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American Association
for Respiratory Care

Notes from the Chair

by John Kimble, RRT, RCP

As I write this column in early June, the Summer Forum is just around the corner. Since we just have completed the budget process for FY 2000 at our hospital, I am really looking forward to the trip to Phoenix. Ray Masferrer, Mari Jones, and the Program Committee have prepared an excellent program for us. I hope to see many of you there, and look forward to networking with managers from around the country.

Continuing with our new "guest editor" format, this issue of the *Bulletin* is brought to you by George Gaebler and the respiratory care managers from the great state of New York. One of the advantages of being section chair is getting to read the articles

ahead of time. You will enjoy this issue. George, et. al., thanks a million!

I have been quite pleased with the utilization of the Management Section Listserve. Everyone seems so willing to share ideas, procedures, and protocols. This "virtual networking" is almost as good as the face-to-face conversations we have at the AARC Congress and the Summer Forum. If you are already accessing the listserv, please continue to do so. If you have yet to sign up, visit the AARC website (www.aarc.org), click on "Members Only," then on "Management Section" and follow the directions to sign up.

Please stay involved with the AARC and your state societies. And have a great summer! ■

Notes from the Guest Editor

by George Gaebler, MS Ed, RRT, director respiratory care and cardiovascular service line administrator, University Hospital, Syracuse, NY

I would like to thank all those who preceded my short tenure as guest editor for their timely articles, which have always been insightful and germane to the daily menagerie of tasks confronting the respiratory care manager at the end of the millennium. Our current format, which calls for managers from specific states or areas of the country to contribute articles to specific issues of the *Bulletin*, seems especially useful in this day of the hectic manager. Personally, I wish to thank John Kimble, section chair, for providing me with the opportunity to provide a voice for the RT managers from New York.

The articles found herein cover a range of issues confronting new and not-so-new managers alike. The authors, whose names many of you will recognize, represent a cross section of folks from institutions ranging from community hospitals to university health science centers. They also

represent new managers, older managers, and multi-dimensional managers who have moved out of the traditional realm of respiratory care department management. To all of them, I send my most heartfelt thanks for taking time out of their busy routines to share their personal expertise and insight into the realm of everyday management. The concepts they present benefit from years of diverse experience gained in the fishbowl of management and leadership.

I am also sure that anyone seeking more information about any of the topics covered in this issue can feel free to contact these authors. Each of them is the type of person who willingly helps others every day, pursuing increased stature for the profession through demonstrative mentoring and just plain hard work.

One of the articles covers the new

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responsibilities that our section chair will take on when the transition to the new AARC governance structure is complete and specialty sections with 1,000 members or more are given a seat on the Board of Directors. Anyone who has ever thought that there was no

direct voice for the clinician, educator, or manager in our Association can rest assured that this will change greatly in the coming years as section chairs take their place on the Board. A direct voice to the AARC Board of Directors through section representation will provide a perspective that was sometimes lost in the past.

In closing, I hope you find these articles worthy of the quality benchmark set by past guest editors of this publication.

For additional information, George can be reached via e-mail at gaeb-lerg@mailbox.hscsy.edu or phone at (315) 464-4490. ■

Decentralization: Not Dead Yet

by Michael McPeck, MS, RRT, director, respiratory care and biomedical engineering, University Medical Center, State University of New York at Stony Brook

Many respiratory care managers continue to confront the threat of departmental decentralization recommended by consultants hired by their institutions. Under the rubric of “patient-centered” or “patient-focused” care, one of the approaches that consultants routinely recommend for respiratory care departments is decentralization. But isn’t this old news? Didn’t decentralization come and go a few years back?

Unfortunately, the decentralization concept isn’t dead yet. Hospitals move at different speeds and many are still moving through the consultant-inspired methods of cost-cutting and revenue enhancement while simultaneously attempting to improve patient care. Let’s face it — hospitals need help. Health care consultants offer valuable services, but most respiratory care managers who have encountered outside consultants know that they miss the boat when it comes to respiratory care. So what do you need to do when the consultants arrive on your doorstep?

First and foremost, be prepared. Know your department’s operations inside and out, and make sure you have historical statistics to explain your costs, revenue, staffing, and resource utilization. Fight fire with fire. If you know or strongly suspect that the consultants will be proposing departmental decentralization, beat them to the punch. Make a very strong argument, supported by real-life examples from your institution, that the respiratory care department is already quasi-decentralized. This is an important concept that neither the consultants nor the hospital administrators fully appreciate. Many still have the erroneous impression that respiratory therapists sit in a central office waiting for the phone to ring. They wrongly believe that RTs have time on their hands that could be put to use if they were assigned full time to a nursing unit.

Teach your administrators and consultants that the only thing truly centralized about a contemporary respiratory care department is that is where the staff hangs their coats. I would wager that in most modern departments, the staff are deployed to the patient care areas and generally remain

there for the duration of their shift. Further, many departments also deploy equipment and supplies to storage locations and satellite offices near patient care areas so that the staff are not required to leave the patient care area on any regular basis. Many departments also have “dedicated” personnel — coordinators, team leaders, etc. — who consistently work in specialized areas such as the NICU, PICU, emergency services, critical care transport team, or post-op cardiovascular ICU. This is clearly another example of how decentralized most respiratory care departments already are.

The supposed benefits of further decentralization (i.e., staff assigned to a nursing cost center), need to be challenged. The AARC maintains a database of departments that underwent decentralization only to be returned to their normal mode of operations after the decentralized approach fell short of expectations.

Second, consider your relationship with nursing. Be aware that nursing may also be faced with downsizing measures and may act to protect their interests. Colleagues have reported that nursing departments may become quite competitive under these circumstances and try to assume additional duties — respiratory therapy duties — in an attempt to save their positions. One respiratory care department, anticipating such a power play at its hospital, preemptively proposed a major program to expand the roles of the respiratory therapists to help support the nursing department. A document entitled “A Proposal for Expanded Duties of the Respiratory Therapist” was created and introduced at restructuring meetings with the consultants.

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Justification was derived, in part, from information available from the AARC which showed an increase in the number of respiratory care departments that offer non-traditional services. Further justification was proffered by suggesting that:

- If our therapists can do arterial puncture, they should be able to perform phlebotomy.
- If our therapists can do arterial line insertion, they should be able to insert peripheral IVs.
- If our therapists can operate and manage mechanical ventilators, they should be able to operate the intra-aortic balloon pump.
- If our therapists can do suctioning and airway clearance, they should be able to perform naso-gastric tube insertion.

The object of that exercise was to identify nursing tasks that *could be* done by respiratory therapists. However, suggesting that these tasks be done by respiratory care is not without risk. You shouldn't offer to take on additional tasks if you do not really want to or do not have the resources to do so. But under the right circumstances, this approach may catch nursing off guard, place them on the defensive, and put a stop to any predatory activity.

To support this proposal, typical respiratory care program curricula can demonstrate the range of education and training possessed by contemporary respiratory therapists. Hospital administrators and consultants may not be aware of the high level of didactic and technical training that contemporary RTs receive. The point here is that a professional with very in-depth, specific scientific training is not a good candidate for menial jobs such as making beds and handing out food trays in between their respiratory care activi-

ties. This can only lead to dissatisfaction and eventual deterioration of job performance.

The other obvious point is that RTs receive specialty training in a wide range of respiratory care procedures, whereas nurses barely scratch the surface and certainly cannot be held to the same standard. One should also investigate licensure issues (if applicable) and compare and contrast respiratory care and nursing practice acts to see if title protection exists or if there are scope of practice limitations that would preclude others from performing respiratory care procedures. And, last but not least, one should present salary data showing that nurses, on average, command higher salaries than RTs. This should certainly lend credibility to the concept that respiratory therapists are the best-qualified and least expensive practitioners for provision of respiratory services.

Third, create a comprehensive list of your department's cost-savings efforts. Go back as many years as you can and pull out data from normal operations as well as special projects. Argue that decentralization will make it difficult to continue these positive financial impacts in the future. Also, consider demonstrating the specialty nature of respiratory care. Most departments have already moved activities such as routine oxygen therapy and incentive spirometry to nursing. Why? So they can concentrate on providing more sophisticated and challenging procedures such as mechanical ventilation, continuous bronchodilator administration, and non-invasive ventilation-procedures that are rarely, if ever, provided by nursing. Indicate the financial impact of these procedures. Not only do they foster the efficient use of resources to move patients through the health care system faster, they speed up the transition of the patient from the inpatient to the outpa-

tient side of the care continuum.

Lastly, point out that the creation of strictly unit-based decentralized respiratory care staffing units generates its own set of logistical problems (staffing for sick days, vacations, educational days, and the like). The institution must either keep a central core of departmental personnel to cover these problems or create a rotational system of substitutes for coverage of staff absences. Once a hospital moves to this sort of model for patient care unit coverage, the movement and sharing of staff becomes inherently difficult. In fact, it is almost the antithesis of what the hospital was trying to accomplish in the first place. Experience has also shown that this kind of a decentralized respiratory care department does not provide the same level of technical expertise and continuity that it did under a more centralized organization.

As you deal with the possibility of decentralization, try to find out specifically what the hospital hopes to achieve via restructuring activities. Offer realistic alternative proposals that will accomplish the same objectives. Attacking the basic premise for change probably will not do much good. Many have taken this approach and have fared poorly, at best.

Remember, too, that the AARC has a lot of information that may be helpful, as the trend to decentralize is not new. Take heart in the fact that most decentralization models have fared with less than intended success. And if yours is one of those busy departments that is already deployed throughout the organization, take advantage of that fact by demonstrating to your administration the extent to which your department is already quasi-decentralized.

For more information contact Mike via e-mail at michael.mcpeck@umc.sunysb.edu ■

Section Leadership: A Look to the Future

by George Gaebler, MS Ed, RRT, director respiratory care and cardiovascular service line administrator,

University Hospital, Syracuse, NY

As a past member of the AARC Task Force for Organizational Restructuring, past speaker of the AARC House of Delegates (HOD), and current AARC Transition Committee member, I thought I might offer some thought-provoking insights

about the future role of the AARC section chairs with respect to the bylaws changes enacted last fall by the AARC HOD and Board of Directors (BOD).

As most of you are aware, the Transition Committee chaired by past president, Cynthia Molle, is in the

process of preparing the final drafts of the policies and procedures that will govern the sections under the changes. These policies and procedures will be sent to the HOD and BOD for discus-

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sion and consideration at the summer meetings immediately following the AARC Summer Forum. This will put the finishing touches on a nearly four-year process that began in 1995 when the respiratory care leadership felt it was necessary to establish a stronger connection between the Association and its members.

The ratification of these very significant bylaws changes in late 1998 led me to the following thoughts for the future. However, it must be clearly understood before I go any further that any enacted bylaws changes or any policy changes drafted for the summer meetings of the HOD and BOD are living documents, responsive to change by the membership much as any performance improvement system in your hospital is responsive to ongoing input from all concerned.

The bylaws stipulate that the BOD shall now include “a Section Director from each Specialty Section of at least 1000 active members of the Association.” This statement probably evokes a combination of elation and fear in current or prospective section chairs, depending on the moment. I hope I can help to dispel the fears.

The new role of the section chairs places them at the apex of communications, with a defined, direct voice for the specialty practitioners in any section meeting of the 1000 member requirement. Never before have specialty practitioners from the grassroots of respiratory care practice had such a clearly defined voice at the AARC

BOD level. This allows any specialty practitioner a clear path for communication directly at the Board level. Likewise, it provides the Board with a clear link to specialty practice grassroots members, allowing them to hear first hand about the issues confronting these practitioners in their everyday practice. This direct pathway is unencumbered by the affiliate communications pathways of the past, which may have unintentionally filtered the messages of individual practitioners so much that they lost the original perspective of those who issued them in the first place.

The big question, however, is, how are the section chairs going to handle all of their current responsibilities and also do justice to the added responsibility of an AARC BOD seat? Being managers, it is obvious to most of us that something has to change. One may choose to think of the specialty sections as mini-associations, representing specially-focused practitioners across the breadth of the Association. Therefore, it stands to reason that the sections will need more depth across their structure to allow for delegation of section activities, with the intent of keeping responsibility levels at current or maybe even lower levels than in the past. We all experience volunteerism time constraints; therefore we must configure the structure and operation of the sections with the same vision for simplified pathways that we had when we restructured the operation of the Association as a whole. Indeed, this simplified and multi-directional membership pathway to

the Association was a baseline assumption by the Task Force for Organizational Restructuring.

Section 7 of the AARC bylaws defines the purpose of the specialty sections, election of their chair-elects, and role of their section chairs in very general terms. It now becomes the responsibility of the sections to begin the process of policy and procedure development to support the new purpose and role of the section chair. Because the Association will “transition” to the new governance system, we have time to accomplish these tasks. It is my suggestion that the sections employ some focus group planning during upcoming meetings, similar to the approach used by the HOD and BOD in their original deliberations regarding these changes in governance. Whether you ascribe to total quality management or continuous quality improvement doesn’t really matter. We must make use of quality team hats from our sites of practice to create a workable policy and structure that minimizes layers but also creates some limits to the amount and breath of volunteer work expected from a few section leaders.

All of the sections probably include members who were part of the HOD and/or BOD process. I challenge them to step up and lead the transition to this new era of governance. I, for one, will certainly agree to help wherever needed.

For more information contact George via e-mail at gaeblerg@mail-box.hsc.syr.edu or phone at (315) 464-4490. ■

Thoughts of a New Department Manager

by Claire Aloan, MS, RRT, director, pulmonary and sleep services, Samaritan Medical Center, Watertown, NY

About two months ago, I began a new job as manager of pulmonary and sleep services at a medium-sized hospital in a small city in upstate New York. While I have managed respiratory care educational programs and home care companies in the past, this is my first experience as director of a hospital department. When George asked me to write a few words for this *Bulletin* on my thoughts as a new manager, I wasn’t sure that I could come up with anything. That’s because there are so many thoughts going through my head at any given moment that I could-

n’t imagine how to categorize, summarize, or otherwise organize them. Of course, George wasn’t taking no for an answer, so I’ll give it my best shot.

The hospital, or rather the health care system that we’re part of, is in transition, as is the respiratory department. It’s an exciting time to be here, as the system (consisting of two hospitals, a skilled nursing facility, an inpatient rehab unit, multiple clinics, and other things I probably don’t know about yet), moves forward in so many directions. I’m responsible for the respiratory care department, the pul-

monary function lab, and the sleep center, which includes the sleep lab as well as EEG and PH/motility testing. We are also involved with the pulmonary rehab program, which is administered by the cardiac rehab department but is really a joint project.

The other hospital in our system is a small, rural hospital with limited acute care activity. We will have our first “system wide” survey from JCAHO in a few months. I work closely with the director of the department in the

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smaller hospital (she is not only the director, she is one of two therapists who staff the department) to integrate equipment purchases, policies and procedures, and other management tasks. At the same time, I am attempting to learn how my own respiratory care department operates – including the simple things, like where do we keep the supplies, as well as complex things, such as which therapists know what.

During this learning process, I am also coping with a multitude of projects, problems, and challenges: our NICU is expanding, our pulmonary rehab program is growing, the hospital is moving outpatient services down the street, we’re getting a third pulmonologist, everyone wants an asthma program, the bedside spirometer doesn’t work most of the time, my best multi-competent therapist who did all inpatient services as well as PFT lab and

pulmonary rehab left to work for the pulmonologist group, we have three brand new school grads coming on board with no structured orientation program, the body box will arrive any day, and my evening shift supervisor has been commandeered to develop the clinical component of the electronic medical record in our new system-wide management information system.

For additional anxiety, the sleep lab has just started contracting its services to two other sleep labs, one of them three hours away from our own. The EEG tech needs an operation on her feet, my secretary is newer than I am, and we are a union shop. To stay on top of finances, the accounting department wants us to break every billable procedure down into labor and non-labor chargeable supply resources needed to complete each procedure – and they want it yesterday (of course). We need to change the way we distribute medications to comply with the New York

State Pharmacy law, and we don’t have enough flowmeters. Last but not least, our space is inadequate and poorly laid out, and the pasteurizer leaks and eats the croup tent hoses.

You might get the impression that I’m not thrilled about being here, but you’d be dead wrong. Every day is a new challenge. My staff is, for the most part, excited about expanding services and increasing their responsibilities. The administration is supportive and encouraging. Other departments are helpful and cooperative. (Well, most of them are, most of the time.) Most days, I am very glad that I made the decision to apply for this position and that the administration had the confidence in me to let me take on the challenge. I look forward to growing as both a manager and leader in this new place in my life.

For more information, Claire can be reached via e-mail at caloan@shsny.com ■

Department Management vs. Organization Leadership

by George Gaebler, MS Ed, RRT, director of respiratory care and cardiovascular service line administrator, University Hospital, Syracuse, NY

Over many years I have pondered the success of certain managers and the failures of others, including myself at times. While there are circumstances beyond even the best manager’s control, based on my many years of observation, most have a large degree of control over their destiny. There is one common denominator that seems to find its way into every really successful respiratory care manager I have met over the years. Whether they identify the trait themselves really doesn’t matter. Others do, and their areas of control flourish because of their leadership and foresight. The trait manifests itself through their behaviors and actions not as department managers, but instead as organization leaders. While this may seem over-simplified, I would argue that nothing could be further from the truth. Grouping these individuals into generalizations such as workaholics or driven individuals really does not define them.

They seem to possess the following outward behaviors:

- They are always the folks who, while already very busy, take on

more when asked and accomplish the activity in a thorough way.

- They look at the world from the “glass is half full” point of view.
- They, and their areas of control, are involved in many different aspects of their organization.
- Watching them for any length of time causes dizziness on the part of many around them.
- One would probably define “professional” by using them as an example, regardless of the person or background of the person doing the describing.
- When a project needs leadership, they usually are volunteered or steered by others to that role because all present know and have confidence in the outcome likely to emerge through their involvement.
- When they leave an organization, there is an overwhelming sense of loss across many lines in the organization.

By now, many reading this article have probably identified one or more of these individuals in their present organizations. (Hopefully, yourself

among them!) That said, how does one become one of these organization leaders? Are these people just special, born that way, or educated that way? I guess I would argue that all of the above are probably true to some extent. I do think, however, that somewhere along the way someone – a teacher, parent, friend, or boss – has taken some of his precious time to mentor and nurture them. The mentor facilitates the molding of the gifts – inherited, learned, and supported – and turns those gifts, along with the individual, into a future organization leader.

Indeed, the lack of mentoring probably accounts for more good, but not great, leaders than any single thing I can think of. The primary ingredients required for mentoring are time and commitment to those individuals we observe to have the blend of raw energy, common sense, intelligence, and communications ability to have future impact. Whether for others or for those of us who aspire to be more, we need to seek out a mentor and ask for help.

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At present, our profession, while strong, needs continued growth and new organization leaders. These folks are needed in our professional organizations at the national, state, and local levels. These folks are needed for all areas of practice, whether in department leadership positions, respiratory care education, patient care, or any area where our profession impacts health care. Each year we meet new employees, students, and colleagues who we know have the spark to be great and impact the profession of respiratory care. But if we just identify them and watch them grow we have failed as organization leaders.

Our profession is an organization represented nationally by the AARC and regionally and locally by various chartered affiliates and local chapters. Activities in those organizations usually lead to advanced knowledge of new and innovative ways to approach clinical care that enhance one’s position in the area of organization leadership.

I have had many discussions with managers who have lamented the fact that they just don’t have time or management support for “outside activi-

ties” like involvement in professional activities. I would argue vehemently that in order to provide value-added leadership to any organization, we have to make time for these activities. When lack of management support is the issue, maybe the problem is simply that management lacks understanding of what may be brought to the organization via your involvement in outside activities.

We also have to grow, nurture, and mentor our charges into organization leaders. Their patient care-enhancing behavior on quality teams mirrors your own leadership abilities and value-added approach to your organization’s operations. The concepts being promoted here really operationalize the cliché “think outside the box.” We need to seek activities that allow for organization-wide involvement, because failure to facilitate the success of the whole organization means you are simply a department manager – not an organization leader. It has been my experience that very few true organization leaders (or their staffs) have suffered or been impacted to the same extent as others when negative change occurs in their organization.

I would challenge each reader of

this short article to find and nurture a member of our profession – someone they recognize from their departments, schools, or professional activities as an individual with potential to become an organizational leader of the future. The value added to our profession through this process cannot be underestimated. Every person we mentor creates positive outcomes that reflect on the profession as a whole.

How do you spot a organization leader? When I asked Claire Aloa to write an article about her experience as a new manager, I expected to see the sort of organization-wide activity described in her article. But Claire is also the delegate from New York to the AARC House of Delegates, so I think we all could agree that she acts as an example of the sort of manager/leader I am proposing we all must become. Organization leadership as a management style creates huge opportunities for the profession, our staff, and last but not least, ourselves.

For more information contact George via e-mail at gaeblerg@mail-box.hscsyr.edu or phone at (315) 464-4490. ■

FYI . . .

A new look at the impact of shift work

Can shift workers be safely rotated between day and night shifts? They can, say investigators from the University of Florida, if the rotation takes place in a rapid manner.

In their study of 37 air traffic controllers in Jacksonville, 19 controllers worked two or three night shifts, from 4 p.m. to midnight, followed by two or three day shifts, from 8 a.m. to 4 p.m. The other 18 worked a rapid rotation of these two shifts, followed by a third shift from midnight to 8 a.m.

Over seven days of computerized testing, the controllers working the rapidly rotating three-shift schedule demonstrated a quicker reaction time during a series of spatial visualization and tracking tasks on the computer than those who worked the more slowly rotating schedule. They also improved their attention skills when learning a new cognitive task, while

the other group did not.

One possible explanation for the poorer performance of people on the two-shift rotating work schedule, say the investigators, is that they may vary their sleep schedule more erratically or become “evening types,” with a loss of alertness during the day. After working two or three consecutive evening shifts, they may get used to staying up after midnight, continuing to do so even after switching to the day shift. (University of Florida)

OSHA combats needlestick injuries

The Occupational Safety and Health Administration (OSHA) is moving to reduce the number of injuries health care workers get from needles and other sharp medical objects that potentially carry blood-borne illnesses such as AIDS and hepatitis. An estimated 590,000 needlestick injuries occur each year.

The action stems in part from a

report summarizing nearly 400 comments from health care facilities, workers, and others who responded to the agency’s request for information last fall. At that time OSHA asked for ideas and recommendations on ways to better protect workers from contaminated needles or other sharp objects.

OSHA is pursuing a three-pronged approach to help minimize the risk of occupational exposure to bloodborne diseases due to needlestick injuries.

First, the agency has proposed a requirement in the revised Recordkeeping Rule that all injuries resulting from contaminated needles and sharps be recorded on OSHA logs used by employers to report injuries and illnesses. Final action in the rule-making, which will be based on OSHA’s evaluation of the public rule-making record, is scheduled for this fall.

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Second, OSHA will revise the bloodborne pathogens compliance directive to reflect the newer and safer technologies now available. The directive is used by OSHA’s compliance officers to enforce the agency’s bloodborne pathogens standard.

Third, the agency will take steps to amend the bloodborne pathogens standard by placing needlestick and sharps injuries on its regulatory agenda. (OSHA)

PPS means longer hospital stays for some

Elderly patients with complex medical needs who would have been transferred to an appropriate skilled nursing or subacute facility last year are lingering in acute care hospitals

this year because payments under the government’s new prospective payment system (PPS) are too low to cover their care in a post-acute setting. In a recent article in the *Wall Street Journal*, the following accounts illustrated the problem:

- A patient in Seattle who had had a below the knee amputation was sent to a skilled nursing facility for six days. The facility had to cover the cost of his prosthetic device — \$3,750. Total reimbursement for the stay (including coverage for the device) under PPS amounted to \$1,830.
- A Wisconsin nursing home closed its ventilator care unit to new patients after PPS went into effect because daily payment for these patients amounted to just \$170. True costs are two or three times that amount. Local hospitals now

have to transfer their ventilator patients to a facility 100 miles away.

- Two hospitals in the same Delaware system used to have between 25 and 30 Medicare patients awaiting transfer to a skilled nursing facility at any one time, and they usually waited for no more than a day or two before being placed. Since PPS that number has skyrocketed to 80 and the wait for placement can take weeks.
- A Washington state hospital found that the only way it could convince a nursing home to take a patient on an expensive antibiotic was to agree to pay for the antibiotic itself. Reimbursement rates under PPS would not have been sufficient for the nursing home to pay for the drug. (Wall Street Journal) ■

Bulletin Deadlines

Issue	Date I must have copy	Date AARC must have copy
January/February	December 1	December 10
March/April	February 1	February 10
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July/August	June 1	June 10
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