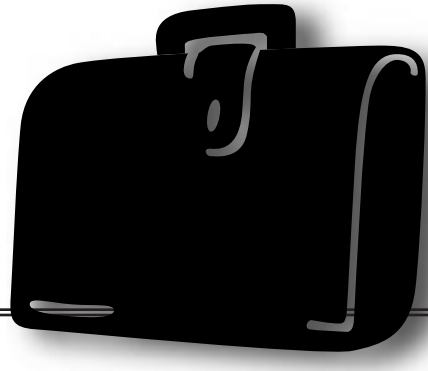
# *Management Bulletin*

THE AMERICAN ASSOCIATION FOR RESPIRATORY CARE

NUMBER 7 FALL 1997



## NOTES FROM THE CHAIR

*by Karen Stewart, BS, RRT, LRT*

The benchmarking project proposed by the Management Section was presented to the AARC Board of Directors at their summer meeting. The primary investigator is David Burns, MD, of the University of California at San Diego (UCSD). Rick Ford, clinical leader of respiratory care at UCSD and myself will serve as his assistants. The Board has recommended that a budget be prepared and submitted to both the Board and the House of Delegates for approval this fall.

The focus of the project is to identify the methodology of data collection and to begin the process of collecting data and presenting the data in a format which is useful and understandable. It is the intention of the investigators not only to collect data, but also to describe exactly where the data originated and how the information was obtained. The data that is collected will include cost information against which departments can benchmark their own costs. Our goal is to provide detail by treatment entity in a format that can be easily translated for any manager's use. Many of you have e-mailed me to express an interest in the project, and I urge you to contact your local delegate to encourage support of the project as it moves to the budget process.

On another note, I have received many requests for information on charting by exception and, in particular, how this area affects the JCAHO site survey process. Specifically, we are interested in how the charting by exception process is being accepted by the accrediting agency during a site visit. If your organization is involved in charting by exception and has recently been through a JCAHO survey, I would like to hear from you. I can assist in teaming you up with others who have made a similar request.

I have also had several requests from people who are considering converting empty acute care beds to skilled nursing beds. There are slight differences between providing services in a related entity and providing services to a free standing skilled nursing facility. If you have provided this service, please e-mail me and I will network you with others who are moving in the same direction.

Lastly, I would like to encourage all of you to participate in the section by working with me to develop short articles for this *Bulletin*. By sharing your experiences in areas like skilled nursing, outcomes, charting by exception, JCAHO survey, and others, you will be helping to increase communication within the section. I have recruited several volunteers for the winter issue, but need many more of you to sign up for the upcoming 1998 issues. *Bulletin* articles are generally between 500-1,000 words, and editing assistance is available through the Executive Office in Dallas. If you have an interesting, rewarding, positive, or even negative experience to share with your colleagues, please consider submitting an article to this publication. (See back page for submission deadlines.)

I do appreciate the e-mail, so keep on communicating. I enjoy hearing from each of you.

## THE UNIFORM REPORTING MANUAL FOR SUBACUTE AND LONG TERM CARE RESPIRATORY CARE SERVICES

*by William H. Dubbs, MHA, RRT*

*William Dubbs is AARC director of management services.*

Increasingly, subacute, skilled nursing, rehabilitation, and other health care facilities which provide substantial respiratory care services are competing in a managed care environment. Ensuring staffing efficiency, monitoring utilization data, and benchmarking with similar organizations will be critical in assuring success. To assist managers in these areas, the AARC is currently developing a *Respiratory Care Uniform Reporting Manual* for subacute and long term care.

This manual will provide managers and facilities with a tool that they can use to track trends in utilization of respiratory care services, determine personnel requirements, and measure demand for and intensity of service. Most importantly, it will provide a foundation for benchmarking performance indicators within the industry.

The manual will contain respiratory care procedures commonly performed in subacute and long term care. Each procedure will be defined and assigned time standards The manual will also contain appendices to increase its utility to the user. For example, one appendix will guide the user through the computation of workload measurements. Another will provide methodology for establishing valid standard times for procedures not covered in the manual.

To provide a framework for the project, a small panel of experts has been selected from the AARC membership. This group is being assisted by consultants representing the major communities of interest. Together, the small panel and consultants have established methodology and guided the project. Specifically, the panel will assure the validity of

the data upon which time standards are based, identify procedures for inclusion in the manual, and ensure that the manual is as "user friendly" as possible.

To validate the contents of the manual, 187 clinical experts, each representing a facility that matches the size and geographic distribution of the population of Medicare-approved free-standing and hospital-based SNFs that provide respiratory care services, are participating in this project. They are responding to a series of surveys that will let the panel know if the procedures included in the manual are commonly performed, if there are commonly performed procedures that were omitted from the manual, and what time standards should be assigned to each procedure.

The project is now in the survey phase, and the manual should be available before the end of the year. Questions about this project may be directed to Bill Dubbs in the AARC Executive Office at 11030 Ables Lane, Dallas, TX 75229, (972) 243-2272, FAX (972) 484-2720.

## ARCF Silent Auction Offers Unparalleled Opportunity for RC Managers

Attention RCPs! If you're planning to attend the AARC's 43rd International Respiratory Congress this December 6-9 in New Orleans there's a new attraction you won't want to miss. In an effort to raise funds for important projects aimed at improving quality of care for patients and positioning the RCP for success in our changing health care system, the American Respiratory Care Foundation is sponsoring the profession's first-ever Silent Auction.

Thanks to the generous support of the respiratory care industry and others in the respiratory community, the auction will feature items ranging from Las Vegas casino/hotel nights and ski lift passes to Disneyland vacations. Medical equipment to be auctioned off includes items such as capnographs, ventilators, and an oxygen system. You may also want to take advantage of the many New Orleans packages available, including fine dining, cruises, and voodoo tours. Since opening bids on all items have been set at just 25% of estimated retail value, its a great way to take advantage of a good deal for yourself and/or your department while supporting your profession at the same time.

The auction will run throughout the four-day meeting and all AARC members and officially registered attendees at the meeting are invited to come by Auction Headquarters as often as they like to place and/or raise bids. A preliminary catalog of items published in the October issue of *AARC Times* tells how the bidding process works, and a final catalog with an updated items list will be available onsite. So take a minute to see what's available, then come and join in the fun.

## Demand Management Emerges as Latest Tactic to Control Utilization

As the nation's health care system moves from fee-for-service reimbursement to managed care, the old adage, "one step forward, two steps back," certainly has applied. Recent attempts by federal and state governments to scale back some of the utilization control measures instituted by profit-seeking HMOs are one example. Now a new report out from Deloitee & Touche LLP and VHA suggests that a new way to "manage" care is emerging that promises to accomplish the same goal (reducing unnecessary services) through a different route.

"Demand management" is the latest buzz word in health care reform, and is being touted by some as the most effective means of managing patient entry into the health care delivery system. Residing at the patient's first point of entry into the system, demand management is intended to provide health/disease management and patient triage by answering patients' questions, providing benefits information, and identifying appropriate services and providers. Twenty-four hour nurse-advice telephone lines are currently the most popular form of demand management, and are being credited with establishing an ongoing communication link between health care consumers and the health care community.

The Deloitte & Touche-VHA report is called *Redesigning Health Care for the Millennium, a 1997 Assessment of the Health Care Environment in The United States.* (Source: PRNewswire, 7/29/97)

## What Is – and Isn't – Important to Patients

What do patients really want from their health care system? That was one of the questions that Deloitte & Touche and VHA attempted to answer in a recent report on the health care environment (see previous article), and RC managers trying to gain acceptance for greater use of RCPs as primary care practitioners may want to take special note of the last item on the list. Here's how health care consumers who were surveyed in 1995 by William M. Mercer, Inc., prioritized their definitions of "health care value" —

| | |
|---|---|
| Seeing the same physician all the time | 61% |
| Being able to get an appointment quickly | 48% |
| Going to a physician who spends enough time | 44% |
| Affordable office visits | 42% |
| Free choice of physicians | 40% |
| No long waits at the physician's office | 34% |
| Convenient location | 29% |
| Convenient hours | 23% |
| No limits on procedures or specialists | 23% |
| Always seeing a physician — not a nurse or other non-physician | 11% |

(Source: PRNewswire, 7/29/97)

## AAHP BATTLES "PRUDENT LAYPERSON" STANDARD IN EMERGENCY SITUATIONS

"Pain" is too nebulous a term to justify a trip to the emergency room, or so says an industry group representing the nation's managed care organizations. The American Association of Health Plans (AAHP) went on the offensive last summer to battle provisions in legislation under consideration in Congress that would apply the "prudent layperson" standard in determining when severe pain is a symptom of an emergency medical situation.

According to the AAHP, "pain is a highly subjective term and has vast differences in meaning among consumers." Saying that the provisions would allow people to receive emergency medical care for conditions that could easily be treated in another, less costly setting, the group circulated a set of "talking points" to Washington insiders detailing its objections to the provisions. Arguments against the provisions included that—

- Overuse of hospital emergency rooms results in higher health care costs.
- Emergency room waiting times are already excessive, causing some people who really need care to leave without receiving medical treatment.
- Incorrect medications are prescribed and conditions are misdiagnosed more often in emergency rooms because ER physicians do not have access to patients' medical records.

(Source: Reuters Medical News, 6/26/97)

## STATISTICS EXPLAIN THE RUSH TO PROSPECTIVE PAYMENT FOR POST-ACUTE PROVIDERS

As Washington tries to get a handle on rising Medicare costs, one of the prime targets has been the post-acute market. Over the next two years, HCFA plans to come up with a prospective payment system to govern reimbursement for post acute providers that will apply the same cost-cutting strategies to that area of care that have been controlling costs on the acute care side since the early 1980s.

Why the new emphasis on post-acute services? If you're still wondering what all the fuss is about, consider the following statistics from the April issue of Hospitals & Health Networks—

- The number of Medicare-certified home health agencies increased from 5,700 in 1990 to 9,800 in 1996.
- About 3/5 of the nation's hospitals now operate home health agencies of their own.
- The percentage of Medicare beneficiaries using home care services nearly doubled during the past seven years, from 5.6% to 10.1%.
- Since 1990, the average number of home visits per patient per year jumped by 43, from 33 to 76.
- Spending on home care services climbed from $3 billion in 1990 to $16 billion in 1996.
- Total post-acute outlays have grown from $8.3 billion in 1990 to more than $30 billion today, and now represent about 1/6 of all Medicare expenses.

(Source: *Hospitals & Health Networks*, 4/97)

## COMING SOON TO AN ORGANIZATION NEAR YOU: ORYX IS ON THE WAY

*ORYX: The Next Evolution in Accreditation* may sound like a title for the latest holiday blockbuster, but health care organizations are soon to find out differently. In keeping with its ongoing efforts to redefine the accreditation process, the Joint Commission on Accreditation of Healthcare Organizations will soon be requiring all organizations to provide objective feedback about their performance to the Joint Commission that can be used "internally to support performance improvement activities and externally to demonstrate accountability to the public and other purchasers, payers, and stakeholders." The Joint Commission plans to integrate the data into its triennial onsite survey process, allowing for what it has termed a more "credible, objective, consistent, and useful" survey.

Long-term care facilities will be the first to come under the new requirements, followed shortly thereafter by hospitals. By the end of December, all accredited long-term care organizations are going to be asked to—

- Choose a performance measurement system from among 60 such systems that have been approved by the Joint Commission and;
- Select at least two clinical indicators from that system that relate to at least 20% of their patient population

—then report both to the JCAHO. Organizations must begin submitting data to the Joint Commission no later than the first quarter of 1999, and continue to submit data on a quarterly basis thereafter. For more information on the ORYX initiative, visit the Joint Commission's website at http://www.jcaho.com. (Source: JCAHO)

## TELEMEDICINE GETS MIXED REVIEWS

Telemedicine may improve quality of care, but the jury is out on whether or not it saves money, say researchers from the University of Missouri (MU) who looked at 80 clinical trials involving the use of telemedicine to treat conditions ranging from osteoarthritis to diabetes.

The telemedicine techniques utilized in the trials ran the gamut from telephone follow-ups and reminders to computer links between patients and practitioners, but the telephone techniques were by far the most common and elicited the largest results. The MU analysis found that telephone

counseling resulted in improvements in mammography and colposcopy rates, and influenza and pneumonia vaccination rates among the elderly improved after patients received telephone reminders. The impact that telephone counseling had on stop-smoking rates was mixed.

The researchers could not, however, link these and other improvements in quality of care to cost savings, saying that, "available evidence is insufficient to determine whether current telemedicine applications are cost effective." The study was published in a recent issue of *JAMA*. (Source: Reuters)

## JAMA Articles Focus on Managed Care's Impact on Clinical Research

A series of articles published in the July 16 issue of *JAMA* confirm what many have suspected: when managed care comes into a market, clinical research suffers.

According to the articles, the decline in clinical research seen in intensely managed care areas of the country warrants concern, and some are suggesting a new tax on managed care companies to ensure that important studies continue to be carried out. Specifically, health officials are proposing a 1% tax over four years on health care premiums, with the money going to clinical research.

The managed care industry is understandably concerned, and has suggested that such a tax be levied on all industries in order to spread the burden of paying for clinical research evenly across the economy. The American Association of Health Plans (AAHP), which represents more than 1,000 MCOs nationwide, called the JAMA studies "incomplete and misleading," but nevertheless issued a statement in support of funding for clinical research. Says AAHP President Karen Ignagni, "We would be very pleased to participate in discussions of how health plans can best contribute to establishing priorities for and advancing the nation's clinical research agenda." (Source: Reuters, 7/11/97)

## Massachusetts Docs Launch Anti-MCO Campaign

Massachusetts physicians are fighting back against managed care organizations that they say are threatening to "transform healing from a covenant into a business contract." Organized by the Ad Hoc Committee to Defend Health Care, which includes representatives from Massachusetts' renowned medical schools and teaching hospitals, the doctors are calling for a moratorium on corporate takeovers of health services and favor placing restrictions on the ability of MCOs to intervene in the physician-patient relationship.

By mid-June a "Call to Action" circulated by the committee had acquired signatures from more than 1,900 physicians. The petition, which is slated for publication in the October issue of *JAMA*, offers no alternative to managed care, but clearly vents physician displeasure with the way things have gone so far. Says committee chair and Harvard professor, Dr. Bernard Lown, "We are troubled by any organization that places an interface between the patient and the doctor." Among the grievances listed in the "Call to Action" are strategies that —

- Deny treatments recommended by physicians
- Dictate the duration of office visits
- Use lower-paid nurse practitioners and physician assistants to provide more care
- Second-guess prescribed medications
- Send patients out of town to get tests to take advantage of lower fees

The Massachusetts Association of HMOs dismissed the campaign as the work of "liberal doctors with a political agenda." (Source: Reuters, 7/2/97)

## Book Reviewer Wanted!

*Respiratory Care Journal* needs an individual with an interest in subacute care to review a recently published book on subacute care by Laura Hyatt, president of Hyatt Associates in Los Angles, CA. *Subacute Care—Redefining Healthcare*, is a 230-page book outlining the subacute care industry and its development over the past decade. If you are interested in taking on this assignment, contact Kris Williams in the AARC Office, (972) 243-2272, FAX (972) 484-2720.

## Profitability Down, Premiums to Rise, Say Insurance Analysts

Intense competition in the insurance market is driving down profitability for insurers, say researchers from the Center for Studying Health System Change in Washington, DC. According to a report released by the group last summer, the percentage of profitable HMOs declined from 90% in 1995 to just 35% in 1996. For that reason, they predict that insurance premiums will rise as much as 4%-5% in 1997, after just a 1% increase last year.

Despite this increase, however, the group foresees little increase in the underlying rate of growth of health care costs, noting that the 3.8% rise in premiums seen so far this year has been accompanied by an even greater increase in the dollar contributions that employees make to their health plans, which are up 7.2%.

Other trends noted in the report include—

- A slight rise in payroll costs for providers (although

the average hourly wage for health care workers still falls below that of all other industries studied)
- Higher spending on drugs than on physician and hospital services (despite the fact that drug spending has been on a downward trend since 1996)

(Source: Reuters Medical News, 7/17/97)

## MEDICARE HMOS REAP UNDUE REWARDS, SAYS FLORIDA STUDY

The federal government's push to enroll more and more elderly people in Medicare HMOs may be doing more harm than good to the financial status of the system, say results from a new study of enrollment trends among seniors. Researchers from the University of Miami School of Medicine have found that many elderly people in south Florida who are enrolled in Medicare HMOs switch back to the traditional plan once they become seriously ill and need extensive medical care—then switch again when their health is restored.

The study, which was published in the July 17 issue of the *New England Journal of Medicine*, was accompanied by an editorial suggesting that Medicare HMOs are reaping undue rewards from this trend. Since Medicare HMOs enroll more than their share of the healthier Medicare population but have premiums that are pegged to the average cost of the fee-for-service system, which cares for most of the sick patients, says Executive Editor Marcia Angell, they are "doubly rewarded."

Even if Congress makes good on promises to reduce the reimbursement for HMOs from its current 95% of the average cost of providing medical care for an elderly person to 90%, says Angell, it may not be enough to even out the differences that currently exist. A recent government study showing that the costs of caring for Medicare patients in an HMO were 12% higher than those in the traditional, fee-for-service plan raises further concerns about discrepancies between the two forms of coverage. (Source: Reuters, 7/16/97)

## 1998 CONGRESS ON INTEGRATED HEALTH CARE MANAGEMENT

Mark your calendars now for the Second Annual Congress on Integrated Health Care Management. The June issue of *AARC Times* highlighted several of the presentations from the first Congress, which was held in March 1997, and next year's event promises to be equally informative. Join other health care managers from each of the allied health disciplines in the second Congress, to be held February 5-8, 1998 in Dallas, TX, and take advantage of this opportunity to expand your management skills in a multidisciplinary environment.

The program begins with the keynote address, "Thriving on Change." Multiple concurrent sessions, as well as the general sessions include: "Exploring Discipline Issues," "Building Effective Relationships," "Achieving Clinical Integration," and "Achieving Balance in Life." The Congress provides multiple opportunities for networking in a retreat atmosphere at the Dallas Lakes Hilton. More information on the Congress program may be obtained by calling CLMA at (610) 995-9580 or (202) 543-7971.

## CALL FOR CONTRIBUTORS

The Management Section is looking for people to share their experiences in several areas. We would like to publish your feedback in future issues of the *Bulletin*. You don't have to submit a formal manuscript to participate—we will accept responses by e-mail or will respond to telephone interviews. You give us the ideas and information and we will do all the work. Call, write, fax, or e-mail Karen Stewart with your contributions at the addresses/numbers listed on the back page of this and every issue.

We are looking for information on the following topics—

- **Integrated Delivery Systems:** Has your hospital become part of an integrated delivery system? If so has there been any increase in the array of services your respiratory care department offers? Have you contracted services to an HMO?

- **Documentation:** Are you doing patient charting by exception? How did you go about the implementation process and what hurdles did you overcome?

- **Age Specific Education Material:** Has anyone at your facility developed age specific education material? What material would you find helpful in developing age specific education material? Would you be willing to share how the development was done?

- **Cooperative Agreements:** Are you in the process, or have you completed a cooperative purchasing agreement for capital purchases or disposable products where both the hospital and the vendor share risk?

**Visit AARC on the Internet —**
**`http://www.aarc.org`**

## MANAGEMENT SECTION RESOURCE DIRECTORY: SIGN UP TODAY!

*We are all of us richer than we think we are.*
*—Montaigne*

The Management Section *Resource Directory*, a new tool designed to help members get in touch with each other to receive advice or share information on topics of concern, is being updated in this issue. However, we are still looking for names to add to the list. If you would be willing to serve as a resource for your colleagues around the country, please take a few minutes to fill out the following form. Your name and area of expertise will be included in an updated version of the *Resource Directory* and used to provide information to members seeking help in your area(s) of expertise.

### RESOURCE DIRECTORY SIGN-UP FORM

Name _____

Title _____

Organization _____

Address _____

City, State, Zip _____

Phone_____Fax_____

e-mail _____

The following are topics frequently requested by those who call the Executive Office. (Please check all that apply.)—

____Competency Documentation
____Performance Appraisals
____Respiratory Care Information Systems
____Benchmarking
____Case Management
____Other _____

_____

_____

_____

_____

Please list any materials (samples of contracts, business plans, etc.) you would be willing to share with others:

_____

_____

_____

_____

_____

Return to this form to:

William H. Dubbs, MHA, RRT
AARC Director of Management Services
11030 Ables Lane
Dallas, TX 75229
Fax (214)484-2720

## AARC DEVELOPS RESOURCE DIRECTORY FOR POST-ACUTE CARE CONTRACTING

*by William H. Dubbs, MHA, RRT*

To facilitate communication about post-acute contracting within the profession, the AARC has established a *Resource Directory for Post-Acute Care Contracting*. The directory contains a list of individuals who have set up contracts with, and/or are responsible for, managing services to SNFs, subacute, or rehabilitation facilities, and are willing to act as a resource for others seeking to do the same.

We would like to add to our list of names in the coming year and are soliciting your help. Please assist us in identifying individuals with substantial experience in this area. If you will provide me with a name and address, I will forward information about this new *Resource Directory* on to your nominees and encourage them to participate. If you are personally interested in serving, please don't hesitate to nominate yourself!

The current directory is available in the AARC's SNF packet and on our Website in the member's resource section.

### RESOURCE DIRECTORY FOR POST-ACUTE CARE CONTRACTING FORM

Name _____

Hospital _____

Address _____

City _____

State_____ Zip _____

Phone_____Fax_____

e-mail _____

Please check the appropriate blank:
I am nominating: ___myself ___a colleague

Please mail or fax to:
William H. Dubbs, MHA, RRT
Director of Management Services
AARC Executive Office
11030 Ables Lane
Dallas, TX 75229-4593
(214) 243-2272
FAX: (972) 484-2720
**Attention: Sheri Lynn Phillips**

*Thank you for your assistance!*

**Visit AARC on the Internet—**
**`http://www.aarc.org`**

# JCAHO Accreditation Visit Report Form

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: _____

Name: _____

Facility: _____

Address: _____

_____

_____

Phone: _____

**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.**

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)

_____

_____

_____

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