MSRC Minnesota Society for Respiratory Care

The Bronchus

Official Newsletter of the Minnesota Society for Respiratory Care

Summer 2008 VOLUME 32 #2 www.msrcnet.com

President's Message
Vicki Engmark

Welcome to our new co-editor of *The Bronchus,* Dave Boeckmann! Thank you Dave for working with Rhonda Brown and Megan Schultz!

At the last MSRC Board of Directors meeting, the board voted on the following priorities: Publications/Website, Education, Membership and Infrastructure. To accomplish the goals set by the board, 3 different task forces are being created. The 3 task forces will be for Publications/Website, Education and Membership.

Publications/Website

The goal set by the board is to have the website become the primary method of communication. The task force will evaluate the current methods of communication and bring options to the board that will achieve the goal.

Education

The goal set by the board is to have an increased attendance at all educational offerings. The task force will work with the Education Committee to evaluate current educational structure and the needs of the respiratory therapists, and bring a plan to the board that will achieve the goal.

Membership

The board has set a goal to increase membership each year. The task force

President's Message *continued on* ***page 12***

Home for Vets

by Joe Buhain, RRT and Tim Strand, Carpentry Instructor, St. Paul College

Saint Paul College Carpentry Program and Saint Paul College Respiratory Program, in conjunction with Homes for Troops, is going to try and raise funds to help build a home for a veteran. We need your support. Make a difference and help support us.

Homes for Our Troops Named a "Top-Rated Charity" by American Institute of Philanthropy

Homes for Our Troops is proud to let you know that the American Institute of Philanthropy (AIP) (www.charitywatch.org), one of the country's premier charity watchdog organizations, has reviewed Homes for Our Troops' finances and they have included Homes for Our Troops in their "Top-Rated Veterans & Military Charities" listing. Only **5** of the **32** Veterans charities listed in AIP's most recent report are included in the Top-Rated Category.

Homes for Our Troops' donors and supporters expect us to prudently manage the funds they entrust to us so that we can build as many homes as possible for the severely injured Veterans we are honored to assist. We are sending you this great news so you can know that we are working diligently to meet your expectations. AIP recently testified before Congress as part of the government's investigation into the questionable practices of some charities in how they report their results and how they spend their money. We are proud of the fact that this watchdog agency, who is in the forefront of insuring that charities report full and accurate figures, has included **Homes for Our Troops in its Top Rated Category.**

AIP's stringent review process focuses on the percent of costs spent on Program Service Costs and the efficiency of organizations in raising funds. Rather than just using the figures reported by charities in their Form 990's, the AIP adjusts for direct mail, telemarketing and solicitation costs that are sometimes allocated to Program Service Costs, and they exclude the value of donated goods and services, which can be difficult to measure.

"Home for Vets" continued on ***page 12***

The Next Step

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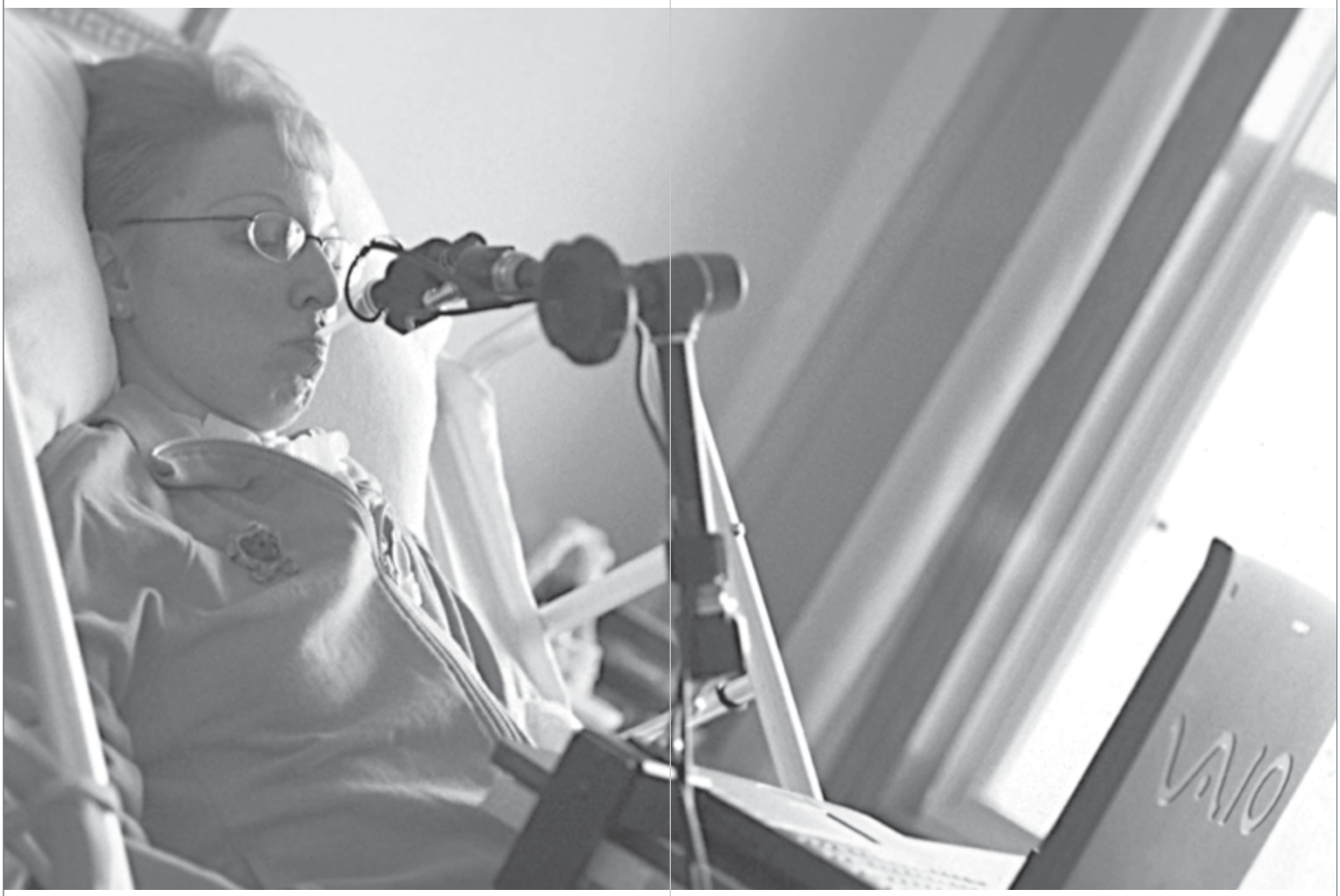

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R E I N V E N T I N G L I V E S

Editor's Note

FALL ISSUE DEADLINE: **August 25, 2008**

As we are putting together the Summer edition of *The Bronchus* it is official, winter is over with temperatures to prove it. We have earned this wonderful weather after such a long winter! We have a great addition to *The Bronchus* as the Co-Editor and his name is David Boeckmann. David has great passion and enthusiasm for our profession which is why I asked him to join me (and Megan of course) as the Co-Editor of *The Bronchus.* Read farther to learn more about him and how he came into Respiratory Care. This issue is full of great information including new asthma guidelines for ages 0–4 submitted by Sue Knight and Greg Beaudoin. Thank you to everyone who continues to support *The Bronchus* and submit wonderful articles for our publication.

Rhonda Brown, RRT
Co-Editor *The Bronchus*

My name is David Boeckmann, I was asked by Rhonda Brown whether I could help her as co-editor of *The Bronchus.* So here I am. I've worked with Rhonda as an RT at Minneapolis Children's for approximately two years. There is much I've learned from her and so I thank her for this opportunity to collaborate with others to produce this fine publication.

I went to North Hennepin C.C. back in the early 70's when "Inhalation Therapist" was our RT of today. The first year of the program was strictly academic. The two-year nursing students had the same first year requirement as did RT. In fact, there was no mention of Respiratory Care until one went onto clinicals in the second year. Then it was full time training in the hospital. I did not last more than a week as I realized I could not detach myself from the sufferings of babies and children. After 30 years of doing other things, I entered the RT program at St. Paul C.C. in 2003 and graduated in 2005. I am now here at Minneapolis Children's working with 400 gram preemies.

David Boeckmann
Co-Editor *The Bronchus*

MSRC Minnesota Society for Respiratory Care

***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.

Co-Editors ..... Rhonda Brown
David Boeckmann
Circulation Coordinator ..... Jeff Anderson
Advertising Manager ..... Nick Kuhnley

FILE SUBMISSION

All materials for publication, including advertisements, should be submitted in electronic form. Acceptable file formats include: Word, InDesign, PDF, EPS, or TIFF. Images should be at highest resolution available.

Send files via E-mail to: Rhonda Brown: bwbrown32@hotmail.com

CHANGE OF ADDRESS

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

Jeff Anderson
8400 Coral Sea St. NE Suite #200, Blaine, MN 55449
(763) 780-0100; jander307@charter.net

It will also be necessary to notify AARC Membership Services to continue to receive AARC publications at:
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Education Committee Update

by Anne Uttermark, RRT, Abbot Northwestern Hospital

The 2008 Spring Workshop was held on Friday, May 2 at the CentraCare Health Plaza in St. Cloud, Minnesota. There were over 50 participants who enjoyed a day filled with great speakers, wonderful vendors and plenty of food to eat. The day featured a wide variety of topics including the latest and greatest in asthma care, current sleep trends (including information on the new machines), education on irritant gases and riot agents, the effects of the methamphetamine industry on children, the use of high frequency ventilation in the adult population, and an update on the tobacco guidelines. It is safe to say that there was something for everyone and the feedback so far has been overwhelmingly positive.

Thank you to all who attended this conference!

Thank you to our very knowledgeable speakers; Dr. Mohamed Yassin, Dr. Troy Payne, Kirk Hughes, RN, EMT, Dawn Bidwell, EMT-P, EMS Educator, Denise Eide, CRT, RCP, and Jan Salo Korby, RRT. They all did a wonderful job and kept everyone engaged!

Thank you to all the vendors—we couldn't put on these valuable educational conferences without your support!

And, finally, a special thank you to the members of the Education Committee. Your hard work and dedication has paid off yet again.

We will soon begin planning the 2009 Winter Workshop, so watch for further updates. If you have any great topic ideas or would like to join the education committee, feel free to speak with a member of the committee.

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In The News

U of M Study Provides First Scientific Evidence That the Freedom to Breathe Act is Creating Healthier Workplaces for Hospitality Employees

— ClearWay Minnesota℠

Submitted by:
Tobacco Abuse Prevention Committee

Study found an 85 percent decrease in carcinogen levels in study participants

MINNEAPOLIS, Minn., March 27, 2008 – A new study released today by the University of Minnesota Cancer Center and ClearWay Minnesota℠ found that since the Freedom to Breathe Act went into effect on October 1, 2007, hospitality workers have significantly reduced exposure to a tobacco-specific cancer causing chemical.

The study measured workers exposure to cotinine (a measure of nicotine exposure) and NNAL, a by-product of a potent lung cancer-causing toxin, before and after the law took effect. The study included nonsmoking employees of bars, restaurants and bowling alleys from throughout the state. Each participant submitted urine samples taken before and after the law was enacted, as well as a detailed questionnaire, to the University of Minnesota research team for analysis. Major findings include an 83 percent decrease in cotinine levels and an 85 percent decrease in NNAL levels inside study participant's bodies.

Dr. Dorothy Hatsukami, a nationally respected tobacco researcher, served as the lead investigator for the study. "The comprehensive smoking ban has had a significant impact in reducing bodily exposure to a powerful lung cancer cancer-causing agent and nicotine in our hospitality workers.

"Protecting our workers (and patrons) from known cancer causing agents, which has been demonstrated to be present in the urine of these workers prior to the smoking ban, should continue to be a high priority," said Dr. Hatsukami, Forster Family Professor in Cancer Prevention, University of Minnesota Cancer Center.

The findings substantiate previous University of Minnesota Cancer Center studies that have shown that nonsmoking restaurant workers and casino patrons have significantly higher levels of cancer-causing toxins in their bodies after working in or visiting establishments that allow smoking. Other research has estimated that restaurant and bar employees who do not smoke have about a 50 percent higher risk of contracting lung cancer than the general population. This risk has been related in part to exposure to secondhand smoke in their workplace.

"We have known for a long time that secondhand smoke is dangerous to nonsmokers. This study underscores the health risks faced by Minnesota hospitality workers prior to the passage of the smoke-free law," said Dr. Barbara Schillo, Director of Research for ClearWay Minnesota. "These data provide conclusive evidence that the Freedom to Breathe Act is working to create healthier workplaces for all Minnesotans."

Methodology

This study involved 24 nonsmoking bar, restaurant and bowling alley employees who typically were not exposed to secondhand smoke except in their workplaces. Subjects were asked to collect urine samples and complete exposure questionnaires prior to the smoke-free law after working a shift equal to or greater than six hours. The second urine sample and questionnaires were collected four to six weeks after the smoke-free law went into effect and after working a shift equal to or greater than six hours. These urine samples were assessed for total NNAL and total cotinine. To view the report, visit www.tturc.umn.edu or www.clearwaymn.org.

University of Minnesota Cancer Center

The Cancer Center at the University of Minnesota is a National Cancer Institute-designated Comprehensive Cancer Center. Awarded more than $80 million in peer-reviewed grants during fiscal year 2007, the Cancer Center conducts cancer research that advances knowledge and enhances care. The center also engages in community outreach and public education efforts addressing cancer. To learn more about cancer, visit the University of Minnesota Cancer Center Web site at www.cancer.umn.edu. For cancer questions, call the Cancer Center information line at 1-888-CANCER MN (1-888-226-2376) or 612-624-2620 in the metro area.

ClearWay Minnesota℠

ClearWay MinnesotaSM is an independent, non-profit organization that improves the health of Minnesotans by reducing the harm caused by tobacco. ClearWay Minnesota serves Minnesota through its grant-making program, through QUITPLAN® Services and through statewide outreach activities. It is funded with 3 percent of the state's 1998 tobacco settlement.

For more information on QUITPLAN Services, call 952-767-1400 or visit www.clearwaymn.org.

In The News

Research Brief: Carcinogen and Nicotine Exposure in Hospitality Workers Before and After the Freedom to Breathe Act

— ClearWay Minnesota℠

Submitted by:
Tobacco Abuse Prevention Committee

March 27, 2008

The Transdisciplinary Tobacco Use Research Center, a program of the University of Minnesota Cancer Center, has conducted a study to assess the extent of the exposure to carcinogens (or cancer causing agents) and nicotine experienced by hospitality workers before and after Minnesota's Freedom to Breathe went into effect on October 1, 2007. The study measured workers exposure to cotinine (a measure of nicotine exposure) and NNAL, a measure of exposure to a potent lung cancer-causing toxin, before and after the law took effect.

Methodology

This study involved 24 nonsmoking bar, restaurant and bowling alley employees who typically were not exposed to secondhand smoke except in their workplaces. Subjects were asked to collect urine samples and complete exposure questionnaires prior to the smoke-free law after working a shift equal to or greater than six hours. The second urine sample and questionnaires were collected four to six weeks after the smoke-free law went into effect and after working a shift equal to or greater than six hours. These urine samples were assessed for total NNAL and total cotinine.

Major findings include an 83 percent decrease in cotinine levels and an 85 percent decrease in NNAL levels inside study participant's bodies.

Conclusions

The results of this study show that the ***Freedom to Breathe Act has had a significant impact in reducing exposure and uptake of carcinogens and nicotine in hospitality workers***. Although the extent of exposure to these toxic agents is dramatically less than in cigarette smokers, protecting our workers (and patrons) from known cancer causing agents, which has been demonstrated to be present in the urine of these workers prior to the smoking ban, should continue to be a high priority.

Author:
Dorothy Hatsukami, Ph.D.
Forster Family Professor in Cancer Prevention
University of Minnesota Cancer Center

To view the full report, visit www.tturc.umn.edu or www.clearwaymn.org.

Funding for the study was provided by ClearWay Minnesota℠

Where We Work

Children's Hospitals and Clinics of Minnesota

by Rick Trevena, CRT-NPS
Neonatal Transport Coordinator

After wondering if we could ever be a part of the ELITE Neonatal Transport Team for Children's Hospital and Clinics, I sat back and pondered what would be the best way to break through the barrier of the strong Minnesota Nursing Association. I thought it would always be a losing battle, seeing everything always had to go through the MNA.

It started 12 years ago when Respiratory Therapists at Children's began attending high risk Neonatal deliveries at Abbot Northwestern. After years of attending these deliveries, our knowledge base grew exponentially and it was at that point when I decided to make the next step behind the scenes so as not to tip our hats and create more turf wars between Respiratory and Nursing.

After many hours of research nationally on Neonatal transport team composition, I discovered a very high number of teams had a Respiratory Practioner involved. It was at that point that I approached the Medical Director and head of the Neonatal Nurse Practioners to present the data I had discovered.

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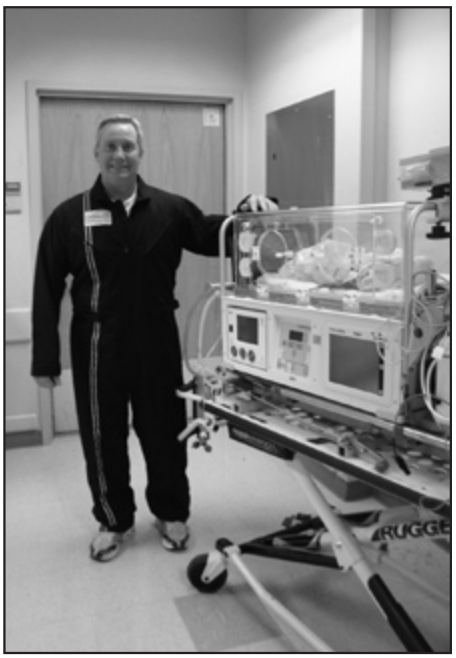
They agreed that Respiratory should be involved, but it wasn't easy and there were still the turf wars. At the start, we were involved in many ground transports throughout the Twin Cities, but were not included in many air transports, unless it included a potential Nitric Oxide patient. With the more advance transport ventilators that are Oscillator capable, we now had the opportunity to prove all that we were capable of performing.



After seven years of minimal involvement my vision was to train all Respiratory Transport Therapists the advanced practice procedures that were being performed by the transport nurse. Minneapolis was the first campus to get up and running with the Respiratory Practioner being a valued team member, and then we created a similar team on the St. Paul campus at the end of 2006.

The turf wars between Respiratory and Nursing are no longer an issue. As a matter of fact, the transport Nurse will gather necessary equipment while the Respiratory Therapist and NNP are getting their flight suits on. The Respiratory Transport Therapist is currently trained in all advanced practice procedures excluding Narcotic delivery, and they are all STABLE trained.

This has been a great hurdle to overcome and to now be recognized as valued professionals and members of the ELITE Neonatal Transport Team of Children's Hospital and Clinics. In 2007 we did 110 air transports and we expect to exceed this number for 2008. I want to thank all the transport therapists from Minneapolis and St. Paul for your hard work, dedication, and helping to get us where we are today!

When Asthma Isn't Asthma

by Dr. Robert Shapiro

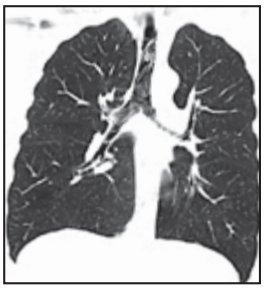
Dr. Shapiro is an adult pulmonologist and critical care physician at Hennepin County Medical Center. He is also the Medical Director of the Pulmonary Function and Bronchoscopy Labs and is the Medical Director for the MSRC.

Dr. Shapiro is the Medical Director for the MSRC, we apologize for the error in the Spring Issue.

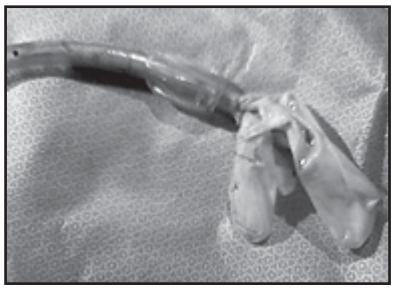
CASE STUDY

HPI: 65 y.o. male smoker with a history of schizophrenia and dysphagia who was walking in the hall of his nursing home when he was witnessed to slump to the ground and become unresponsive and cyanotic. CPR was started and by the time EMS arrived the patient had a pulse and respiratory efforts. He was intubated without difficulty in the ER. Emesis was noted in the upper airway during intubation. Following intubation, it was noted that he was somewhat difficult to bag, had a prolonged expiratory phase, and diminished but symmetrical breath sounds. CXR showed ETT to be in good position, and the lung fields were clear.

With a VT of 300 mL and a RR of 14/min, his peak airway pressure was 65, plateau was 24 cm H2O and measured auto-PEEP was 12 cm H2O. ABG was 7.26/42/115. Neither suctioning nor manipulation of the ventilator setting to prolong the expiratory time improved auto-PEEP, peak or plateau pressure substantially. He was paralyzed, given broncho–dilators and steroids, and a CT of the chest was obtained, which was read as bilateral subsegmental pulmonay emboli, and "mucous/ debris" in the trachea (Fig 1).



Bronchoscopy revealed a foreign body in the trachea just distal to the ETT, which couldn't be removed with the fiberoptic scope (Fig 2). Rigid bronchoscopy was then performed with Anesthesia standing by. The foreign body was too large to pass through the ETT and extubation with re-intubation was requried to remove it with the rigid scope (Fig 3).



Following removal, the patient's pulmonary mechanics normalized. Unfortunately, he had suffered severe anoxic brain injury with his arrest and eventually expired. Further discussion with the caregivers at the nursing home revealed that the patient habitually put things in his mouth and chewed on them.

Super Heroes Convention

NRRCC, Tuesday September 30th
8:00 p.m.

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American Lung Association

2008 Public Health Service Guidelines: Summary

Submitted by:
Tobacco Abuse Prevention Committee

First published in 1996 and updated in 2000, *Treating Tobacco Use and Dependence* is a Public Health Service Clinical Practice Guideline. This document is based on a review of over 8,700 research articles on tobacco use. The document contains strategies and recommendations designed to help clinicians; tobacco dependence treatment specialists; and healthcare administrators, insurers, and purchasers in delivering and supporting effective treatments for tobacco use and dependence.

Below is a summary of the Guideline's key recommendations, adapted from the 2008 Executive Summary:

1. Tobacco dependence is a chronic disease and tobacco users often must make several attempts to quit. However, these Guidelines detail effective treatments that can increase smokers' success in quitting.
2. It is essential that clinicians and healthcare delivery systems consistently identify and document the status of a patient's tobacco use and treat these patients in a healthcare setting.
3. Tobacco dependence treatments are effective across a broad range of populations, and all tobacco users willing to make a quit attempt should be encouraged to use these counseling and medication treatments.
4. Brief interventions can help tobacco users quit. Clinicians should offer every patient who smokes at least the brief treatments shown to be effective.
5. Individual, group and telephone counseling are all effective and their effectiveness increases with intensity of treatment. This counseling should emphasize (1) practical skills and (2) social support.
6. There are numerous medications for tobacco dependence that are effective and clinicians should encourage their use by all patients attempting to quit smoking (except when medically contraindicated). These medications are:
   - Buproprion SR
   - Nicotine gum
   - Nicotine inhaler
   - Nicotine lozenge
   - Nicotine nasal spray
   - Nicotine patch
   - Varenicline

   Clinicians should also consider using certain combinations of the above medications to increase a smoker's chances of quitting successfully.
7. Counseling and medication are effective when used by themselves for treating tobacco dependence. However, the combination of counseling and medication is more effective than either alone. Thus, clinicians should encourage all individuals making a quit attempt to use both counseling and medication.
8. Telephone quitline counseling is effective with diverse populations and has broad reach. Therefore, clinicians and healthcare delivery systems should both ensure patient access to quitlines and promote quitline use.
9. If a smoker is unwilling to make a quit attempt at the time of service, the clinician should use motivational interviewing techniques to increase the likelihood of quit attempts in the future.
10. Tobacco dependence treatments are both clinically effective and highly cost-effective. Providing insurance coverage for these treatments increases quit rates. Public and private healthcare systems should cover the counseling and medications identified as effective in the Guideline.

For more information, please contact:

Kathy Schultz – St. Francis Regional Medical Center, 1455 St. Francis Ave., Shakopee, MN 55379; Email: kathleen.g.schultz@allina.com — or —

Jan Salo Korby – Coordinator, Tobacco and Respiratory Health Programs, ALA of MN, 424 W. Superior St., Suite 203, Duluth, MN 55802; Phone: 218-726-4721; Email: jan.salo.korby@alamn.org

Camp: Not Just for Those Without Asthma

by Jonathan Oney, Program Coordinator for Asthma Camps & Professional Education.
American Lung Association of Minnesota

Camp is a type of place where a kid can be a kid. Sports, high ropes course, nature at its fullest and definitely, water activities. Summer is fast approaching and many families are picking out camps for their children to attend. There are many camps where children can run, play and make new friendships that will last many years after camp. But what if camp was a place where you could not go? Every time you went, you had bronco-spasm, airway constriction, airway inflammation and increased mucus production, blocking your airways?

At Camp SuperKids children do not need to worry about such things. With a staff of 40 volunteers with all sorts of medical expertise, children with asthma can feel safe. Camp Superkids gives children with asthma a chance to be a kid, without worry of being stopped short of breath. Camp provides asthma education to campers so the children can prevent and know what to do if an asthma episode were to occur. These children leave camp feeling more confident in themselves as well as being more educated on asthma management. Children with asthma do not need to be left at home while other children are sent to camp. Children who have asthma can attend a camp designed especially for their needs. They can meet other children with asthma, form the same friendships at camp, and leave camp being more knowledgeable on how to more effectively manage their disease.

Statistics have shown that, because of the education that children receive at Camp SuperKids, children with asthma significantly lower their emergency department visits, develop better self-esteem, and are more likely to know what to do to be in better control of their 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. 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. Last year, we had over 40 medical volunteers to whom the American Lung Association of Minnesota is very grateful for the support they have provided. The staff helps 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 by email: jonathan.oney@alamn.org or phone: 651-268-7598.

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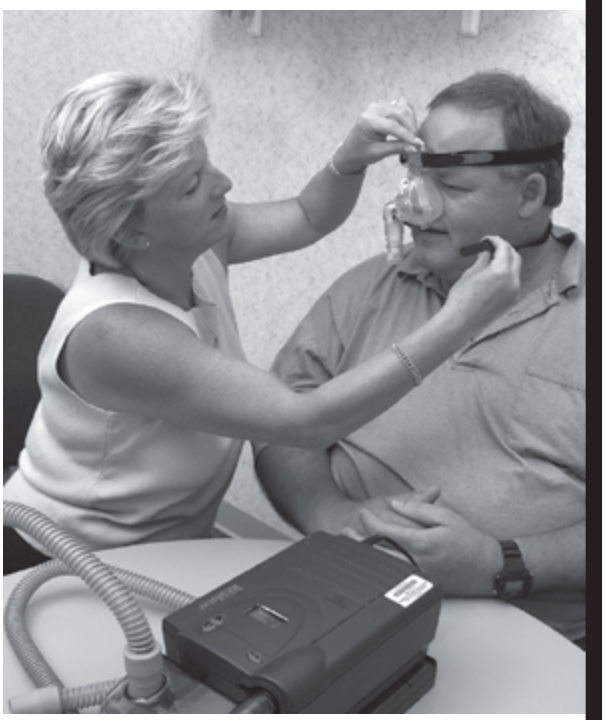

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Home for Vets

(continued from cover)

AIP rates charities from A+ to F. Of the 32 charities they rated, only 5 were in the "A" category, including Homes for Our Troops.

Because of their thorough review process, the AIP is described as **"the pit bull of watchdogs"** by the New York Times. *Newsweek* said "It's the toughest of the bunch. Because it disregards certain, potentially suspect, expenses and donations, it fails some nonprofits that the other raters approve."

Please look for more information in support of Homes for Troops through Respiratory Therapy and Saint Paul College. For more information on how to get involved, please contact **Joseph.Buhain@saintpaul.edu** or **Tim.Strand@saintpaul.edu.**

MSRC Annual Election — Coming Soon

A big thank you to Shelly Klein and the nominations committee for their hard work securing candidates for the fall election. The candidate list is as follows:

President – Elect

Jerry Ebert
Sue Knight

Vice – President

Chris Gerlach
Connie Knipp

Treasurer

Pat Johnson

Board of Directors

Thoeme Bernsten
Heidi Gibson
Chad Langton
Betty Sprengeler
Kim Borgstrom
Al Kendall
Ryan Philpot

The official ballot along with the candidate photos and bios will be mailed in August to all Active and Life MSRC members (those eligible to vote). Check your mail; let your voice be heard!

President's Message

(continued from cover)

will work with the membership committee to achieve the set goal.

Infrastructure

The board has set a goal to review the current structure of the MSRC, which includes, but is not limited to committee practices, by-laws, budget and other processes. The board of directors will be responsible for achieving this goal.

The 3 task forces are being created now. Any respiratory therapist with interest or ideas in that area can be part of the task force. Let me know your interest or ideas and I will get you connected to the right team.

Some MSRC Committees that need assistance are the FUN committee, and the membership committee. If you are interested in planning FUN activities or assisting with membership, please let me know!

Need to Reach Someone with the MSRC?

All Board Members and Committees Chairs are listed on the web site: www.MSRCnet.com

COPD Committee Report

by Kris Mrosak, RRT, RCP, Methodist Hospital

The COPD Committee recently provided information regarding Pulmonary Rehabilitation Programs, and Support Groups to the MSRC for listing on the MSRC website. Additional information regarding frequented helpful websites for those who work in the field of pulmonary rehabilitation were also listed. Please keep the MSRC updated if you have a program/support group that was not listed or if changes in your status occur. Also a reminder for those who are currently listed on the ALAMN website to keep their data updated. These locations provide information to patients and peer support to all of us in the field of pulmonary rehabilitation!

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

Pressworks™

North Regional Respiratory Care Conference Update

by Paul Lamere, MS, RRT

This coming fall the North Regional Respiratory Care Conference (NRRCC) Meeting will take place at the Rochester Mayo Civic Center on September 29 thru October 1. The program will offer another great opportunity to hear some informative presentations and participate in a variety of other fun activities. Mark your calendars now! The speaker agenda includes noted national speakers such as David Pierson, MD and Dean Hess, RRT, in addition to an array of regional experts. Once again breakout sessions will be offered in order to focus on topics of interest for the major specialty tracks in respiratory care. 13.3 CRCE credits have been applied for through the AARC. In excess of 90 exhibitors are expected to be setup in Rochester to share information on current technology, diagnostics, services and employment opportunities in the profession.

Entertainment will include a "Meet the Board Social Hour" on Sunday evening, September 28, immediately after the individual state chapter board meetings.

The ever popular Sputum Bowl Competition will take place on Monday evening. Come cheer for your favorite team and then plan to stick around for the bi-state championship competition. The winners of the preliminary state competitions will represent the two states in the NRRCC championship as well as at the next AARC International Conference. A golf tournament is scheduled to take place on Tuesday afternoon at the Eastwood Golf Course. Reservations are required for this event so plan ahead. The entertainment venues will wrap-up with the Allina Home Dance on Tuesday evening. "Super Heroes" will be the theme for the night. You might want to start thinking about a costume.

Brochures for the NRRCC Meeting are anticipated to be mailed in early June. You can also check the MSRC website
for updates.

See you in Rochester!

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New Asthma Guidelines for Ages 0–4

by Greg Beaudoin and Sue Knight

1

2007 - Guidelines For The Diagnosis & Management of Asthma (EPR-3)

- (Almost) no new medications.
- Restructuring into "severity" and "control" .
- Domains of "impairment" and "risk".
- Six treatment steps (step-up/step-down).
- More careful thought into ongoing management issues.
- Summarizes extensively-validated scientific evidence that the guidelines, when followed, lead to a significant reduction in the frequency and severity of asthma symptoms and improve quality of life.

2

New Strategies of the EPR-3 Summary

	Assessment	Management
Severity	The intrinsic intensity of the disease process	A clinical guide most useful for initiating controller therapy
Control	The degree to which symptoms are minimized & goals are met	(After therapy is initiated) a clinical guide used to maintain o r adjust therapy
Responsiveness	The ease of which prescribed therapy achieves asthma control	(Variable) frequent follow - up to step -up and step - down therapy to achieve the goal of control

EPR-3, Page 36-38

3

NOT Currently Taking Controllers

Components of Severity		Classification of Asthma Severity (0–4 years of age)			
		Intermittent	Persistent: Mild	Persistent: Moderate	Persistent: Severe
Impairment	Symptoms	≤2 days/week	>2 days/week but not daily	Daily	Throughout the day
	Nighttime awakenings	0	1–2x/month	3–4x/month	>1x/week
	Short-acting beta$_2$-agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week but not daily	Daily	Several times per day
	Interference with normal activity	None	Minor limitation	Some limitation	Extremely limited
Risk	Exacerbations requiring oral systemic corticosteroids	0–1/year	≥2 exacerbations in 6 months requiring oral systemic corticosteroids, or ≥4 wheezing episodes/1 year lasting >1 day AND risk factors for persistent asthma		
		← Consider severity and interval since last exacerbation. Frequency and severity may fluctuate over time. →			
		Exacerbations of any severity may occur in patients in any severity category.			
Recommended Step for Initiating Therapy (See figure 4-1a for treatment steps.)		Step 1	Step 2	Step 3 and consider short course of oral systemic corticosteroids	
		In 2–6 weeks, depending on severity, evaluate level of asthma control that is achieved. If no clear benefit is observed in 4–6 weeks, consider adjusting therapy or alternative diagnoses.			

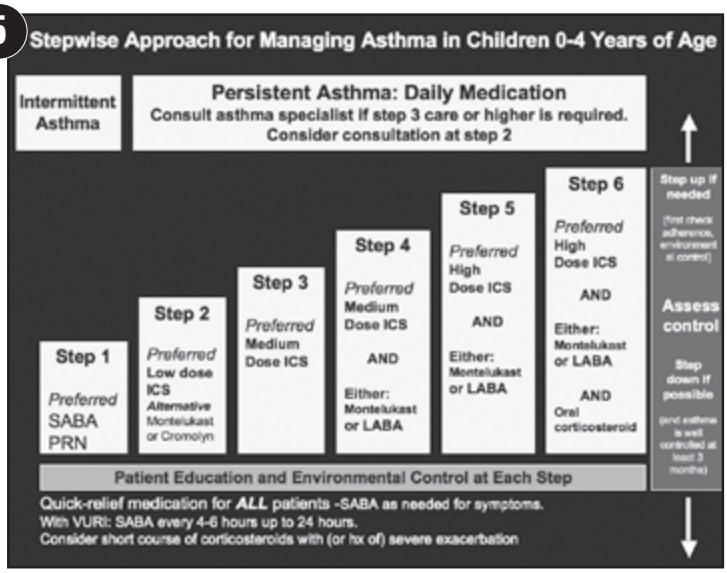
Level of severity is determined by both impairment a & risk. Assess impairment by caregivers recall of previous 2-4 weeks.

4

Figure 3–5a. Assessing Asthma Control In Children 0 - 4 Years of Age

Components of Control		Classification of Asthma Control (Children 0–4 years of age)		
		Well Controlled	Not Well Controlled	Very Poorly Controlled
Impairment	Symptoms	≤2 days/week	>2 days/week	Throughout the day
	Nighttime awakenings	1x/month	>1x/month	>1x/week
	Interference with normal activity	None	Some limitation	Extremely limited
	Short-acting beta$_2$-agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week	Several times per day
Risk	Exacerbations requiring oral systemic corticosteroids	0–1/year	2–3/year	>3/year
	Treatment-related adverse effects	Medication side effects can vary in intensity from none to very troublesome and worrisome. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk.		

5



Don't miss the next issue of

The Bronchus

www.msrcnet.com

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- **If you are a Hospital Manager, Home Care Manager or School Director, you can make sure those you work with continue to receive the educational and timely information in *The Bronchus* through an annual subscription.**

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North Memorial Health Care
3300 Oakdale Avenue North
Robbinsdale, MN 55422-2900

NAME

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ADDRESS

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Save the Date

Important Dates for Upcoming Events.
MSRC 2008

July 6–11, 2008	**Camp Superkids**; Loretto, MN. Visit: www.LungMN.org
July 11–14, 2008	**AARC Summer Forum**; Phoenix, AZ.
August 3–6, 2008	**Camp We No Wheeze**; Wolf Ridge Environmental Center, Finland, MN.
August 20, 2008	**BOD Teleconference Meeting**
Sept. 28–Oct. 1, 2008	**NRRCC Bi-State Conference;** Rochester, MN

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