I hate listening to the news these days. Almost every day you hear of some individual or group shifting the blame for their latest faux pas on someone or something else. If an elected official is caught in a compromising position with someone not necessarily his spouse, he blames the pressure of politics or the loneliness of the campaign trail. If a child is expelled from school for cheating, he blames the pressure of school or his parents. Does no one take responsibility for their own actions anymore? Responsibility is an easy term to define, but a difficult virtue to live up to.

I began my respiratory care education in 1979 at Saint Philip’s College in San Antonio, TX. I started my first job in respiratory care that same year on Christmas Eve. Although I have held multiple positions in respiratory care, I am first and foremost a therapist. A respiratory therapist, in my opinion, has the following responsibilities:

1. To remain competent in the field of respiratory care. A respiratory therapist cannot stagnate; you cannot think that because you’ve graduated and gotten your credentials, learning is complete. A respiratory therapist must continue to educate himself through college courses, seminars, new and revised textbooks, medical journals, and more. If you work primarily with adults, increase your pediatric skills. If you are primarily a general care therapist, increase your knowledge of intensive care equipment and procedures.

2. To develop excellent “soft skills.” By this, I mean communication skills, conflict management skills, team building and teamwork skills, presentation and public speaking skills. We work with people, on people, and through people. These people have faults, perceptions, misconceptions, prejudices, and alternative viewpoints. Sometimes these people are our patients, sometimes they are our co-workers, sometimes they are our bosses. We can’t let these people ruffle our feathers. We can’t respond in kind in any situation.

3. To develop a service attitude. We need to be ever mindful that we must do what is necessary to improve the health status of our patients, the operational efficiency of our departments, and the financial standing of our institutions. This is achieved through service. Our main goal needs to be not just meeting, but exceeding the expectations of our patients and employers.

4. To become comfortable with change. New drugs, new procedures, new equipment, and new regulations call for new ideas, new processes, new ways of thinking. If we are stuck in the “good old days” mindset, we will not be able to meet the expectations of the change. When faced with what may seem like impossible tasks, we have to resist the temptation to succumb to the “it’s not fair” syndrome and look for ways to succeed with change. As Eleanor Roosevelt said, “You must do the things you think you cannot do.”

5. To be able to separate from a work setting that either is not meeting your needs or is one in which you are not meeting the needs of the work setting. I get very tired of hearing, “same s___, different day,” when I ask people how it’s going. If you feel this way at work, you need to consider changing your position, your department, or your hospital. Let’s face it, we work for a multitude of reasons. Most therapists will say they got into the field to help people, but we also work for a good salary, for a sense of belonging, for promotion, etc. If your individual needs are not being met, you can become bitter, resentful, and uncooperative. You need to find a setting where your needs can be met OR you need to reevaluate your needs.
Older Americans are living longer and better than ever before, but many of those age 65 and older face disability, chronic health conditions, or economic stress, according to a new report from the Federal Interagency Forum on Aging-Related Statistics, a consortium of U.S. government agencies working together to improve the quality and usefulness of data on older Americans.

The 128-page report, “Older Americans 2000: Key Indicators of Well-Being,” covers 31 older Americans. It improve the quality and usefulness of data on government agencies working together to Aging-Related Statistics, a consortium of U.S. report from the Federal Interagency Forum on tions, or economic stress, according to a new and older face disability, chronic health condi- tions, or economic stress, according to a new and older face disability, chronic health condi- tions, or economic stress, according to a new and older face disability, chronic health condi-}

Population

• The number of older people in the U.S. has increased tenfold since 1900. Today, an estimated 35 million people, 11% of the population, are age 65 and older. By 2030, 20% of Americans, about 70 million, will have passed their 65th birthday.

• The population age 85 and above is currently the fastest growing segment of the older population; its growth is particularly important for anticipating health care and assistance needs, because these individuals tend to be in poorer health and require more services than people below age 85.

• In 2000, an estimated 18% of the popula- nation age 65 and older is non-Hispanic white, 8% non-Hispanic black, 6% Hispanic, 2% non-Hispanic Asian and Pacific Islander, and less than 1% non- Hispanic American Indian and Alaska Native. By 2050, those proportions are projected to be substantially different: 64% of the older population is expected to be non-Hispanic white, 16% Hispanic, 12% non-Hispanic black, and 7% non-Hispanic Asian and Pacific Islander, with the non- Hispanic American Indians and Alaska Native populations remaining at less than 1%.

• Today’s older Americans are better educat- ed than their counterparts 50 years ago, a factor that can positively influence socioeconomic status and health. In 1998, a high school diploma was held by some 67% of older Americans, compared with just 18% in 1940. About 15% of older Americans had earned at least a bachelor’s degree in 1998, increasing from 4% in 1950.

Economics

• In 1998, 11% of older Americans had incomes below the poverty threshold, compared to 33% in 1959. The proportions of the older population in poverty vary, however, by age, gender, and race and ethnicity.

• The importance of Social Security to the lowest-income elderly cannot be overstated. It accounts for some 80% of income for people in the lowest two-fifths of the income spectrum.

• Net worth (the value of real estate, stocks, bonds, and other assets minus outstanding debts), an important measure of economic security, has increased in recent years. Estimates of the amount of the increase vary, but in one survey, median net worth among households headed by older people jumped 66% between 1984 and 1999. However, there is a large disparity in net worth between older black and white households.

Health status

• Chronic disease, memory impairment, and depressive symptoms affect large numbers of older people, and the risk of such problems often increases with age. In 1995, almost 60% of people age 70 and older reported having arthritis, up slightly from the proportion reporting arthritis in 1994. The prevalence of arthritis and other chronic diseases, such as hypertension, heart disease, cancer, diabetes, and stroke also vary by race and ethnicity. Increases in memory impair- ment and depressive symptoms occur with advancing age: one-third or more of men and women age 85 and older have moderate or severe memory impairment, and 23% of this group experience severe depressive symptoms.

• Despite the prevalence of illness or chronic conditions, the proportion of Medicare beneficiaries age 65 and older with a chronic disability was 21% in 1994, down from 26% in 1982. During this time period, the older population grew significantly, and the number of older people estimated to have functional limitations increased by 600,000. This was considerably fewer, however, than the 1.3 million increase projected had disability rates not declined.

Health risks and behaviors

• A large majority of older people report social contacts with friends, neighbors, and relatives or say that they engage in activities such as going out to restaur- ants. The proportion of older Americans engaged in physical activity is increas- ing: between 1985 and 1995 the percent- age who were sedentary decreased from 34% to 28% for men and 44% to 39% for women.

• From 1989 through 1995, the proportion of older people who were vaccinated against influenza and pneumonia increased, but reached the 60% coverage target set by Healthy People 2000 for only one group: non-Hispanic whites. An increasing trend also holds true for older women getting mammograms: 55% of older women (vs. 43%) reported having had a mammogram in the previous two years, compared with 25% in 1987.

Health care

• Between 1992 and 1996, there was a slight increase in average inflation-adjusted annual health care expenditures (both public and private) for older Americans. In 1996, the average annual

“Older Americans” continued on page 3
expenditure was $5,864 for people age 65 through 84, and $12,485 for age 85 and older. In 1996, 69% of noninstitutionalized Medicare beneficiaries had some type of private or public coverage for prescription drugs, while 33% did not. Out-of-pocket expenditures for prescription drugs were 83% higher for those not covered than for those with coverage.

- People age 85 and older are the most likely Americans to live in nursing homes. In 1997, only 11 people per 1,000 age 65 through 74 lived in a nursing home, compared with 192 people per 1,000 among those age 85 and older. About three-fourths of nursing home residents are women, roughly equal to their representation in the population age 85 and older. People in nursing homes today are more functionally impaired than their counterparts in previous years. The percentage of nursing home residents who were incontinent, who needed help with eating, or who were dependent on others for mobility increased slightly between 1985 and 1997.

- For those who receive home care, the nature of assistance may be changing. Most home care is provided informally by family, friends, and the community, as it has been for quite some time. But since the 1980s, the use of informal support as an exclusive means of help appears to be declining. The percentage of older people receiving only informal care dropped from 74% in 1982 to 64% in 1994, while the use of combined formal and informal care increased from 21% to 28% during the same time period.

(Administration on Aging)

**FYI...**

**Hospitalization rates for occupational asthma**

Canadian researchers have shown that workers with occupational asthma are at higher risk for hospitalization than employees who have suffered a musculoskeletal injury. Using data from 1980 to 1993 from the Ontario Workers Compensation Board, investigators studied 644 workers with occupational asthma, 1,566 musculoskeletal injury victims, and 402 asthma patients from an outpatient clinic. They found that the hospitalization rate was slightly over 39% for occupational asthma patients, while it was just over 29% for injury claimants. Asthma clinic patients had a hospitalization rate of 47%. (American Journal of Respiratory and Critical Care Medicine, 7/00)

**Clinically silent acid reflux may be common in asthma**

Sixteen of 26 asthma patients without gastrointestinal reflux symptoms showed abnormal esophageal acid levels when tested over a 24-hour period. Leading researchers to believe that clinically silent reflux may be commonly associated with asthma. Although 30 clinic patients controls with reflux symptoms had more severe asthma that those with no symptoms, the latter had higher amounts of acid in the esophagus. Studies have shown that identifying and treating reflux, regardless of symptoms, improves asthma control. (American Journal of Respiratory and Critical Care Medicine, 7/00)

**Diabetes diagnosis leads smokers to quit**

A new study has found that a diagnosis of diabetes can encourage long-time smokers to kick the habit. The University of Michigan study looked back at the smoking habits, diabetes status, and other health and socioeconomic characteristics of more than 1,000 middle-aged men and women whose health was monitored between 1992 and 1996 as part of a larger study. Though only a small percentage of the smokers were diagnosed with diabetes during that period, those that did learn they had the disease between 1992 and 1996 were more than twice as likely to have quit smoking by 1996 as the others. The finding supports the results of another recent study by the same researchers, which showed that another kind of life-threatening health event—a heart attack—also was enough to prompt many middle-aged smokers to quit. (University of Michigan)

**Vitamins C and E no help to smokers**

Although many people take supplements of vitamins C and E as antioxidants, a new study casts doubt on their ability to reduce the addition of copper. There were no changes in the groups given vitamin C or placebo. The group receiving both vitamins showed no increase in rate of oxidation but did decrease their maximal rate of oxidation significantly by 3%. In contrast, two separate measures of oxidation by white blood cells, thought to be more reflective of what happens in the body, showed no changes as a result of any of the antioxidant treatments. (Journal of the American College of Nutrition, 6/00)

**OAS may cause cluster headaches**

The majority of people with cluster headaches may also have sleep disorders that trigger attacks, according to a study of 25 people with cluster headaches who were evaluated in a sleep laboratory. Of those 20 people, 80%, showed signs of obstructive sleep apnea. In the study, those who reported that their headache attacks typically started in the first half of the night tended to have more severe drops in blood oxygen levels. Researchers don’t know why many people with cluster headaches have sleep apnea, but one hypothesis is that the hypoxia that occurs when breathing stops may trigger the attacks. The argument is bolstered by the finding in this study that more severe hypoxemia seemed linked to the early nighttime timing of the headaches. (Neurology, 6/27/00)

**JCAH0 Site Visit Reports**

As of the end of August, the section had received the following response to its request for information about JCAHO site visits.

**St. Joseph’s Hospital**

Janet Pangborn
July 17-21, 2000

What was the survey team’s focus during your site visit?

MD bylaws and practices, restraints, case in finding things in charting, scopes of care and interdisciplinary focus, turn-around time of transcription reports, especially, diagnosis.

What areas were cited as being exemplary?

Environment of care, living our Mission, our system approach to PI and to HR practices.

JCAHO Site Visit Reports

Assure compliance to licensure requirements, refine criteria concerning behaviors for restraints, assure H&Ps done in timely fashion, keep OP orders for diagnostic studies.

What changes have you made to improve compliance with the guidelines?

In progress.
The AARC is currently seeking information on JCAHO accreditation site visits. Please use the following form to share information from your latest site visit with your colleagues in the Association. The information will be posted immediately on the AARC web site at http://www.aarc.org/members_area/resources/jcaho.html and will also be featured in the Bulletin.

Accreditation visit you are reporting (choose one):

- Home Care
- Hospital
- Long Term Care
- Pathology & Clinical Laboratory Services

Inspection Date: __________________________________________________________________________________

Facility Name: ___________________________________________________________________________________

Contact: ________________________________________________________________________________________
(Please provide name and email address.)

1. What was the surveyors’ focus during your site visit? __________________________________________________
   _______________________________________________________________________________________________
   _______________________________________________________________________________________________
   _______________________________________________________________________________________________

2. What areas were cited as being exemplary?
   _______________________________________________________________________________________________
   _______________________________________________________________________________________________
   _______________________________________________________________________________________________

3. What suggestions were made by the surveyors?
   _______________________________________________________________________________________________
   _______________________________________________________________________________________________
   _______________________________________________________________________________________________

4. What changes have you made to improve compliance with the guidelines?
   _______________________________________________________________________________________________
   _______________________________________________________________________________________________
   _______________________________________________________________________________________________

Additional comments:

Mail or fax your form to:
William Dubbs, RRT
AARC Associate Executive Director
11030 Ables Lane
Dallas, TX 75229
FAX (972) 484-2720