



Management

July / August 2002

Bulletin

Word on the Web

This issue, we feature sound bites from a recent discussion on the Management Section listserve regarding sign-on bonuses. Postings have been edited for space and style considerations.

Manager #1: As we prepare to revisit our recruitment and retention tactics, we are curious: (1) Do you offer sign-on bonuses? (2) If so, do they apply to all shifts and positions or just the typically hard-to-fill ones? (3) What amount of sign-on bonus do you offer and what time commitment is required to receive it? (4) What percentage of new hires do NOT fulfill the time requirements to receive the full bonus?

Manager #2: We offer sign-on bonuses for full time employees only. It does apply to all shifts (\$2,000-\$2,500 upon hire, \$1,000 after 90 days, \$1,000 per year for a three year commitment).

Manager #3: We have a sign-on bonus for all currently open positions (\$1500, two years). However, we have yet to hire anyone under this program.

Manager #4: We have not offered a sign-on bonus; however, we have offered a recruitment bonus of \$3000 to any employee who successfully recruits a new RT!

Manager #5: We offer \$2,000-\$3,000, depending on how desperate we are. Commitment is for one year. No one in the bonus program has ever left before the year was up.

Manager #6: Our R&R strategies do not include sign-on bonuses. We have: (1) Offered per diem to anyone who has left in good standing, helping with travel and lodging (our own contract service). (2) Offered Cobra assistance until they are established with our insurance.

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Section Connection

GET IT ON THE WEB:

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JCAHO ACCREDITATION REPORT:

Please consider sharing information about your most recent site visit by filling out the form on the AARC web site found at the following link: www.aarc.org/members_area/resources/jcaho.asp.

SECTION LISTSERVE:

Start networking with your colleagues via the section listserve. Go to the section homepage on www.aarc.org and follow the directions to sign up.

AARC Releases New Pulmonary Rehabilitation Clinical Practice Guideline

Respiratory care departments with pulmonary rehabilitation programs now have a new clinical practice guidelines they can use to ensure quality care for patients receiving these services. In keeping with its longstanding reputation for providing state-of-the-art, leading-edge guidelines, the AARC published its first Pulmonary Rehabilitation Clinical Practice Guideline (CPG) in the May issue of *RESPIRATORY CARE*. The guideline was developed by an eminent team of professionals, including co-chairs John E. Hodgkin, MD, FAARC, and Lana Hilling, CRT.

"The AARC understood that those who were practicing pulmonary rehabilitation did not have a guideline that was developed from their perspective - that of the respiratory therapist," says Carl Mottram, RRT, RPFT, FAARC, chair of the AARC's CPG committee. "Now, these key providers have influence from their profession related to this important therapeutic endeavor."

Mottram believes the two co-chairs add integrity to the guideline. "We were fortunate to have a leading physician co-chair this important project. Dr. Hodgkin took on the guideline because he, too, recognized the importance of the respiratory therapist in the provision of pulmonary rehabilitation. He effectively brought his extensive expertise to the table."

Dr. Hodgkin is medical director of the respiratory care department and the pulmonary rehabilitation program at St. Helena Hospital and Health Center in Deer Park, CA. He is the author of several textbooks and peer-reviewed articles about pulmonary rehabilitation, and has served the AARC in various volunteer positions, including as a member of the Board of Medical Advisors.

"Lana [Hilling], who co-chaired the committee, also brought a good deal of expertise and experience to the committee," says Mottram. "She has been a long-term member of the Association and provider of rehabilitation services in her position in the pulmonary rehabilitation department at Mt. Diablo Medical Center, Concord, CA."

The rest of the leading CPG committee included:

- Phillip D. Hoberty, EdD, RRT, assistant professor, respiratory therapy division, school of allied medical professions, Ohio State University, Columbus, OH
- Rebecca Hoberty, BS, RRT, Ohio State University Center for Wellness and Prevention, Columbus, OH
- Christine Kelly, MPA, RRT, University of California at San Francisco, Oakland, CA
- Trina M. Limberg, RRT, FAARC, University of California at San Diego, San Diego, CA
- Kevin Ryan, RRT, Deer Park, CA
- Paul A. Selecky, MD, FAARC, Hoag Memorial Hospital - Presbyterian, Newport Beach, CA
- Dennis C. Sobush, MA PT, associate professor, program in physical therapy, Walter Schroeder Health Services and Education, Marquette University, Milwaukee, WI
- Peter Southorn, MD, department of anesthesiology, Mayo Clinic, Rochester, MN

The AARC published its first CPGs in *RESPIRATORY CARE* in 1991. The addition of the Pulmonary Rehabilitation CPG brings the total number of guidelines to 52. ♦

Healthy Lifestyles Benefit the Very Old

Elderly people who exercise more and smoke less are more likely to remain healthy into very old age, new research reveals. The study, published in the May/June issue of *Psychosomatic Medicine*, provides evidence that engaging in "proactive health-promoting efforts," even late in life, has important long-range benefits.

The investigators, from Case Western Reserve University, followed 1000 people age 72 and older for nine years. All lived independently in retirement communities in Clearwater, FL, and were free of major mental or physical illness at the beginning of the study. Participants were interviewed annually about their health status and behaviors.

By the end of the study, 374 subjects had died and another 78 were too ill to continue. Researchers then compared this group to those still taking part in the study. Results showed participants who had smoked were less likely to survive than those who had never smoked, with the risk of dying more than twice as high among those who were smokers at the beginning of the study compared to those who had never smoked. Those who exercised the most at the start of the study generally reported fewer physical limitations, more frequent positive emotions, and a greater sense of meaning in life at the final interview, even when their health problems were taken into account. ♦

Want to receive this newsletter electronically?
e-mail: mendoza@aarc.org for more information.

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Alarm Systems Make JCAHO List

Respiratory care departments will be facing additional scrutiny regarding their alarm systems next year. Based on recommendations from the Joint Commission on Accreditation of Healthcare Organization's Sentinel Event Alert Advisory Group, JCAHO has included the following patient safety goal on its initial list of six goals for 2003:

Improve the effectiveness of clinical alarm systems.

- Implement regular preventive maintenance and testing of alarm systems.
- Assure that alarms are activated with appropriate settings and are sufficiently audible with respect to distances and competing noise within the unit.

Health care organizations will be surveyed for compliance with the new goal beginning in January.

The Advisory Group was set up earlier this year to conduct a thorough review of all existing Alert recommendations and identify candidates for inclusion in the final list of goals approved by the Joint Commission Board. We'll highlight the other five goals in the next issue of the Bulletin. ♦

Updated Asthma Guidelines Highlighted in AARC Times

Check out your August issue of *AARC Times* for an analysis of the updated Guidelines on the Diagnosis and Management of Asthma issued earlier this summer by the National Asthma Education and Prevention Program (NAEPP).

Tom Kallstrom, RRT, the AARC's representative to the NAEPP and director of respiratory care services, cardiac rehab, and biometrics at Fairview Hospital in Cleveland, OH, provides an overview of the changes and what they mean to RTs and their patients. Specifically, he explains the rationale behind the major change in the updated version: a recommendation stating that inhaled corticosteroids are safe, effective, and the preferred first-line therapy for children and adults with persistent asthma.

The NAEPP Guidelines were first released in 1991 and updated in 1997. The current update is the first in a series of periodic revisions on selected topics aimed at ensuring the guidelines reflect the latest scientific advances in asthma care. ♦

Texas SNFs Say No to Vent Patients

Nursing homes in Texas are becoming increasingly hesitant to accept patients requiring ventilator care, says a new report in the *Houston Chronicle*. The article, which appeared earlier this summer, noted that out of 1,200 skilled nursing facilities in the state, just eight accept ventilator patients.

Nursing home executives pointed squarely to insufficient reimbursement as the reason why they are refusing to admit vent patients, noting that even though Medicaid pays more for vent patients - three times as much as for low-maintenance residents - the added expense in labor and supplies involved in caring for a vent patient outweighs the additional reimbursement.

Consumer advocates interviewed for the article were quick to deny these claims, however. They say the reimbursement is adequate, and what's more, nursing homes licensed by the state have an obligation to take care of a wide variety of people, regardless of their health needs. ♦

Pulmonary Doc Appointed to MedPAC

The U.S. Comptroller General has appointed a pulmonary physician to serve on MedPAC, the independent federal body responsible for advising Congress on Medicare revisions and rates. Dr. Nicholas Wolter, pulmonary and critical care physician and chief executive officer of Deaconess Billings Clinic in Billings, MT, will join three other new appointees on the 17-member commission. ♦

New Codes On the Way

A Health and Human Services Department subcommittee is recommending that the government begin using a new set of more accurate clinical codes. The International Classification of Diseases, 10th Revision, should replace the current International Classification of Diseases, 9th Revision, says the National Committee on Vital Health Statistics' subcommittee on standards and security.

Health care leaders believe updating the codes is important because they play such a large role in benchmarking, quality assessment, research, public health reporting, and strategic planning - not to mention accurate reimbursement for the nation's health care providers. The ICD-9 codes are rapidly becoming outdated and will be phased out. The new ICD-10 codes are expected to bring significant improvements to the system, although health officials admit they will present challenges to hospitals in terms of training of personnel and computer upgrades.

The final implementation date for the new codes is expected to be October 2005. ♦

New Resource on Allied Health Professionals

Joint Commission Resources (JCR), a subsidiary of the Joint Commission on Accreditation of Healthcare Organizations, has published a new guide aimed at helping hospitals ensure the quality of care delivered by allied health professionals.

The Joint Commission Guide to Allied Health Professionals looks at administrative issues pertaining to these professionals from both a human resources and medical staff perspective, including:

- Credentialing
- Privileging
- Assessing competence
- Ongoing education

Example forms, tools, checklists, and tables are included. The publication is available from JCAHO's Customer Service Center at (630) 792-5800 for \$55 (use order code AHC-100). Or visit Infomart on the JCR web site at www.jcrinc.com. ♦

HMO Patients Receive More Services

People enrolled in health maintenance organizations (HMOs) are more likely to receive health counseling and other services, say researchers publishing in a recent issue of the *American Journal of Managed Care*. The Wake Forest University investigators found that even though HMO enrollees spent about two minutes less with their doctors during the average visit than those in other types of health plans, they were 17% more likely to get important information about health choices and to receive preventative screening tests such as blood pressure and cholesterol checks, mammograms, PAP smears, and PSA tests.

The study compared patients enrolled in capitated HMO plans with those in health plans where doctors were not paid a set fee for each patient. Data were taken from the National Ambulatory Medical Care Survey for 1997 and 1998. ♦

We're Going Electronic!

The Management Bulletin is getting ready to fully enter the electronic age. Beginning in 2003, our newsletter will be published exclusively via an e-mail newsletter format. The change, approved by the Board of Directors this summer, will be more cost effective for the AARC, thus freeing up funds for other efforts important to managers, and will also result in more timely delivery of news to section members.

So, if you have yet to supply the AARC with your e-mail address please do so ASAP. Send your address to: mendoza@aarc.org. ♦

New Rules Apply to Wireless Monitors

The Federal Communications Commission (FCC) has voted to adopt new rules aimed at protecting patients who use wireless medical telemetry devices such as heart, blood, and respiratory monitors from radio signal interference. The rules will effectively establish eligibility for the use of bands adjacent to the radio spectrum allocated for wireless medical telemetry devices to protect them from interference. They will also apply to the 1.4 GHz band in which many new wireless medical telemetry service licensees will operate.

The proposed technical rules were developed by FCC staff in conjunction with the American Hospital Association and industry groups representing wireless medical telemetry manufacturers. ♦

Viasys Sponsors Professor's Rounds Program

Viasys Healthcare sponsored the third program in this year's series of Professor's Rounds videoconferences offered by the AARC. The session "Neonatal and Pediatric Ventilators: What's the Difference?" featured Mark Heulitt, MD, FAAP, FCCP, who provided participants with an excellent overview of the issues and concerns regarding these ventilators. Moderating the program was Richard Branson, BA, FAARC.

A video of the session is available at the AARC store at store.yahoo.com/aarc.

By the time you read this notice, there will be only three live teleconferences left this year:

- Pressure Versus Volume Ventilation: Does It Matter?: September 10
- Inpatient Management of COPD: October 22
- High-Frequency Oscillatory Ventilation: November 19

Sign up for any or all of these informative programs at www.aarc.org. ♦

CRNA Salaries Top Some Physicians'

A new survey from Allied Consulting in Dallas, TX, has found some certified registered nurse anesthetists (CRNAs) are making more money than many physicians. According to the poll, taken earlier this year, CRNA salaries are reaching as high as \$180,000 a year - about \$40,000 more than what the average family physician or pediatrician earns. The main reason for the high salaries, says the survey, lies in the current shortage of anesthesiologists, although the firm also says the pay scale represents a growing appreciation of allied professionals and their services. ♦

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WORD ON THE WEB

(3) Offered a modest moving allowance. (4) Raised our wage scale \$2/hour and added better shift differential and never-before weekend differential.

Manager #7: We do not have a sign-on bonus. We feel it is a take-away from the staff who have been here through the tough times. Our hospital has worked on programs that reward everyone for picking up extra shifts.

Manager #8: A sign-on bonus is available, but is negotiated with each hire. We currently offer a bonus for both RT and sleep tech positions. Sleep techs in my state need an RT license, and RTs are in demand here right now. We usually offer a bonus of \$2,500 per year. But we haven't been doing it long enough to know whether people stay the year or not!

Manager #9: Yes, we do offer a bonus, if it is asked for. The amount varies: \$1,500 is the average. We haven't had anyone leave before the time requirement was up. ♦

AARC 2002 48th International Respiratory Congress
Tampa, Florida, October 5-8, 2002
Register online at www.aarc.org

Payment Errors Add Up, says Government

The Office of Management and Budget (OMB) estimates payment errors cost the Medicare system more than \$12 billion in 2001, or about 6.3% of its total expenditures. That represents nearly half of the \$20 billion in total payment errors made by all federal agencies last year. The \$20 billion figure equals the total budgets of the Departments of State and Labor combined. The OMB says more needs to be done to reduce payment errors in the Medicare system and other government agencies, and believes an overhaul of the government's financial and asset management programs is in order. ♦

U.S. Comes Out on Bottom

The United States came out on the bottom in a new survey comparing health care access in five developed nations.

According to the Commonwealth Fund study, one in five Americans had problems getting the care they needed in the past year, mainly due to the costs of the services involved. Results showed 21% of Americans had trouble paying medical bills, compared to 20% of New Zealanders, 17% of Australians, 9% of Canadians, and 4% of people in the United Kingdom. Among those who didn't fill prescriptions because of the costs, 39% were in the U.S., 22% in Canada, 21% in Australia, 20% in New Zealand, and 7% in the U.K.

The study was conducted in conjunction with researchers from Harvard and published in a recent issue of *Health Affairs*. ♦