



AMERICAN ASSOCIATION FOR RESPIRATORY CARE
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March 26, 2008

Ms. Kelly Fugate
The Joint Commission
One Renaissance Blvd.
Oakbrook Terrace, IL 60181

Dear Ms. Fugate

On behalf of the American Association for Respiratory Care (AARC) and its 46,000 members, I want to take this opportunity to provide comment regarding the proposed revision of Standard/EP: NR.01.01.01,EP2. As the Standard reads, if adopted, ancillary services such as pharmacy, physical therapy and respiratory therapy will be required to provide service under the coordination of the nurse executive. This requirement, if adopted, will eliminate flexibility in organizational structure for hospitals. The standard as currently written is flexible enough to permit the organization of ancillary services under the nurse executive or under another individual such as a vice president for clinical services who is not a credentialed nurse, but rather holds a graduate degree in health care administration, or another related area.

Under the current rule, hospital CEOs have options to exercise based on the needs of the institution. Why eliminate flexibility when it's unnecessary to do so? It makes no sense for the Joint Commission to virtually micromanage the tables of organization for hospitals providing a wide range of clinical services which include both nursing services as well as ancillary services under the umbrella term "patient care programs." The standard does not have to be revised to permit the nurse executive to accept administrative responsibility for all clinical services, and therefore only requires revision if the goal of the Joint Commission is to eliminate qualified persons acting in the role of executive vice president for clinical services from doing what they're currently employed to do.

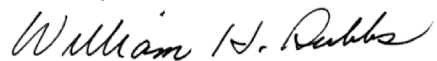
Even though prospective payment is commonplace, we should also be aware that there still exists payments based on fee for service. Combining ancillary services under nursing may create unintended consequences related to reimbursement. This could result in hospitals losing their ability to bill separately for ancillary services.

Our final point is that respiratory therapists throughout the United States are licensed and virtually all licenses require respiratory therapists to work under medical direction, not nursing direction. Since RTs follow physician orders, they work in effect as physician extenders. Since RTs value their relationship with the medical community and their respective medical directors, their legal status within the state may change if not working under active medical direction.

The AARC opposes adoption of the proposed revision for the foregoing reasons. We will be happy to provide additional information if you'd like to discuss any of the foregoing points. We would also respectfully request a statement describing the rationale supporting such a proposed revision. We have been unable to locate any published studies related to the benefits of folding ancillary services under the nurse executive.

Thank you for permitting us the opportunity to comment.

Sincerely,

A handwritten signature in cursive script that reads "William H. Dubbs".

William H. Dubbs
Director of Education and Management Services