or are having problems receiving *The Bronchus*, please notify the MSRC c/o:

Jeff Anderson

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It will also be necessary to notify AARC Membership Services at:
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President's Message (continued from cover)

- *Joined with a state group to promote lung health?*
- *Attended an Asthma Walk, COPD walk (let us know about your team)*
- *Pulmonary Rehab awareness?*
- *Served in the military?*
- *Spoke to schools, churches, and work groups?*
- *Tobacco abuse prevention work?*
- *Volunteered at an Asthma Camp? (or as in my case, home medical equipment company that donated supplies and equipment)*
- *Legislative work on behalf of respiratory care?*
- *The MSRC is very involved in state disaster preparedness – we'd like to know what you've done to help your town prepare.*
- *Do you have a picture of your event?*

If I've over-looked something; I apologize.

The one item that the AARC looks closely at that we can't seem to rise above is membership numbers. Our membership committee has tried a number of things to increase the number of members to the MSRC. When you join the AARC you automatically join the MSRC and we receive a rebate for your membership. If any of you have a great idea to increase our MSRC numbers please let me know.

There is a very simple way of submitting your information to the MSRC.

1. Write up your information in a Word document and save it.
2. Go to www.msrcnet.com
3. Double click on MSRC
4. Choose "contact us"
5. My email address will appear in the Outlook e-mail box.
6. In the subject line write Summit Award
7. Go to "insert"; "file attachment"
8. Attach your Word document
9. Send!

You can send us information anytime during the year; we'd love to get it as it happens so it is not forgotten about. We must have the information by the end of January of each year.

Thank you all for your professionalism and your dedication to our profession. Our society wouldn't be where we are today without all of you. We appreciate your work and your activism; let us tell the AARC about you!

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The Freedom to Breathe Act of 2007: Thirty-Two Years in the Making

by Jan Salo Korby

In 1975, Minnesota became the first state in the nation to pass legislation limiting smoking in the workplace. The historic Minnesota Clean Indoor Air Act (MCIAA) regulated most workplaces, with the notable exception of the hospitality industry. Although a landmark piece of health legislation, the law only went so far as to require restaurants to provide nonsmoking sections for customers.

2007 session

In May 2007, the Freedom to Breathe Act was passed by a bipartisan majority of the Minnesota Legislature and signed into law by Governor Pawlenty on May 16. The law, which takes effect on October 1, greatly expands the reach of the MCIAA by extending secondhand smoke protections to customers and employees alike in virtually all indoor workplaces, including restaurants, bars and private clubs.

Why was the Freedom to Breathe Act of 2007 passed and signed into law?

The Freedom to Breathe Act of 2007 recognizes the evidence of the Surgeon General's 2006 report, *The Health Consequences of Involuntary Exposure to Tobacco Smoke*. The report concluded that there is no safe level of exposure to secondhand smoke indoors and that nonsmoking sections and ventilation systems don't effectively protect the public or employees. It's estimated that each year 580 secondhand smoke-related deaths occur in Minnesota, and that more than \$215 million is spent annually in the state to treat health conditions caused by secondhand smoke exposure.

The Freedom to Breathe Act of 2007 will help to reduce the death and disease associated with exposure to secondhand smoke. It will also help to reduce absenteeism and health care costs associated with smoking-related illness and will encourage people who smoke to quit.

**The MSRC would like to thank
Pressworks, Inc. for their support and help
in printing this issue of *The Bronchus*!**



Highlights of the Freedom to Breathe Act of 2007:

- No smoking is allowed in bars, restaurants, private clubs or other workplaces
- Smoking is permitted on outdoor patios, but can be regulated at the local level
- Smoking may occur in places of work and public places in the following locations or situations:

Hotel and motel sleeping rooms, tobacco products shops for sampling purposes only, certain family farms, public transportation vehicles when in personal use, cabs of heavy commercial vehicles, farm vehicles and construction equipment when used for intended purposes, certain nursing home rooms, certain rooms occupied by patients in locked psychiatric units, peer-reviewed studies on the health effects of smoking, traditional Native American ceremonies, the Disabled Veterans Rest Camp in Washington County and by actors performing in theatrical productions.

For more information on the Freedom to Breathe Act of 2007, visit www.freshairmn.org.

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COPD Committee Report

by Kris Mrosak

The COPD Committee had representation at the second Annual Respiratory Rally held July 11th at the Marriot in Bloomington.



Many people attended and visited our booth which promoted the MSRC, correct inhaler techniques, awareness of pulmonary rehab, benefits of exercise, and knowledge of lung diseases.

We held drawings for 1# and 2# weights and spacers. We also spoke to the group in the afternoon on Exercise and the Pulmonary Patient.

We were able to give participants a look into the types of exercise pulmonary rehab offers via PowerPoint and demonstration. It is exciting to see the interest from our patients in exercising!



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Honorable Mention

St. Paul College has engaged in aggressive recruiting to attract more men to the Health care profession and respiratory care in particular. They've used the media to Highlight prominent men working in the health profession. They've also relied on a highly visible department chair to showcase faculty in nontraditional occupations.

The number of men enrolled in the respiratory care program at St. Paul College increased dramatically in only a four year period increasing to 88 participants in 2006

(out of a total 169 enrolled students; pre-major and major students). There has been an increase in **male graduates** from the respiratory care program as well. Since 2005, male graduates have made up anywhere from 42 to 62% of respiratory care graduates.



Minnesota Respiratory Care Practitioner of the Year 2007

by Lisa Hamel

Congratulations to this year's Minnesota RCP of the year. He's a well known practitioner most everyone has been familiar with either through education or clinical experience.

With over 30 years of experience as a practitioner he's practiced in the Twin Cities with most of his year's at HCMC. For the past five years, he's relocated to Mankato provided his expertise over the Mayo Health System. If you don't know yet who we're talking about yet, Charles McArthur has made his mark in our state.



Charles McArthur

As an RCP at Immanuel St. Joseph's, Charlie has been instrumental on leading improvement efforts for our patients. As part of the Institute of Healthcare Improvement efforts, care bundles such a Ventilator Associated Pneumonia, Sepsis, Central Line, and Community Acquired Pneumonia have been implemented. Charlie's role in our organization's Code Blue Team and Rapid Response has lead to decreases in patient mortality from 21% to 15% in 4 years. Code Blue decreases have been seen over the last 4 years with better early recognition of failing patients through rapid response.

Most importantly, Charlie's work with the respiratory care department has lead to a full implementation of a protocolized therapy service for our patients. We can proudly say, every patient who is admitted, who needs care by an RCP, get the service each and every time. It took three years of work but the patients are reaping the benefits.

" I feel very honored to be recognized by my peers in the MSRC. I want to thank all the folks I have worked with over the years and I hope you know that I share this award with you."

The work outside our institution by Charlie has really been recognized by his peers. He participates in our Education Committees by helping plan the North Regional Respiratory Care Conference. He has been elected and served many positions for our state as well as nationally, BOD, President, and Delegate. Nationally as Chair of the Cardiopulmonary diagnostics section as well as elected as a Fellow to the American Association for Respiratory Care.

We're proud to recognize Charlie as a valuable state asset and reward him as our State RCP of the year. Those that know him. love him and he's very deserving of this recognition!

RCP of the Year Nominees



"Pat is an outstanding therapist and mentor. Shas been involved in the community raising awareness about Asthma, COPD and much more by volunteering so much of her time to the profession of Respiratory Care."

– Pat Johnson, C.O.R.E Respiratory Services



"He is a true advocate for the profession of Respiratory Care. Randy also helps the community by donating staff and resources to a variety of causes including Camp Superkids, assisting with COPD Foundation Spirometry Mobil Unit, even donating his own time to this effort."

– Randy Kuzel, C.O.R.E Respiratory Services



"As a member of the MSRC Disaster Preparedness Committee she has been instrumental in both the development of the State's Oxygen Conservation Protocol and in Ventilator triage and allocation."

– Vicki Shrupp



"Nick as well as many others, has spent an inordinate amount of time and energy to put together a disaster preparedness plan for the bird flu. He has also served his community and profession within the MSRC for many many years."

– Nick Kuhnley, North Memorial"



"Stacey has a unique position as both educator and consultant for the Northfield Hospital, as well as establishing ties to her community through disaster preparedness.I applaud her innovation and accomplishments."

– Stacey Zell, Northfield Hospital



"Angela is one of the smartest R.T.'s that I have ever met and she is only a few years out of school. She caught on really fast when she started at the hospital and I consider her one of our 'Rising Stars'"

– Angela Mahawald, Minneapolis Children's Hospital



"Sue has been involved with the MSRC for many years and in several different capacities. She is a current Board Member, chairs the Asthma Committee, and is also on the Education Committee. Not only is Sue an exceptional RCP, she has carried the respect and love of her profession to her children, by having a son who is also an RT."

– Susan Knight, Gillette Children's Hospital



"Joe has continually gone beyond his call of duty in his realm of teaching and his personal life which involves the Army where he was chosen one of America's 50 Heroes from 50 States. Joe always puts other people first."

– Joseph Paul Buhain, Program Director for Saint Paul College

The 2007 MSRC Election Results are In!

The 2007 MSRC election results for 2008 Officers were announced at the MSRC Board meeting held September 18, 2007 at the North Regional Respiratory Care Conference. The results are as follows:



Shelly Klein
President Elect



Steve Sittig
Vice President



Lori Vogelpohl
Secretary



Curt Merriman
Delegate



Cindy Darnell
Board of Directors



Gary Johnson
Board of Directors



Brianna Long
Board of Directors



John Wheeler
Board of Directors

Congratulations to those listed above! A special thanks to ALL the candidates for their willingness to run for office.

Student's Corner

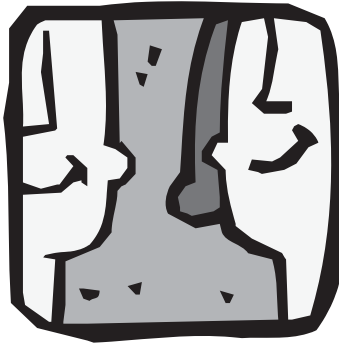
Mayo Team goes to Nationals!

Congratulations to the Mayo Student Sputum Bowl team who will be competing at the 53rd AARC International Respiratory Congress National Sputum Bowl this December in Orlando, Florida. **Good Luck!**

Camp SuperKids: Summer Camp for Kids Who Have Asthma

The laughter fill the air as a canoe full of kids is tossed around on a windy July lake. It is summer in the Midwest and camp season is in full swing. For some kids, however, summer is a lonely time as they watch their friends and siblings leave for outdoor adventures in which they cannot participate. These kids are unable to attend regular summer camp or enjoy the usual summer activities because of a chronic disease called asthma.

Unfortunately, asthma is a widespread and serious disease for today's youth. About 8.9 million American kids suffer from asthma. Annually, kids miss a total of 14.7 million school days and account for 727,000 emergency department visits. With statistics such as these, attending a regular summer camp is out of the question, but the American Lung Association of Minnesota believes that no child should be held back from the summer fun because of his or her asthma.



Camp SuperKids has a 41 year history for kids who have this chronic inflammatory disease. It is a place where a kid can be a kid. A kid can laugh and play, but also learn about their disease and how to manage it in a fun outdoor setting. At Camp SuperKids 2007, there were 138 attending campers. Camper education time, a time specifically intended to educate the kids about their asthma, is taught by nurses and medical volunteers who donate their time.

Camp is an important experience for staff and campers alike. This year, we had over 50 medical volunteers to whom we are very grateful for their support. The staff helped with assessing and giving medical treatment to kids who have asthma. It is exciting to see campers becoming more confident as they learn to successfully manage their disease. If you would like more information on becoming a Camp SuperKids staff member or would like information on the camp, log on to www.lungmn.org or contact Jonathan Oney at the American Lung Association of Minnesota at 651-268-7598.



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Walking in My Oxygen Patients Shoes (continued from cover)



to me that plastic cannulas are not as comfortable. The one glitch was that I could not get a gas supplier to fill the composite cylinders to their full capacity at 3000 psi so I did not have the range per cylinder that I had hoped for.

Second step, monitor the trip

The challenge for home care is to document everything you do and get it published. If it is not documented, it didn't happen and evidenced based research is going to be the foundation of respiratory therapy. My son in law was along for the trip so I used him as a control and fitted him with a recording oximeter. I wore a recording oximeter and brought a spot check oximeter for others in the group. The recording oximeters displayed oxygen saturations and heart rate, which was both good and bad. At times my heart rate was so high and saturation so low, that if I had been in an ED, someone would have put a tube in me!

Third step, begin the adventure

We started the day at 6 am to try to beat the thunderstorms that happen almost every afternoon on the mountain top. I did not want to be in a thunderstorm with lightening as I was using aluminum walking poles and carrying oxygen. At the base we assembled our equipment and

discussed the hike. I was going to save my oxygen and only put it on when I felt I needed it. Even though my oxygen saturation was 89 at 10,000 feet, I felt OK. How many times have we heard that from our patients that they don't want to wear their oxygen because they feel OK?

We began to walk and within 100 yards, my heart rate was up and my oxygen saturation was down. I put on the oxygen. As we walked I realized I was breathing very fast and could hear my oxygen conserving device clicking away in my back pack. I assumed that the oxygen would compensate for my lack of conditioning, it didn't! So now I had the same dilemma our patients have. I have a fixed amount of oxygen, a trip that will take at least 6 hours, a needed pulse setting and a fast respiratory rate. How do I make my oxygen last for the trip? I dropped the pulse setting as it was the only variable I could control. Again, doesn't this sound like oxygen patients rationalizing their prescription?

With the lower dose, the high workload and high respiratory rate I was going through my oxygen quickly. Half way through the climb, my first cylinder was empty. I switched to my second tank and did a quick calculation as to the remaining distance and my amount of oxygen; I didn't want to run out near the top when I would need the oxygen the most.

Running the OCD at the lower dose, my oxygen saturation would drop quickly so I would take breaks and stand still to catch my breath. I would say I was observing the fantastic scenery, yet I was really watching my oximeter to see if I could get back into the 90's. Again, how many times have we seen our oxygen dependent patients do the same thing; need to sit down and catch their breath.

I made it to the summit with a little oxygen to spare. At the top you can see for miles and the view is spectacular and made the trip worth all the effort. I thought to myself that I would not have made it without the oxygen and that this gave me the opportunity to enjoy life. Our oxygen dependent patients want to enjoy life too.

Maybe not a mountain top experience, yet doing normal activities of daily life are wonderful and often taken for granted until they are no longer possible.

What I learned

- When you can't breathe nothing else matters (ALA slogan)
- Oxygen does make a difference in abilities.
- You can get light weight or long lasting oxygen systems, you can't have both
- When you accomplish your objective nothing feels better

We need to help our oxygen patients meet the challenges they face every day with oxygen systems that allow for normal activity. With proper conditioning, many of these patients can go back to doing what they did before prescribed oxygen and lead as normal a life as possible. We are respiratory therapists and we find solutions and make a difference in our patient's lives.

Charity sponsoring the climb
www.climbforjustice.org

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Camp We No Wheeze

by Peggy Lane

Camp We No Wheeze 2007 Central was held August 3-6 at the Camp Courage Facilities in Maple Lake MN. Medical direction of the camp is by allergy and asthma specialists, primary care providers, respiratory care practitioners, nurses and counselors trained to care for kids with asthma.



39 campers from around MN, attended the weekend long camp with many activities to keep everyone busy. Daily education sessions included topics: "What is asthma", "How to control triggers", "Early warning signs", "Medications and tools", "Feelings about asthma" and "Asthma action plans". This camp is for children ages 7-13 that have asthma and are on daily medications. Half of the children were return campers and half were new to the camp. This year, two previous campers came back as junior counselors. We were glad to see them!



Emphasis is placed on managing asthma and keeping active. At Camp the activities include: Outdoor games, including "Zoo Escape", "Bonkers", swimming, team contests, fishing, tubing, horseback riding, arts and crafts, and great food! Two community health interns from St Cloud State University helped with designing

education games of "Capture the Flag" and a night of "Design your own medication".

One of the interns wrote the annual Staff Song to the tune of YMCA, using asthma terms! We give many apologies to the Village People. Our costumes were a sight to see...meaning...you would have to see us to believe it! Someone has a videotaped copy- we hope never gets shown anywhere!

If you know of kids from anywhere around the state that would benefit from the camp, give us a call. We welcome Respiratory care students to help also. There is great experience with teaching the campers to take medications correctly and working with them on their peak flows!



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Emergency Preparedness Tested by 35W Bridge Collapse

by Judy Hannigan, RCP, Director of Respiratory Care, HCMC

By now, another article about the 35W bridge collapse may seem like old news. Most of us have shared our personal stories, altered our commute or travel routes, and seen countless images of the site or visited the scene itself. We have settled into acceptance and moved on. But for those of us who were directly faced with responding to the disaster, the actual impact of that experience will no doubt last at least as long as the images in our minds and will become part of our histories as Respiratory Care Practitioners.

It's common knowledge throughout Minnesota that Hennepin County Medical Center is a state-wide resource for major trauma cases and routinely handles high ventilator volumes per patient census. Shortly after 6 pm, on August 1st, however, we were suddenly faced with the prospect that we were about to be tested in a whole different and surreal way.

"The 35W bridge has collapsed into the Mississippi river! There are people and cars everywhere in the river!"

"Where did you hear that?"

"It's all over television!"...

All week, we had been experiencing higher than normal numbers of patients requiring ventilator support. At the beginning of evening shift, we started with 36 operating ventilators, plus an additional 14 patients who required some form of non-invasive ventilation. Already stretched over our comfort zone of caring for 28 to 30 ventilator dependent patients on an average day, the news of the bridge collapse brought with it the potential to use all available human and mechanical resources very quickly. If there was any comfort to be had, it was in the knowledge that we had reached a record high volume of 53 ventilators operating at HCMC just months earlier. What we had previously identified as our "surge capacity" for emergency response had already become a reality. We knew we had been tested and were capable. But now, eerie moments passed as we tried to anticipate the impact of the 35W bridge collapse. What could we expect from those frightening images? 10, 30, 50 new trauma cases? Within moments, RCPs began collecting, setting up, and counting all available ventilators.

Senior RCPs were already busy determining how to best staff for the unknown surge. Questions arose that did not have easy answers. Should we activate the entire disaster call list? How do we anticipate staffing needs? How and when do we modify staffing plans to respond to a sudden influx of patients?

"Attention all hospital personnel, Alert Orange is now in effect. Attention all hospital personnel, Alert Orange is now in effect."

Almost immediately, pagers started going off, beckoning additional RCPs to the Stabilization Room in the Emergency Department. Two stabilization cases were already in progress before the overhead page. Within minutes, one trauma patient from the disaster arrived, then the second, a third, and then the first death. A code in the hospital. 40 vents and counting...

As images and information started coming in from different sources, it was often difficult to separate rumors from reality. The pictures of the bus hanging precariously on the bridge led to immediate concerns about our ability to handle a large volume of children. Then, news that the bus was empty. No sooner had we started to convert the newborn/pediatric ventilators to adult circuits, when we heard that 60 children were in fact on the bus next to the burning semi-truck and they were being evacuated, conditions unknown.

Before long, RCPs who were off duty were calling into the department to find out if they were needed. This was a tremendous time saver as the call list seem to be activating itself. Staff were quickly activated or put on notice to "wait and see".

Calls went out to rental companies. How many ventilators and what type were available? Nothing consistent with our current machines could be found.

As luck would have it, competency checks for all staff in the department had just been completed that day on a new transport ventilator that we had just purchased. Ten of them were sitting in Bioelectronics, awaiting final performance checks before being put into service. Within moments, contact was made with Bio. As if to provide a moment of comic relief in the midst of increasing intensity, an inevitable "Of course you are!" situation occurred.

"Hello. Bioelectronics."

"Hi. You've heard about the disaster, right?"

"Yes. We're just starting to get calls."

"Okay. You know those 10 transport ventilators that you have down there?"

We need them checked out and sent up to Respiratory Care right away."

"....okay....but I'm the only one on, and I'm new."

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Delegates Report

RT 2012 and Beyond: Summer Delegates Report by Debra Skees, Jr. Delegate

You can avoid having ulcers by adapting to the situation: If you fall in the mud puddle, check your pockets for fish.
~Author Unknown

Gosh, I like that quote a lot! How often in our life do we end up struggling and expending so much energy to fight against the inevitable change that is prevalent in our life? There are so many outside stressors that obligate us to find different ways to do the things that we are so comfortable doing. For some, it is tough sell to consider that there may be a different or better way to do something as they see only the loss. But just as the quote suggests, there just may be a happy surprise in the end result.

The same is true for our profession as it continues to evolve with the external pressures imposed by regulating bodies, demand for hospital profitability, decreasing government reimbursement, cross-training and overlap of other disciplines to name a few. Having recently returned from Summer House of Delegates meeting, it is exciting to hear how the AARC is adapting to keep our profession strong and even perhaps coming up "with a few fish in our pockets".

One important project the AARC is undertaking is "RT 2012 and Beyond". The AARC has charged a committee, made up of a broad range of professionals and organizations that have an interest in the role of the respiratory therapist in the future, to identify future roles and responsibilities, the necessary training and competencies, and the strategy on how to get there. The work will take place in 3 separate conferences beginning in early 2008 and be completed within a year.

Several other important contributions have been created on behalf of AARC members or consumers:

- The "Life and Breath" video can be used for teaching and increasing awareness of the career path of a Respiratory Therapist.
- The Aerosol Device Book that arms you with evidence-based information to base discussions with physicians and patients on the most effective method of inhaled medication delivery.
- The Mobile Spirometry Unit (MSU) was created to work in conjunction with the COPD foundation to bring awareness to the public about respiratory health and the key role of the respiratory therapist in education and care. The Minneapolis convention center was the site of the MSU in March and had several local RTs providing spirometry and education to consumers that were concerned about their lung health.
- A guidance document was created to review any state's proposed legislation on polysomnography licensure. This "litmus test" has 3 goals: to assure that patient care and safety is first and foremost, to remain true to the historical path of the AARC and to maintain a good relationship between affiliates and the AARC.

Although North Carolina Society for Respiratory Care was named the 2007 Summit award winner, Jessie and I were very proud to hear that Minnesota was named as honorable mention in 3 of the 5 categories (education, political advocacy and promotion of the profession). Truly the many contributions of the MSRC members are acknowledged across the country.

Jessie and I also participated in discussion on pending and new resolutions brought forward by other affiliates. I will provide you with a condensed version of the work, but feel free to contact either of us if you have any questions.

Update on the status of previous HOD passed resolutions:

House Resolution #22-06-02 (from summer, 2006 HOD meeting), which states: "Resolved that the American Association for Respiratory Care develop, in conjunction with the National Association of EMS Physicians (NAEMSP), a standardized curriculum for training paramedics in the safe and appropriate use of ventilators for transport of patients outside the hospital setting".

Board Action: Defeated. This resolution was defeated by the AARC board of directors as the AARC can not unilaterally force competency on any given group. The board did create a new resolution that would appoint a task force to develop a position statement on the desirable skill set required for pre-hospital ventilator competency.

HOD Resolution #94-06-19 (from 2006 HOD meeting), which states: "Be it resolved that the AARC develop the process for the Chartered Affiliates to have the option of on line voting for state (Chartered Affiliate) elections".

Board Action: Remains open - the Executive Office will survey state presidents to see what initial interest there is, assign a work group from the state presidents to pull together the specifics and to cost it out. A report on the findings will be given at the December HOD meeting..

(Continued on page 17)

Delegates Report

(continued from page 16)

HOD Resolution #94-06-22 (from 2006 HOD meeting), which states: "That the AARC investigate the feasibility of providing Internet Domain to each affiliate for the purpose of setting up and maintaining their web sites for the Affiliate".

Board Action: Defeated. as not feasible to take on a major project at this time. It would require many additional resources and would be too expensive.

New summer 2007 HOD meeting proposed and passed resolutions:

HOD Resolution #29-07-07 which states: Resolved that the AARC create and charge an ad hoc committee to include several members of the HOD to investigate the issues surrounding transition from two NBRC (CRT & RRT) credentialing examinations to one NBRC (RRT) exam for qualified applicants".

Board Action: Defeated. It is expected that Project 2012 will address this

HOD Resolution #32-07-02 which states: "Be it resolved that the AARC develop Clinical Practice Guidelines for Delivery of Moderate Sedation."

Board Action: Defeated. Rationale for this decision: There is an AARC position statement for the Administration of Sedative and Analgesic Medication by Respiratory Therapist. It also recently was revised to include that a physician need not be physically present during the administration and it also references transport.

HOD Resolution #32-07-04 which states: "Be it resolved that the AARC survey the membership to see if there is enough interest to proceed with the development of a roundtable group to support the Respiratory Therapist's Role in the delivery of Moderate Sedation.."

Board Action: Accepted for information only. There was a proposed policy approved to assist with the development of Roundtables at this BOD meeting.

Other AARC board of director actions included:

- Approval of bylaws changes and a plan for a 5 year renewal schedule for affiliates
- Funding approval for a consultant resource that can be accessed by affiliates for strategic planning or organizational development

As you can tell it was a busy HOD meeting in Sparks, Nevada. As the brush and forest fires burned in the hills surrounding the meeting location, there were also "burning" conversations and "sparks" of creativity happening within. As always, Jessie and I are honored to represent the interests of the MSRC members and invite your questions and ideas for future resolutions. We can be contacted at debra.skees@allina.com or jessica.christopherson@respirionics.com.

Here's wishing you "pockets full of fish!"

Where We Work

Evo Medical Solutions

by Kirk Knutson, RCP

Hello! I would like to introduce myself. My name is Kirk Knutson and I am a RCP/clinical sales specialist. I am part of the sleep implementation team with Evo Medical Solutions of Adel, IA. I have been a Respiratory Therapist a long enough time that I have seen many important changes in this industry, most recently in the areas of home care and specifically in the sleep world.

With Evo Medical Solutions I have the great pleasure and opportunity to be part of the future of sleep testing, technology and treatment by helping to create awareness and better access to care for the current hot topic in respiratory care which is the major public health problem that is OSA and the issue of diagnosis and treatment. My position allows me to travel the United States and discuss

the growing problem of undiagnosed OSA with physicians, sleep labs and DME companies and share Evo Medical Solutions answer to this hot topic. We are promoting active screening of all adult patients which, when scoring positive for the likelihood of OSA, leads to sleep clinics in the physicians offices. Doing this allows me to talk to physicians across our great nation, become part of their health care team and encourage a pro-active stance on OSA.

Since becoming a member of the Evo team it has been exciting to be part of the future of sleep. As RCP's we always want to promote our profession and take a new pathway to make a difference to not only the sleep patient but respiratory patients everywhere.

Emergency Preparedness Tested by 35W Bridge Collapse

(continued from page 14)

Sometimes, faced with unusual challenges, people are most effective at finding quick solutions. Within the hour, new ventilators began streaming into the department.

In the Emergency Operations Center (EOC), the RC manager had donned the vest of the Cardiopulmonary Services Unit Leader. Like a beehive, people in different roles from Administration and Medical staff, Nursing, Respiratory Care, Pharmacy, Environmental Services, Food Services, etc. were communicating updates and information at periodic briefings and waiting for more information to be shared from the Emergency Room and First Responders.

Then, a lull.

Within less than two hours of the collapse, reports from the Chief of Emergency Medicine indicated that while the Emergency Department was continuing to see a high volume of minor injuries, there did not appear to be additional major trauma patients. Images that we had all by now seen glimpses of, conflicted with the information. "Was it possible?" Our disbelief lingered into the next hour. Then a mere three and a half hours later,

*"Attention, all hospital personnel,
Alert Orange all clear."*

*"Attention, all hospital personnel,
Alert Orange all clear."*

As with any real disaster or disaster drill, a debriefing occurred that reviewed what went really well and what could have gone better. Beyond the details, there are some broader lessons that were reinforced:

Take disaster drills seriously. What you learn when practicing them will serve you well when faced with a highly stressful situation that may test your skills and wits.

Know your resources. Connections within the Respiratory Care community are invaluable. Support from other hospitals, vendors, and suppliers provided reassurance and comfort that additional resources and supplies were readily available.

Respiratory Care Practitioners play a vital role in disaster preparedness and response. Our technology savvy and role in interdisciplinary assessment and care of the patient is essential, especially when extraordinary demands are placed on a hospital or community for quick care and treatment of patients.

Many thanks to all of the outstanding RCPs and SRCPs at HCMC who responded so efficiently and calmly to the disaster and to those at other hospitals that were also impacted. They have much to be proud of. Thanks, also, to the extraordinary RCPs and RC leaders in the community who have served on the MSRC Emergency Preparedness Committee or represented us at the state or national level to make sure that we are involved in critical decisions affecting Emergency Preparedness and planning; most notably, Nick Kuhnley from North Memorial Medical Center, Steve Sittig from Mayo, and Diane Saunders, from Fairview University Medical Center. Thanks to all RCPs who have served on DMAT teams and have taught us from their previous experiences about responding to national disasters. And finally, thanks to all of the supporting community, including vendors, who made their resources available to us if and when we needed them. This experience reinforced the knowledge that we are all the most prepared and capable when we are supported by and belong to a strong community.

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Save the Date

Important Dates for Upcoming Events.
MSRC 2007-2008

October 21-27, 2007:	Respiratory Care Week!
November 9, 2007:	North Memorial Annual Respiratory Fall Symposium; Robbinsdale, Minnesota. Contact Terrie Newton at 763-520-7457 for more information.
December 1-4, 2007:	53rd AARC International Respiratory Congress; Orlanda, Florida.
January 28, 2008:	MSRC Winter Workshop; St. Cloud, Minnesota.
February 28, 2008:	2008 MSRC Job Fair, College of St. Catherine; St. Paul, Minnesota.

Legislative Update

MSRC Striving for Licensure in 2009!

by Carrie Bourassa



Timeline

Now:

- MSRC Adhoc Committee formed, reviewing cost analysis and specific updates to current practice act. This will be an ongoing process with regular updates on the MSRC website (www.msrcnet.org).
- Further develop Minnesota's grassroots communication team (All MN RTs).
- Regular communication with Minnesota respiratory therapists via the Bronchus, emails, and the MSRC website.

Fall 2008:

- Ready to submit to the Minnesota Legislature for 2009-2010 legislative cycle.

Minnesota's Respiratory Advocates 1500+ Strong

Minnesota therapists needed for grassroots efforts!

The MSRC is further developing its grassroots communication by inviting every respiratory therapist in the state to join the Respiratory therapist email communication tree. This enables the MSRC to provide critical alerts, information and when contacting legislators is needed. **The MSRC advocacy efforts are only as strong as the MN respiratory therapists who make their voice heard at the state and national levels.**

The MSRC invites you to join this grassroots communication team by emailing Carrie Bourassa on the MSRC website to receive critical and timely information that affects our patients, community and profession.

MSRC Legislative Committee:

- Federal Affairs: Julie Clarke
- State Affairs: Carrie Bourassa
- Adhoc Committee for Licensure: Lisa Hamel
- Carrie Bourassa
- Legislative committee members:
- Lori Rausch
- Carrie Bourassa
- Laurie Tomaszewski
- Julie Clarke
- Curt Merriman
- Lisa Hamel

If you would like more information or would like to be involved on the Legislative Committee please contact any MSRC Legislative committee member.



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