

AARC Times Round Table:

Respiratory Therapists Influence Treatment and Buying Decisions

Respiratory therapists have traditionally played a big role in the respiratory care purchasing decisions made by their hospitals. However, now there's a growing sentiment among respiratory care vendors that the proliferation of group buying and other initiatives is diminishing this role. Not so, says a group of leading respiratory therapists and physicians from around the country who gathered at the AARC International Respiratory Congress in December for a roundtable discussion on the issue. If anything, they say, the growing use of respiratory protocols and

consult services is increasing the respiratory therapist's influence in buying decisions. The following interview contains excerpts of that discussion.

William Dubbs: How do you all believe your respiratory therapy departments impact buying decisions in your hospitals?

Rick Ford: The respiratory therapy department at UCSD treats about 13,000 patients a year. About 21,000 patients are discharged from UCSD Medical Center each year, so that means we treat nearly 60 percent of the

total patients. When it comes to the plan of care, we have a protocol system; so the therapist is engaged with every single one of those patients in terms of their clinical care plan. I think that says a lot about our influence.

In regards to purchasing, annually we spend about \$5 million of the hospital's money — including \$200,000 on supplies, about \$150,000 on gases, and about \$200,000 on oximetry and sensors. In addition, the medical center has a capital budget that runs anywhere from \$6 to \$10 million each year. Between the pulmonary func-



tion testing (PFT) labs and respiratory care, we end up spending \$600,000 to \$700,000. When it comes to making such purchases, we are engaged in negotiations and respected for our knowledge of technology and our ability to make good decisions.

Dr. Steve Peters: Our Critical Care Service at Mayo is a joint service formed from the departments of medicine, pulmonary medicine, and the department of anesthesia, surgery, and pediatrics. Anesthesia actually directs respiratory care in the

administrative structure. That has worked to our advantage because the Critical Care Service is multidisciplinary.

Within this structure, respiratory has a very detailed involvement with equipment purchases. For example, when we are considering purchasing new ventilators, the ventilators are brought in by respiratory, the displays are set up by respiratory, the ventilators are tested by respiratory, and they are maintained by the respiratory department. Mayo has an equipment committee; but Curt Buck, who is our director, and the respiratory therapists who

have looked at this equipment, significantly influence their decisions.

In terms of influencing orders, I don't think there's any question that the respiratory therapist can influence the order — all the way from making a recommendation to deferring the completion of a resident's order and instead going back to that individual to ask him if he really meant what he said or to point out reasons why the patient might not benefit from or tolerate the procedure he had asked for. It's a very intimate involvement in practice.



Rick Ford and Dr. Tim Morris

Carl Mottram: We also have a purchasing committee in the outpatient facilities that provides a systematic approach to device evaluation.

Dubbs: How does the committee structure work? Do you vote on things?

Mottram: Yes. For example, we just finished a major purchase in our outpatient pulmonary lab. We specified five criteria in the evaluation process — equipment validation, data management, patient interface and technologist feedback, cost, and intangibles. Each variable was weighted according to its effect on patient outcome and scored appropriately. Then everyone on the committee voted based on this information. Using this methodology, it became very clear which device was the best choice for our laboratory.

Doug Orens: As many of you may know, The Cleveland Clinic has had a protocol program (The Respiratory Therapy Consult Service) in place for almost a decade now. We are a teaching

institution — 1,000 beds — and the number of inappropriate therapies that had been ordered through the years prior to our protocol program was very high. We studied that and were able to identify that a number of those therapies that were not clinically indicated were very costly to us. We were able to put a protocol program in place, turn that around, and the result has been a decline in costly high-volume therapies. We have saved, literally, hundreds of thousands of dollars through the program over the last

decade. So, in terms of influencing orders and practice, that sort of says it all.

In terms of equipment purchases, we're relied on very heavily to evaluate equipment and make those decisions for the respiratory component. We do have a committee of respiratory therapists, which does a thorough evaluation. We sit down and talk with the sales representatives; and if we need any ancillary support within the institution, we bring those personnel in as well and try and make an educated guess as to what we need to purchase and what will have the greatest long-term impact for us.

Dr. Neil MacIntyre: Just out of curiosity, how many times have you given your purchasing department or administrators your input and then had them say, "No, we're not going to do that. We're going to do this instead?"

Orens: I'd have to say we've been very fortunate. Obviously, if there's no money available, that's a big issue. However, when monies are available, we've really



Dr. Tim Morris, Dr. Carolyn Kercksmar, and Doug Orens

been able to purchase. Is that true around the table?

Mike Gentile: If the capital budget and resources are such that they can't do what we're asking, then they don't do it. As far as product selection is concerned, usually there isn't even an alternative presented. So, I've never had anybody at Duke say, "We don't want to buy that ventilator; we want to buy the other one."

Ford: We have the privilege of having our own respiratory therapy biomedical division within the department, which provides us with a tremendous amount of technical expertise. So when it comes down to selecting equipment, it doesn't matter if it's an

oximeter, or brand of nasal cannula, or a major ventilator, or PFT system purchase (which we did have last year), the ability of the respiratory therapy department to work through the decision-making process and determine what makes sense in terms of meeting our patients' needs and being efficient economically for the hospital is highly respected. I've been at UCSD for 13 years, and I can't think of a single time when we submitted a request that was denied.

Dr. Carolyn Ker csmar: At our hospital (Rainbow Babies & Children's), we've always been very interested in testing modalities and new equipment and developing new programs; and we have a lot of protocols as well,

many of which have been initiated or heavily influenced by the respiratory care department. That has led over the years to publication in peer-reviewed literature, which then heavily influences what gets implemented and used in the hospital.

For instance, we have an inpatient asthma unit and several innovative and unique asthma care paths that have resulted in changes in the medications that are used. These changes, all of which involved respiratory therapists, have reduced treatments, hospital costs, and length of stay. When respiratory therapy makes a recommendation, it goes to the administrators; and if the money's there, it's what gets done. There's not a lot of opposition.

Round Table Participants

William Dubbs, MHA, RRT, FAARC, is an associate executive director of the American Association for Respiratory Care, based in Dallas, TX.

Rick Ford, BS, RRT, FAARC, is director of respiratory therapy at University of California San Diego (UCSD) Medical Center in San Diego, CA.

Steve Peters, MD, is a consultant in the division of pulmonary and critical care medicine at the Mayo Clinic in Rochester, MN.

Carl Mottram, BA, RRT, RPFT, F AARC, is coordinator of the pulmonary function laboratories and rehabilitation program at The Mayo Clinic in Rochester, MN.

Doug Orens, MBA, RRT, is manager of the respiratory therapy section of the pulmonary and critical care medicine department at The Cleveland Clinic Foundation in Cleveland, OH.

Neil MacIntyre, MD, F AARC, is affiliated with respiratory care services at Duke University Medical Center in Durham, NC.

Carolyn Ker csmar, MD, is professor of pediatrics and medical director of pediatric respiratory therapy at Rainbow Babies and Children's Hospital in Cleveland, OH.

Tim Myers, BS, RRT, is administrative manager of pediatrics in the department of respiratory care at Rainbow Babies & Children's Hospital in Cleveland, OH.

Tim Morris, MD, is the medical director of respiratory care at UCSD Hospital in San Diego, CA

Mike Gentile, BS, RRT, is associate director of respiratory care services at Duke University Medical Center in Durham, NC.

Bob Campbell, MBA, RRT, is clinical education coordinator at Duke University Health System in Durham, NC.

Tim Goldsbury, BA, RRT, is director of advertising for the AARC.



Dr. Neil MacIntyre, Bob Campbell, and Mike Gentile



Dr. Neil MacIntyre, Tim Myers, Doug Orens, and Dr. Carolyn Kerksmar

Tim Myers: At Rainbow Babies, the standing orders for our asthma care path, cystic fibrosis (CF) care path, and the consult service basically read, “respiratory therapy to see, assess, evaluate, and treat.” That provides a lot of leeway on the types of treatments we provide. The respiratory therapist can choose, for example, if he or she wants to use a Flutter® versus an Acapella™ versus a ThAIRapy® Vest for airway clearance.

We also have the same types of purchasing committees you’ve heard about here today, where the respiratory therapist is heavily involved in the decision-making process. For example, we’re going to spend a million dollars for ventilators over the next three years; and that was really driven by the department of respiratory care. Since we are a system, one of the things they asked us was that if this is good for University Hospitals of Cleveland, maybe we should look at the entire system. So what started off as about a 50 to 60 ventilator purchase for our facility, ended up rolling into approximately 100 to 150 ventilators across the system.

Dr. Tim Morris: How much of the protocol system in both your departments is mandatory and how much of it is a good solid suggestion that people have a hard time arguing with?

Orens: We started using protocols in 1992, and by 1995 or 1996 our medical executive committee approved the protocol system for all non-ICU inpatients. So we had to sell it initially, then do it and report it; but eventually the evidence was so strong that it was unanimously voted in. The positive attributes of a protocol program in terms of appropriateness of therapy, therapist satisfaction, and reduction in costs far outweigh any reasons not to develop such a program.

Dr. Kerksmar: We work pretty much the same way — with asthma it is 100 percent. CF is the same way. With most of our protocols, it is not a suggestion; it is not an option.

Dr. Peters: So if a physician says, “OK, I appreciate that you gave my patient this much bronchodilator; but as his physician, I

think he needs a little bit more,” you say, “no”?

Dr. Kerksmar: No. We would honor the physician’s wish, unless it was totally out of line. It just doesn’t happen very often; and when it does, there’s usually some negotiations first. The physician will sit down and discuss it with the therapist; or they can call one of us and, by and large, we can work things out.

Myers: I think good experience with protocols can really increase the respiratory therapist’s influence on care-planning decisions. For example, we often see a patient who is cruising along, maybe in the asthma care protocol, and having their aerosol therapy advanced; but by the time they get out to Q4, they’re still on oxygen. Our protocol program is to the point now where the respiratory therapist will go to the resident and say, “You know, this kid’s still on a liter and a half of oxygen, and we’re out to Q4; maybe we should get an x-ray, because maybe it’s just not asthma that we’re dealing with here.” Low

ROUND TABLE DISCUSSION

and behold, they get an x-ray, the child has pneumonia, and the child gets started on antibiotics. So having respiratory therapists who are really out there assessing those patients and looking at the overall complexity of the patient really impacts care. We like to refer to them as physician-extenders.

Dr. MacIntyre: At Duke, we have a system in the general care arena where advanced-level people run the protocols. It requires a certification process — not everybody can do this. These therapists are called “assessors” in general care; and they have a set of things that they can do, including changing a frequency or a dose to a more standardized format without the physician’s approval. They notify the physician, but they don’t have to get the approval.

In the ICU arena, I, too, like the term “physician-extenders” because I think that’s where the future of respiratory care really lies. That’s really what our respiratory therapists do with our very in-depth ventilator protocol, which takes the patient right from intubation to extubation.

The protocol follows roughly the National Institutes of Health protocol, but we’ve made our own in-house variations on it.

Duke respiratory therapists are looked upon as the experts who know what technology is all about — including hemodynamic monitors, ventilators, or PFT equipment. We also have an equipment committee that goes through a process very similar to what others have described here today. Our purchase recommendations have never been rejected.

Bob Campbell: Part of our success in influencing patient care lies in the core teams we have developed at Duke over the years. We try to match the skills of our respiratory therapists with the patient population they work the best with. We have people who have worked, for instance, in the coronary care unit or medical intensive care for several years in a row. By doing that, they have developed a close personal relationship with the attending physicians who rotate through or manage those units. This, coupled with the types of care we provide — ventilator management,

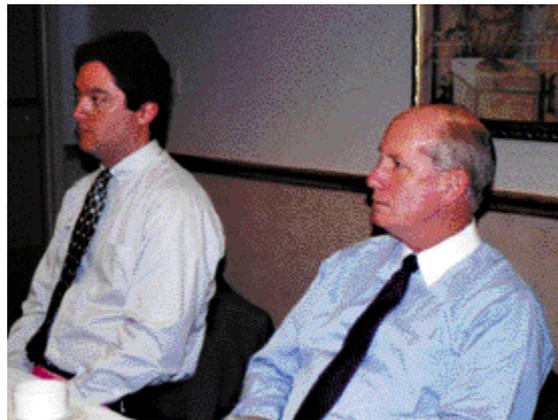
ventilator management by protocol, insertion of a-lines, etc. — has earned us a lot of respect. Also, we have heavily participated in the development of care paths at our institution.

Gentile: In terms of equipment purchases at Duke, respiratory therapists have been blessed or cursed — depending on how you look at it — with a lot of responsibility. We get a call from the administrator saying, “We need you to look into product X” — sometimes it has nothing to do with respiratory care — “and we’d like you to make this project happen.” It could be noninvasive blood pressure or something like that. So, respiratory therapists spend a lot of money for the hospital. In addition, Duke has now acquired two other hospitals, and we’re in the process of working with them on projects.

As a result, we have long-standing relationships with multiple companies related to research and development. Respiratory therapists are influential in every product decision. We analyze everything from nasal cannulas to heat and moisture exchangers



Carl Mottram, Dr. Steve Peters, and Rick Ford



Tim Myers and Dr. Neil MacIntyre

through a systematic approach. In terms of capital equipment, we've never been turned down. Of course, we have to justify our decisions, but the only reason we would ever be turned down is lack of budgetary funds.

Our success, though, is really all about relationships with the physicians. We provide a multitude of services — such as extracorporeal membrane oxygenation and nitric oxide — and that's helped too; because as everyone has alluded to, getting along with all these different services sometimes proves challenging. However, since we're the one common bond throughout the institution, we've got an advantage. In the last couple of years we've gotten involved in everything from renovations to gas systems design to anything that has anything to do with critical care. Outside of radiology, we pretty much are the ICU people.

Dubbs: So, are you saying that the perception that the respiratory therapist is playing a less important role in purchasing decisions simply isn't true? Tim, what feedback do you get from industry regarding their perception of the respiratory therapist's role in decision making?

Tim Goldsbury: I had a meeting yesterday morning with the CEO of one of the major ventilator companies who expressed concern that ventilators were becoming a commodity item. I don't think that I'm hearing that here. All of you seem to look at a number of ventilators before making a decision. There is the feeling among a lot of vendors that a lot of things are stated on a contract for group buying; and

the therapist, therefore, has no input on which vendor gets the contract. I certainly don't think that exists at all with ventilators. From what all of you are saying, I don't think it exists for other products — such as metered dose inhalers and aerosols — either. Industry is always very concerned that their advertising dollars reach the real decision makers. It is, indeed, apparent to me from the comments made here today that respiratory therapists are decision makers. It is also apparent that those therapists rely on information found in the AARC's two publications, *AARC Time* and RESPIRATORY CARE, to help them stay informed about equipment, supplies, and pharmaceuticals.

Myers: They should also understand that it's not just the people on the purchasing committees who drive the whole decision either. The bedside practitioner plays a big role, as well. In our hospital, we really consider how a piece of equipment works on the patient. Sometimes things look great in the department; but when you get them out on the patient, they are not as great. So the decision-making process really starts at the ground level and works its way up.

Orens: I agree with Tim that input from the staff therapists is critical to the decision-making process. The input we receive from our staff guides us in the right direction and sets the tone for any purchase. I think this also gives our staff a sense of ownership when we're using a ventilator or any other product for which they provided input into the selection process.

Ford: At UCSD we recently had a ventilator purchase that came down to two options. Both systems were technically acceptable and about the same cost. The respiratory staff made the final decision based on their clinical experience, and we went out and spent \$150,000 on ventilators based on staff preference.

Dr. Morris: We purchased ventilators last year and relied highly on the staff respiratory therapist's perspective to make the decision on what to buy. That worked out very well, because they all had opinions — very strong opinions.

Campbell: I agree. We have vendors who bring ventilators in and leave them for a certain period of time. You know right away what the staff thinks about it if you go up to an ICU and it's sitting in the annex and not on the patient.

Myers: I want to go back and address something that was mentioned about advertising. I just had a situation last week before we left for the convention where we were renting a piece of equipment very, very frequently; and I thought, the cost on investment, cost on return, has got to be very large. Let's see if I can buy one of these. I didn't have my *AARC Time* Buyer's Guide with me — it was at home on my desk. So, I just turned around to my shelf of RESPIRATORY CARE journals and started looking through the pages, because I knew somewhere in there I would come across an ad for that piece of equipment. I found the ad with a phone number and the web site address. I went to the web,
(continued on page 77)

printed everything out in detail, sent it to our secretary, who got pricing, and that went out as a capital purchase request before we left that day. It was RESPIRATORY CARE journal — and your advertisers — that led very quickly to the right information and saved me a ton of time in terms of trying to find a vendor and those types of things.

Gentile: You can also look at the OPEN FORUM and see how we are impacting equipment decisions. There's what — 260 abstracts this year? I would almost guarantee you that 70 percent of them are looking at equipment or evaluating equipment. So, I agree that it is simply a false statement to say that there is no decision-making there on the part of the respiratory therapist.

It's so ironic, because I flew out here from Atlanta with a respiratory therapist who was coming to the AARC Congress because she was part of a contractual hospital that wanted to change products. She was out here looking at products so she could go back to her product manager and say, "This is what I want, and this is why I want it" to get out of the group purchase situation. If that's not influence, I don't know what is. 🐾