NOTES FROM THE CHAIR
by John M. Graybeal, CRTT

The last time I wrote this column, I commented on the winds of change and how change relates to the continuation of our profession. Well, it never fails. Soon after I wrote that the storm seemed to be abating, clinicians at our institution were informed of a significant change taking place would have a direct impact on them.

Completely unexpectedly, the University announced a merger between “our” medical center and another large referral center in the northern portion of the state. While I believe this merger will be good for everyone (employers, employees, and, most importantly, patients), this is a fresh reminder that change often moves fast, and will eventually happen to all of us.

Although the announcement was completely unexpected, the merger does not actually occur until July of this year, which gives us almost six months to prepare for the change. Given the way these mergers are sometimes handled, I feel we are lucky. I have become aware, for example, of another large referral center where all of the medical centers in the city were merged into one. In this case the employees were given notice by way of a flyer included with their pay checks. The notice stated that in 30 days their present positions would no longer exist. They were then given a chance to sign-up and reapply for their jobs within the “new institution.” Talk about stress!

Now I’ll say it again—change is happening. If the winds of change have not reached your area, it’s only a matter of time. With that as an introduction, I would like to welcome our guest editor for this issue, Dennis Hastings, RRT. He has done an outstanding job of developing the theme for this issue (what the future holds for our profession), as well as coordinating the material. Thanks, Dennis, for a job well done. I know our members will benefit from your efforts.

On another note, you may notice that this issue does not include a nomination for our Section Member of the Quarter, and for good reason—if no one submits a nomination, the Section could appoint a winner each quarter, but this award is intended to foster the recognition of a practitioner by his or her peers. Look around to see who you know who is deserving of this honor, then recognize their efforts by submitting their names for this award.

Until next issue, let’s all hang together . . .
Health Care And Information Technology By The Year 2000
by Wadie Williams, RRT

Wadie Williams is senior manager, pulmonary care services, at St. Luke’s Episcopal Hospital in Houston, TX.

As the year 2000 approaches, we, as health care professionals, are faced with new challenges and expectations and are exploring new ways to accomplish our responsibilities. As we attempt to trim health care costs, improve patient and customer outcomes, and develop efficient but smaller workforces, we can look for computerization to be an integral part of our efforts to achieve our goals.

Technological improvements in communications and imaging technologies, faster data transmission rates, more flexible data input and retrieval devices, and greater use of the Internet and the fast developing Intranet are but a few of the enhancements that are currently in the line of sight or just over the horizon. Driven by the managed care environment (which will increasingly shape our delivery and reimbursement systems), we must develop innovative means of delivering quality and timely care.

What’s changed and how does it affect me?

The most important change has been the emphasis placed on managing the costs associated with the care delivered. This, coupled with the demand from our customers that quality not be sacrificed to reduce costs, places additional burdens on providers to be competitive and resourceful. The implementation of care plans, protocols, etc., is a means to address these two vital concerns.

Patient care documentation is rapidly moving from multiple, independent department documentation, to a single electronic patient care record that is shared by multiple disciplines. This is largely accomplished by utilizing a single patient care documentation system for nearly all disciplines, but can also be achieved with interface engines that allow legacy or “boutique” systems to talk and share data with the hospital’s mainframe.

What’s out there now?

As indicated above, most hospitals have a mainframe computer that allows for patient registration, admissions/discharges, and billing. Others have incorporated components to allow for nursing, laboratory, and other personnel to document results and billing information. Still others have interfaced specific legacy or “boutique” systems (i.e., respiratory care, physical therapy, laboratory, cardiology) to the mainframe to share data and information with all other care providers.

The use of computers has rapidly spread from just a handful of the lucky few to include just about all health care providers and personnel. These devices are not just the traditional computers we readily identify with, but also include barcode readers, laptops, personal data assistants (PDAs), and now the wireless phones being utilized by some nursing and medical staff.

What’s 2000 going to be like?

One can anticipate that the further development of handheld devices will increase their functionality. Laptops will have more built-in features, such as multimedia capabilities, that are now only available with desktops. One major advantage of such features is that they will allow the provider to do on-the-spot training or teaching with the most current information. The PDA will allow the field worker (nurse, therapist, physician) to access patient information via wireless or fast modem connections. Further development of the faster DSVD modems will allow for practical use of simultaneous transmission of data and voice between care providers—or even insurers—to improve the delivery of care.

Two-way pagers that allow the user to receive and send e-mail, faxes, and messages to other pagers, and smart phones (devices that incorporate the features of the phone and PC to allow for “anywhere, anytime” wireless communication, including e-mail, net access, or sending information to field staff) are other communication tools likely to be utilized by year 2000 practitioners.

The Future Of A Respiratory Care Practitioner
by Marta Tingdale, RRT

Marta Tingdale is manager of pulmonary care services at Baylor University Medical Center in Dallas, TX.

For those of us who have practiced respiratory care for more years than we would like to admit, the future may seem very nebulous. The future is just tomorrow. However, we do know that to predict tomorrow, you must at least glance at the past and survey the present.

When I was a child, I wanted to be a nurse. Society, both then and now, has had very clear definitions of what a doctor or nurse is, but it has never had a clear definition of what a respiratory therapist is. Perhaps this lack of clear definition is what gives us a future and grants us the opportunity to go as far as our educational growth and our professional and personal initiative will take us.

The job description that I began my career with in 1968 certainly would not cover all the patient care that I deliver today. Likewise, the job description I have now will soon be out of date due to the role expansion RCPs are experiencing in the institution where I am currently employed. I could have never conceived of doing the patient care that I do today back when my world consisted of Mark 7s, MA-1s, and Baby Birds. An infant less than 30 weeks had little chance of survival, no thought was given to wellness programs, sleep studies, or asthma carepaths, and the concept of a pulmonary rehabilitation program would have brought snickers from all around. Acute intensive care was the only thing of any value. If you didn’t work in the intensive care unit, you weren’t worth very much.
Now we have RCPs who are leaders in the care of the asthmatic, in wellness programs, and in the development of carepaths, and are indispensable in the home care arena. Neonatal intensive care units certainly could not boast of the successes they have today with infants less than 28 weeks if it weren’t for the RCPs who labored to develop better ventilators and better forms of therapy through research. Our successes of the present are certainly impressive. The question is: Will we have the same successes in the future health care world?

Health care economics are driving medical schools to train more and more physicians as primary care physicians or “generalists.” I believe this trend will result in the RCP becoming more valuable for his/her specific knowledge of the respiratory system in relationship to the rest of body. Already we have therapists who are employed by physicians in their private offices. These therapists enhance the care that the physician provides. Certainly they would not employ RCPs and pay them a salary if they didn’t feel they were getting good value in return.

Another trend in health care that will continue to grow is the use of physician extenders. Because of the aging patient population, increasing air pollution, and new therapeutic modalities, however, these physician extenders, physician assistants, and nurse practitioners will have little time to be educated in the specific concepts of respiratory disease. They will need our expertise when faced with the increasing complexity of respiratory medicine, especially in the rural areas. Indeed, with the right initiative and strategic manipulation of our practice acts, we may even become the physician extender for patients with pulmonary diseases.

As patient care continues to move from the acute care arena into outpatient services and home health, our value becomes increasingly clear. Wellness programs for the asthmatic (a dramatically growing population) are now recognized by insurance companies. Who better than a respiratory care practitioner to organize and manage these programs? Research will be necessary to gain more expertise in managing asthma and other respiratory ailments, and again, RCPs will become the driving force for inventive concepts and outcomes. Home health will find the acuity of its patients on the rise and these patients will need a variety of caregivers to ensure that they don’t return to the hospital and utilize a larger portion of the health care dollar. Reimbursement dollars will finally come to the respiratory profession on a fee-for-service basis, just as they have to the physical therapist today.

Outpatient respiratory services and home health will grow, but what about the old acute care setting and the therapist who lives off the adrenaline high of the intensive care unit? That RCP will continue to thrive as well, perhaps in an “expert” adviser mode. Why should this expert be doing oxygen therapy and unassisted bronchodilator therapy? He or she is the one who will know how artificial lungs work with artificial hearts. New and innovative ventilators will require a technological thinking that we cannot conceive of today. The boundaries of this RCP are indefinable.

I have no reservations about tomorrow or whether I will be providing patient care or not. I’ve contributed to patient care for the last 29 years as a therapist. I don’t perform the same tasks or deliver care the same way today that I did yesterday, and I won’t deliver patient care tomorrow as I do today. The role that I play may change, but as long as I am well educated, well trained, and my profession enhances the patient care that is delivered, I will have the ability to define what that role will be.

Let me close with a quote from Franklin D. Roosevelt, who certainly must have had questions about his future during the dark moments of his life when he contracted polio in the 1920s: “The only limit to our realization of tomorrow will be our doubts of today.”

Susan Lane is an RT student at the University of Texas Medical Branch-Galveston.

In four years the world will experience the dawning of a new millennium. As we enter the new century, we will witness new and exciting breakthroughs in medical research. Frequently we hear about new vaccines, new cures, and the latest home testing devices. But the quality of health care services rendered to the patient must also improve in order to maintain the pace set by these advances. In order to compete, the RCP of the future must possess good computer skills, have excellent patient assessment skills, and be able to effectively communicate through channels with other health care providers, patients, and their families.

As time goes by, society as we know it is becoming more and more computer oriented. A decade ago no one thought it was necessary for the therapist to be computer literate. Twenty years ago surfing the web and pulling respiratory articles off the Internet was literally unheard of. RCPs today who possess the computer skills necessary to access these services and others take them for granted. Modern pager technology, for example, allows the therapist to use the computer to page superiors and let them know about crucial aspects of patient care. The mechanical ventilators on the market today are much more advanced than those offered 15 years ago. The ventilators that students currently learn about in school contain microprocessors and touch screens, and even feature interfaces for printers (null modem connectors), so we are able to instantly print out the beautiful graphics they display. Many of these options were unavailable on any of the ventilators offered in the early 1980s.

The advantages of this technology are enormous. The printout, for example, gives us a visual aid to use when we are discussing the patient’s progress with doctors and other health care providers. It also serves as a reference when making changes to the patient’s ventilator settings. To take advantage of this feature and others—such as the computer based charting that will appear in the future—computer skills will be a necessity. As these examples indicate, it is mandatory that future and present therapists be extremely...
familiar with computer technology.

In addition to good computer skills, the RCP of the future will also need enhanced assessment skills. The training we receive in school will prepare us for our role as future health care practitioners. After all, this is where we will learn all the basic skills required to deliver the best care possible. Students will then be ready to incorporate their assessment skills as they change from an acute care setting to a home health care or subacute setting. This will be particularly essential in the home health setting, since the convenience of the various hospital equipment will no longer be available. While in training we will also learn the latest advances in respiratory care equipment and gain the skills necessary to utilize telemedicine. This will allow physicians to consult the therapist regarding a patient without physically being at the patient’s bedside.

Effective communication among health care providers is an integral part of competent medical care. Health care practitioners need to be well-versed in written and oral communication skills. As computer charting becomes more predominant, for example, the need for quality writing skills will increase. The knowledge of, and the ability to correctly pronounce, medical terminology will enhance our ability to efficiently communicate with other health care practitioners as well. The joining of other disciplines with our own ensures patients the best care available.

As long as RCPs allow themselves to adapt and grow with the changing times, they should always have a future in the medical field. The increase in the elderly population in the near future will allow some therapists to branch out from the hospital setting to a home health setting. The environmental toxins being released today may increase the incidence of asthma, therefore allowing the therapist to venture into education and preventive medicine for the general public. Our training is the cornerstone of our success and the future of respiratory care. But coupled with that training is the need for students to keep abreast of current journals, new medications, and the latest advances in technology so that we may bestow the best possible care on our patients once we enter the job market.

ALTERNATIVES: ONE THERAPIST’S APPROACH TO THE CHANGES IN THE PROFESSION
by Hanan Khalil, RRT

Hanan Khalil is a staff therapist at UTMB-Galveston.

After finishing high school, I realized that one of the ways to broaden my horizons both academically and intellectually was to continue my education by enrolling in college. Through college course work, volunteering in hospitals, and other community service, I realized that I enjoyed helping others. I also realized that my academic strength was in the field of science. Because of my personal situation, the obvious choice of academic pursuit for me was in the medical sciences. My mother has long suffered from asthma and her constant struggle against this potentially fatal disease led me to choose the field of respiratory care. While diseases such as asthma take a physical and emotional toll on their victims, they also have a profound effect on the family members of the afflicted. This made my choice of respiratory care an easy one.

Attending the University of Texas respiratory care program provided me with the academic and clinical experiences, and the knowledge necessary to gain a broad and comprehensive understanding of pulmonary physiology and pulmonary diseases. In addition, I’ve attained the fundamental knowledge base in areas of diagnosis and treatment of pulmonary disease. Just as important, I’ve attained a professional and personal rapport with my patients and coworkers.

I recently graduated from the University of Texas and I’m currently working as a staff therapist at the University of Texas Medical Branch in Galveston. I currently hold credentials as a registered respiratory therapist, and I’m pursuing my credentials in pulmonary diagnostics.

While my current position and responsibilities afford me the opportunity to take care of patients suffering from pulmonary disease or requiring ventilatory support, I feel somewhat limited in the scope of diagnosis and treatment that I can provide. In many situations I wonder whether the patient outcome would be different if I were allowed to interpret diagnostic tests and make treatment decisions based on those tests and my physical assessment of the patient. I often find myself asking the question, “What would I have done differently?”

Looking down the road I question the opportunities for advancement that await me in this profession. Professional tracts in management and academics are the two primary avenues that are available. While these are both valuable and honorable pursuits, I have chosen another path that I hope will provide me with the professional fulfillment I seek.

I have chosen the field of physician assistant as my choice of medical professions. While a degree in nursing was an option, I felt that it, too, would eventually be self-limiting. I also felt that my background as a respiratory therapist would be advantageous to my pursuits. My decision was not an easy one and the road ahead will be equally challenging. I’ve applied for admission to virtually every PA program in the country and now the hard part begins; waiting!

Physician assistants are licensed health care professionals who practice medicine with physician supervision. PAs deliver a broad range of medical and surgical services. They practice in virtually every medical specialty and in virtually every setting, from large university hospitals to rural clinics. After spending time observing PAs interacting with other health care professionals and their patients I feel that this is the field of endeavor that will best satisfy my professional needs.

If accepted into a physician assistant program, I would like to specialize in pulmonary medicine. I feel that with my training in respiratory care, I will be able to offer a unique perspective on the care and treatment of patients suffering from pulmonary disease. A second option would be to assist an anesthesiologist in caring for patients undergoing surgical procedures requiring anesthesia.

I feel that by continuing my education as a physician assistant I will fulfill my professional endeavors, both in the
field of respiratory care and physical medicine in general. I also see myself as being able to offer a different perspective to fellow respiratory therapists on issues or events that would affect their lives as health care professionals. Through excellent communication and professional support, the relationship between respiratory therapists and other health care professionals can only benefit from having RCPs move from one level of health care to another.

**EMERGING TECHNOLOGIES**

by Dennis Hastings, RRT

Dennis Hastings is assistant technical director, critical care and clinical research, in the department of pulmonary services at the University of Texas Medical Branch (UTMB) in Galveston, TX.

Remember the device that the crew members of the Starship Enterprise wore for communication and tracking? It consisted of a triangular-shaped pin symbolizing the Enterprise that was worn on the left breast of their uniforms. All the crew member had to do was tap the pin and speak. Many times I have thought to myself that it would be really cool if we could replace beepers with such a device. Being a manager, I thought it would be nice to know where my employees and equipment were in the institution at any given time.

With the introduction of the Traverse Tracking system it is now possible to keep in much closer contact with your employees, as well as gain a more efficient tracking system for your equipment. The system utilizes "state-of-the-art" infrared technology for tracking and synthesized audio transmissions for communication purposes. While two-way communication is not yet available, it is surely only a matter of time before it will be.

One of the most time-consuming tasks faced by clinicians at the bedside is the documentation of performed procedures, patient assessments, and/or clinical interventions. Whether the documentation is done manually or via a computer interface of some sort, it still consumes an inordinate amount of time.

Applied Voice Recognition Inc. recently introduced the Voice Commander, an intuitive voice recognition software system that allows the user to interface with a computer by utilizing only his or her voice. Picture the clinician at the bedside describing the procedure being performed, the patient’s reaction to the intervention, and the outcome without having to write or enter any information into a computer. This technology allows for dictation up to 100 words per minute while combining voice-activated computer commands. The user can order the system to save the information to a file, print it at a remote station, or fax it directly to a remote location without ever physically touching a computer keyboard.

This company also markets voice-activated command technology that can be utilized to control equipment to perform specific functions from a remote location.

Imagine the day when the bedside clinician enters a patient room, identifies him or herself, and begins a patient assessment while dictating into a headset. The clinician then commands the infusion pump to increase the medication drip rate, the ventilator to increase the $F_{IO_2}$, and the arterial blood gas analyzer to aspirate a sample of blood and analyze it—all while standing at the foot of the patient’s bed. With emerging technologies such as these we are not far away from this scenario...

For more information about the Traverse Tracking system, contact Versus Technology Inc., Traverse City, MI 49684, (616) 946-5868. To find out more about the Voice Commander, contact Applied Voice Recognition, Inc., Houston, Texas 77027, (713) 621-5678.

**LETTERS . . .**

Chair’s Note: The authors of the Pro/Con section on using multiple brands and types of ventilators that appeared in the last issue of the Bulletin were asked to take a certain position on the topic, whether or not they actually agreed with that position. The purpose of the section was to stimulate your thoughts and, hopefully, encourage some of you to write in with a reply. Well, it seems to have worked—we received the following letter and I include it here for your consideration. If you have an issue to discuss, please fax, e-mail, or post your question, comment, or concern to me at the addresses/numbers listed on the back page of this and every issue.

Dear Editor,

I just read the winter edition of the Adult Acute Care Section Bulletin and wanted to comment on Robert Campbell’s advocacy of using multiple brands and types of ventilators.

In terms of staff education, it is specious to argue that the therapist-ventilator interface is of little consequence because the important part is knowing the underlying concepts of mechanical ventilation. It is uncomfortable enough to move among the different keyboards on the Nellcor Puritan Bennett 7200 series for example, without having to deal with a number of other ventilators, such as a Servo 900C or Hamilton Veolar, which are not volume cycled (and the 900C is a minute volume divider to boot!). While the controls of all these ventilators may be “user friendly,” they are very different from one another.

The entire first paragraph under “fleet maintenance” fails to address this issue. Then, he admits that having multiple types of ventilators means multiple parts need to be stocked, and the personnel in biomedical engineering need to go to numerous different manufacturers’ training meetings. All of this increases cost and complexity (and makes no friends in the biomedical engineering department!).

Claiming that having multiple types of ventilators keeps a flaw or setback from “devastating the fleet” similarly does not ring true. While some older ventilators had “character
flaws” (who could forget the Ohio CCV which divided the set rate by 10 when placed in the IMV mode) or serious software defects (as exemplified by the disastrous introduction of the Chemetron Gill I), those problems are pretty rare these days. In this litigious society, manufacturers cannot afford not to debug a ventilator completely prior to its introduction.

In talking about the ability to provide “patient-focused care” by having every ventilatory bell or whistle available (albeit not on the same machine), he again speaks to the opposite side of the argument. By having ventilators with different capabilities, he leaves his staff to deal with changing a ventilator at 3 a.m. because it lacks pressure control. The paragraph on avoidance of stagnation seems to have no point. Setting up the same ventilator helps to insure that it is set up the same way each time, even by different people. And if a physician is asking for a specific inspiratory time, perhaps he needs some education on mechanical ventilation.

—Robert R. Fluck Jr., MS, RRT, clinical coordinator, department of cardiopulmonary sciences, State University of New York, Syracuse, NY.

ARCF Award Increases Announced

The American Respiratory Care Foundation (ARCF) recently renamed all Foundation scholarships. The new names are now designated as Education Recognition Awards. This change will allow recipients an opportunity to apply for assistance to agencies which only consider applicants who have not received prior scholarships or grants.

The trustees of the ARCF are happy to announce enhanced awards for a number of programs sponsored by the Foundation. Effective with the 1997 competition, winners of the Education Recognition Awards will receive round-trip airline tickets to the AARC International Respiratory Congress in New Orleans, one night’s lodging, and registration to attend the meeting.

Additionally, the trustees have increased the Morton B. Duggan Jr. Education Recognition Award to $1,000 and four nights’ lodging at the AARC International Respiratory Congress.

For further information concerning ARCF awards, fellowships, and grants, please contact Marie Queneau at (972) 243-2272, 11030 Ables Ln., Dallas, TX 75229.

JCAHO Accreditation Visit Reports

In an effort to keep you informed regarding JCAHO site visits, the AARC has been requesting information from organizations that have recently gone through the review process. (See JCAHO Accreditation Visit Form in this issue to provide input on your visit.) Here are two recent responses from hospitals—

**The Jewish Hospital**
3300 Burnet Avenue
Cincinnati, OH 45229
Contacts: Debbie Nesbit, Manager; Jackie Caccia, Supervisor
(513) 569-2125
**Inspection Date: November 18-21, 1996**

1. What was the surveyors’ focus during your last site visit? Life safety issues, policies on patient restraints, multidisciplinary approach to patient care.
2. What areas were cited as being exemplary? Performance improvement, multidisciplinary focus.
3. What suggestions were made by the surveyors? Change some paperwork to reduce redundancy.
4. What changes have you made to improve compliance with the guidelines? Definitive changes not yet decided. Final report not yet in - preliminary report indicates our final grade will be 97-98 with possible commendation (which we’ve earned in last 2 reviews).

**Sacred Heart Hospital**
5151 N. 9th Avenue
Pensacola, FL 32504
Contact: Cindy Carter, RRT, (904) 416-7760
**Inspection Date: October 28, 1996**

1. What was the surveyors’ focus during your last site visit? Bronchoscopy service, H & P, conscious sedation, bronch reports.
2. What areas were cited as being exemplary? Protocols that showed ↓ LOS/↑ (improved) pt outcomes, TQM problem solving process.
3. What suggestions were made by the surveyors? Improve process for positive bronch reports on in & out patients and forwarding to physicians. Could simplify H & P if info. was sent w/pt from physician’s office.
4. What changes have you made to improve compliance with the guidelines? Worked w/medical records and transcription to utilize reporting options available to reduce turnaround time and issue multiple reports to appropriate physicians and to pts chart for inpts.

Additional comments: In cases where needle re-capping is done, state that a needle re-capping device is used, or the syringe cap is not held when the needle is inserted into the cap. They did ask about where bronchoscopes were cinedexed and monitoring employee exposure to sources of radiation in the bronchoscopy suite.

Deadlines for submitting copy for publication in the Bulletin—

<table>
<thead>
<tr>
<th>Issue</th>
<th>Deadline</th>
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<tbody>
<tr>
<td>Spring Issue: February</td>
<td>February 1</td>
</tr>
<tr>
<td>Summer Issue: May</td>
<td>May 1</td>
</tr>
<tr>
<td>Fall Issue: August</td>
<td>August 1</td>
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<tr>
<td>Winter Issue: October</td>
<td>October 1</td>
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**ARCF FELLOWSHIPS PROMOTE RESPIRATORY CARE RESEARCH**

Every year, the ARCF joins with sponsors from industry to award more than $10,000 to RCPs and others engaged in clinical research projects designed to further the scientific basis of respiratory care. Fellowships available through this alliance include—

**Respironics Fellowship in Non-Invasive Respiratory Care:** This fellowship is designed to foster projects dealing with non-invasive techniques to provide ventilatory support. Projects can focus on device development, device evaluation, cost-effectiveness analysis, and education programs.

Current fellowship funding includes a cash award of $1,000, plus airfare and one night’s lodging to attend the Awards Ceremony at the AARC International Respiratory Congress.

**Monaghan/Trudell Fellowship for Aerosol Technique Development:** The fellowship is designed to support projects dealing with aerosol delivery issues. Projects may include modeling studies, in-vitro studies, or clinical studies. The focus should be on developing cost-effective approaches to aerosol delivery.

Current fellowship funding includes a cash award of $1,000, plus airfare and one night’s lodging to attend the Awards Ceremony at the AARC Convention.

**Lifecare Fellowship in Mechanical Ventilation:** This fellowship is designed to foster projects dealing with mechanical ventilation, especially outside of the intensive care unit. Projects may include device development, device evaluation, protocol development, cost-effectiveness analysis, or education programs.

Current fellowship funding includes a cash award of $1,000, plus airfare and one night’s lodging to attend the Awards Ceremony at the AARC Annual Convention.

**Glaxo-Wellcome Fellowship for Asthma Education:** This fellowship provides supplementary support for a one-year period to permit fellows to complete a project in asthma education. The purpose of the fellowship is to foster projects that address issues of asthma education, asthma self-management, and asthma awareness.

Current fellowship funding includes $3,500 per year, plus airfare and one night’s lodging to attend the Awards Ceremony at the AARC Convention.

**Application Procedure**

- Applications must be received by June 30 to qualify for awards beginning January 1 of the following year. They will be judged on merit by the ARCF Board of Trustees in consultation with appropriate reviewers and the fellowship sponsors.
- The application must consist of no more than 20 pages, including references, tables, and figures.
- The application must have the following components:
  - Background of the projects. This should include a scientific review of the problem and previous work in the field.
  - A description of the planned project. This should include the hypothesis (if applicable), the methods to be used, the analytical plan, the expected outcome, and the clinical relevance.
  - The facilities and resources that are available, including consultants and supervisors (appropriate CVs are requested).
  - Other financial support that is anticipated.
  - The significance of the project and how it meets with the intent of the fellowship
- A letter of support from the program director or department director stating that adequate time will be made available to carry out this project. If other resources are going to be required, this needs to also be stated in the letter.
- A curriculum vitae of the applicant

Applications for the Respironics, Monaghan/Trudell, Lifecare, and Allen & Hanburys Fellowships will be accepted from January 1-June 30.

Recipients will be selected by September 1 and the fellowships presented by the ARCF during the Awards Ceremony at the AARC International Respiratory Congress.

Additional information about these four fellowships is available from Brenda DeMayo, ARCF Executive Office, 11030 Ables Lane, Dallas, TX 75229, (214) 243-2272.

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**AARC Online: A Readily Available Resource for Busy Managers**

by William Dubbs, MHA, RRT
AARC Director of Management Services

The content of the AARC World Wide Web site (http://www.aarc.org) is expanding weekly and may have the information you need readily available for instant downloading. When you reach the site, click on “AARC Online Services and Information.” There you will find the following areas, many of which are of particular interest to managers—

Physician Letter of Support: In October of 1996, the American Society of Anesthesiologists issued this statement in support of respiratory care practitioners versus substitute caregivers. The content of this letter is reproduced here along with instructions on how to obtain a signed copy of the letter on ASA stationery.

Conventions, Meetings, and Seminars: Learn about the AARC International Convention and Exhibition, Affiliate Meeting information, and Special Seminars.

Products and Services: Products and services related to respiratory care, and the 1996 Buyer’s Guide of Cardiopulmonary Care Equipment & Supplies, are available here.

AARC Clinical Practice Guidelines: All 46 of the AARC’s Clinical Practice Guidelines are available online.

$1,000,000 Fund Grant Application: The AARC has established a fund of $1,000,000 to promote research into the...
clinical and economic value of respiratory care practitioners. Details on how to apply can be found here.

Links to Other Respiratory Care Related Sites: Links to other sites of interest—
More information for managers can be found in the "Member’s Only Section." In this section (members get their unique password through e-mail) you will find—
The AARC Help Line: In this area members can pose their questions or respond to the questions of others. You can review the responses others have made to the questions posted. Some of the questions under discussion this month related to management issues are—
- Extended/advanced practice
- Institutions using TDPs without a respiratory care information system
- Patient assessment skills
- Inpatient pulmonary rehab
- Criteria for discontinuing RC services
- Outsourcing respiratory care in acute care settings
- Charting by exception
- Cardiac rehabilitation
- RCPs as case managers
- Differences in duties (CRTT and RRT)
- Joint Commission experiences
- Therapist-driven protocols
- Respiratory therapists starting IVs
Position Statements: The AARC has advanced a number of position statements and guidelines regarding the provision of services or the practice of respiratory care. These statements are presented here.
CRCE: The AARC approves respiratory care educational programs for CRCE credit, which many states use as the basis of continuing education. A month-by-month listing of the courses approved by the AARC is posted here.
Resources: This is a particularly rich area for managers. Information here includes the following—
- Post-Acute Care Contracting Resource List: A list of AARC members who are engaged in contracting post-acute care services.
- Restructuring Resource List: This is peer counseling network of AARC members who have been involved in hospital restructuring initiatives.
- Model Transfer Agreement: This is a sample of a transfer agreement between a hospital and skilled nursing facility.
- Model Management Agreement: This is a sample of a respiratory therapy program management agreement between a hospital and a SNF.
- Overview of the Medicare Program: A white paper providing a general description of Medicare.
- Utilization in Respiratory Care: A white paper describing utilization review in acute and post acute settings.
- Recentralized Respiratory Care: A list of organizations that have recently recentralized respiratory care services.

There is much more to come, so I encourage you to check the site frequently. For example, in the near future we will be posting the AARC’s JCAHO Cross Walk document. This identifies the 1997 Standards that managers of respiratory care services in acute care facilities should be familiar with when preparing for an accreditation site visit. Also, those who visit our site in the future will be able to quickly determine the current adjusted hourly salary equivalency amounts and standard travel allowances for respiratory care practitioners providing services to residents in skilled nursing facilities covered by Medicare Part A.

ARCF ANNOUNCES HELMHOLZ RESEARCH FUND APPLICATION CHANGE

In 1994, The National Board for Respiratory Care/Applied Medical Professionals (NBRC/AMP) established an endowment to the American Respiratory Care Foundation (ARCF) to provide support up to $3,000 for educational or credentialing research, a Master’s thesis, or Doctoral dissertation with practical value to the respiratory care profession. This educational research endowment is named for H. Frederic Helmholz, Jr., MD, in recognition of his outstanding contributions to the respiratory care profession.
The ARCF has approved a more “user-friendly” application that can be submitted at any time during the year. The ARCF trustees feel the new, simplified application is more relevant to education research and is tailored to assist individuals applying for credential-related research grants. The Helmholz award will include registration, round-trip airfare and one night’s lodging to the 1997 AARC International Respiratory Congress in New Orleans, LA.
Applications may be obtained through the ARCF Executive Office at 11030 Ables Ln., Dallas, TX 75229-4593, (972) 243-2272.

ATTITUDES REGARDING LIFE-DEATH DECISIONS CHANGING

The age-old belief among physicians and patients alike that life should be prolonged at all costs is changing, say researchers from the VA Medical Center in White River Junction, VT. When they compared the percentage of deaths in a San Francisco ICU that were preceded by a recommendation to withdraw or withhold life support in 1987-88 with the percentage preceded by such a recommendation in 1992-93, they found that the rate had nearly doubled.
During the first period, 51% of ICU deaths came after further treatment would be futile. By the second period, that number had risen to 90%. As might be expected, the use of CPR in these cases declined from the first period to the second as well, from 49% in 1987-88 to just 10% in 1992-93.
Says lead study author Dr. Thomas J. Prendergast, chief of the pulmonary section at the VA Medical Center, “The traditional ethic for doctors was that you couldn’t stop treating patients because life is precious, and neither doctors nor patients’ families were willing to discuss the issue of over-treatment. The new findings indicate this has changed, and they run counter to the perception that physicians over-treat and prolong life against the wishes of patients and families.” The study was published in the January issue of the American Journal of Respiratory and Critical Care Medicine. (Source: Reuters Health eLine, 1/16/97)

Studies highlight adverse drug reactions

Adverse drug reactions are no small problem for the nation’s hospitals, say a series of studies published in the January 22 issue of JAMA. The evidence comes from—

• LDS Hospital in Salt Lake City, UT, where researchers found that inappropriately ordered drugs nearly doubled the risk of death.
• Albany Medical Center in Albany, NY, where scientists noted that nearly four out of every 1,000 medication orders contained an error.
• Brigham and Women’s Hospital in Boston, MA, where researchers found 190 adverse drug reactions among 4,000 patients over a six-month period, 60 of which could have been prevented. (Source: Reuter, 1/21/97)

Don’t release community acquired pneumonia patients too soon, says study

It takes an average of four days for patients hospitalized with community acquired pneumonia to have their vital signs stabilized, says a study involving 700 patients at four medical centers, and they should remain in the hospital for the entire time. Researchers from Massachusetts General Hospital in Boston who conducted the study found that patients who were discharged prior to achieving stability “had a two-to-threefold increased risk of (mortality) during the 30 days following discharge.”

According to the study, vital sign stability is defined as a temperature of 100 degrees F, respiratory rate of 22 breaths per minute, and oxygen saturation of 92%. The authors believe their findings are troublesome because a median stay of four days conflicts with the current trend in hospitals, which is to release patients with community acquired pneumonia earlier than that. The study appeared in the November 15 issue of Internal Medicine News. (Source: Reuters Medical News, 12/6/96)

Readmission rate for congestive heart failure patients is too high

Current practice patterns aren’t preventing hospital readmissions among congestive heart failure patients, says a study of readmission rates for all Connecticut Medicare patients admitted to 33 acute care hospitals between 1991 and 1994. Forty-four percent of the 17,448 patients studied landed back in the hospital within six months of discharge. Says study author Dr. Harlan M. Krumholz, “This striking rate of readmission in a common diagnosis demands efforts to further clarify the determinants of readmission and develop strategies to prevent this adverse outcome.” The study was conducted at Yale University and published in the Archives of Internal Medicine. (Source: Reuters, 1/23/97)

1997 Open Forum is your voice to the ear of the respiratory care profession!

The issues that are near and dear to your heart are valuable to the entire body of AARC professionals.

Your original study, evaluation of a method, device, or protocol, or a case or case study is important. Submitting it is as easy as calling the editorial office at 972-243-2272 or looking for the 1997 Call for Abstracts in each issue of Respiratory Care.

Final Deadline: May 27, 1997
The following survey form is provided to enable the reporting of recent JCAHO accreditation site visits. Compiled results will be published regularly through select section newsletters and the AARC Times. Please return your completed survey to:

William H. Dubbs, MHA, RRT
AARC Director of Management Services
11030 Ables Lane
Dallas, TX 75229-4593
Phone #(972) 243-2272 Fax #(972) 484-2720

Inspection Date: ________________________________

Please check the type of accreditation visit you are reporting:

Pathology & Clinical Laboratory Services □
Hospitals □
Home Care □
Long Term Care □

What was the surveyors’ focus during your last site visit?

What areas were cited as being exemplary?

What suggestions were made by the surveyors?

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

Please offer any additional comments about the site visit that will be helpful to others. (use additional sheet if necessary)

_______________________________________________________________________________________________________________
_______________________________________________________________________________________________________________
_______________________________________________________________________________________________________________

If you are willing to discuss your accreditation visit with others check this box □ and this information will be added to a list that is available to AARC members. If you do not check the box your response will remain anonymous.
Don’t forget to make your nominations for the Adult Acute Care Outstanding Section Member of the Quarter award. The winner of each Outstanding Section Member of the Quarter award will be featured in an article in the Bulletin and our Specialty Practitioner of the Year will be chosen from these four winners. The winner of the Specialty Practitioner of the Year award will be honored during the Awards Ceremony at the AARC International Respiratory Congress. The recipient of this award will be determined by the Section Chair or a selection committee appointed by the chair. Each nominee must be a member of the AARC and a member of the Section. Use the following form to send in your nominations for this important award—

I would like to nominate ______________________________ for Adult Acute Care Outstanding Section Member of the Quarter because

____________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________

Nominee ______________________________ Your Name ______________________________
Hospital/School ______________________________ Hospital/School ______________________________
Address ______________________________ Address ______________________________
City, State, Zip ______________________________ City, State, Zip ______________________________
Phone ______________________________ Phone ______________________________

Mail or FAX your nomination to the Section Chair at the address/number listed on the last page of this issue.
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