



# Management Bulletin

Mar./Apr. '00

2

**Restructuring's Next  
Wave: Revisiting  
"What We Say Versus  
What We Do"**

**What We Say Versus  
What We Do**

4

FYI

**Bulletin Deadlines**

6

**Specialty Practitioner  
of the Year**

**American Association  
for Respiratory Care**

## Notes from the Chair

by John Kimble, RRT, RCP

It hardly seems possible that Vegas, Christmas, and the dreaded Y2K have all passed since I last wrote this column in late fall! I would like to thank everyone who attended the Management Section business meeting in Las Vegas this past December. We had a great meeting with lively discussion. I would like to offer a heartfelt thanks to Jerry Berthoff for telling us about the changes at his hospital. Jerry's position was eliminated, and the department now reports to nursing. On a positive note, I recently received an e-mail from Jerry and am happy to report that he has found another job. He is working for Hastings Home Health Care in Virginia, seeing patients in their homes, and will also begin working at a subacute care facility close to his home. He reports, "less pay but also less stress." If you would like to drop Jerry an e-mail, his address is jberthoff@hotmail.com. If you would like to see the PowerPoint presentation of the meeting in Vegas, go to the Management Section area on the AARC web site.

Managing a respiratory care department these days is extremely stressful. It truly pays to stay abreast of any and all reimbursement changes made by Medicare, Medicaid, and other payors. Your fiscal services or billing and insurance departments can help. As you receive information regarding reimbursement, send a synopsis of the changes to the section listserv. Include the source, and if available, the web site or contact name and phone number.

The *AARC Times* has been providing volumes of information on the continuing saga of restructuring. In this issue of the *Bulletin*, AARC Associate Executive

Director Bill Dubbs continues that trend with an article titled, "Restructuring's Next Wave: Revisiting 'What We Say Versus What We Do.'" The article introduces an editorial written by AARC Executive Director Sam Giordano in 1996 on a topic that is still as pertinent as ever to our departments today.

Our section has, for the most part, been "self-reliant" in producing copy for the *Bulletin* over the past few issues. We've accomplished this goal by enlisting "guest editors" to collect articles of interest from their peers in their hospitals and communities. These articles benefit all of us because they help us to see how other managers are coping with change in their hospitals and areas of the country. Unfortunately, this issue does not have a "guest editor," because I didn't get any volunteers for the job. If you would like to volunteer to organize an issue, send me an e-mail and I'll help you get started. Remember, we can't continue to provide this kind of information without the willing participation of you, our section members. We all have our "stories to tell." So please consider sharing them with your fellow managers by acting as a "guest editor" for the *Bulletin*.

By now, everyone should be aware of the election process for Management Section chair. We received many excellent nominations before the February 16 deadline and those are now waiting to be reviewed by the Elections Committee. Thanks to everyone who took the time to give their input, and good luck to all the nominees.

Take care everyone. See you in Vail! ■

## Management Specialty Practitioner of the Year: Karen Stewart, MS, RRT

Respiratory care managers have been dealing with hospital restructuring for nearly a decade now, with results ranging from total failure (i.e., the elimination of the respiratory care department) to stunning suc-

cess. Karen Stewart is definitely among the latter group. "A few years ago, Karen's institution underwent a restructuring

"Practitioner" continued on page 2

"Practitioner" continued from page 1

process, and through her efforts, respiratory care came out a winner," says friend and associate Susan Rinaldo-Gallo, RRT, MEd. But that, alone, isn't why she received last year's Specialty Practitioner of the Year award. Her willingness to share her experiences with others made the real difference.

"Karen has taken this experience and, through presentations to various respiratory groups, has enlightened others," says Rinaldo-Gallo. "She promotes some of the latest management strategies in her numerous presentations." By spreading the word about what worked and what didn't during her hospital's restructuring, she is helping

to ensure similar success for other managers facing similar situations.

Says Stewart, "My most significant achievement on the job is having others understand the importance of the respiratory therapist."

Despite being the busy manager of what is now a multi-department service at Charleston Area Medical Center in Charleston, WV, Stewart has found time to serve as chair of the Management Section, and she stays active at both the state and national levels of the AARC as well. She also volunteers her efforts on behalf of the American Lung Association and was the

1999 president of the Clinivision Users Group. On top of it all, she recently went back to school to earn her master's degree.

Membership in the Association and the section, she says, is important because it provides "an opportunity to network with others and to help others when the need is noted." The AARC's ability to represent practitioners in the political arena is another key selling point. "The greatest benefits of belonging to the AARC are the professionalism, networking, and the political action that the AARC represents." ■

## Restructuring's Next Wave: Revisiting "What We Say Versus What We Do"

by William H. Dubbs, MHA, RRT, AARC associate executive director

In this season of political primaries, the candidates are expending considerable energy and resources trying to provide a clear message about the issues important to them. In the 1992 presidential campaign,

Bill Clinton's strategists coined the phrase, "It's the economy, stupid!" to focus everyone's attention on what they believed was important to the voting public. It is equally important for the respiratory care profession to have a clear understanding about the important issues that will shape its survival and prosperity in the future.

I suggest we paraphrase the old Clinton phrase, and declare "It's misallocation, stupid!" This must be our focus. Many of the issues facing our profession today spin off of misallocation — the provision of services that are not indicated. If we could provide only that therapy which matches clinical indications, we could bring down direct costs while reducing the risk of therapy complications for patients. If we could minimize unnecessary therapy, the use of unqualified substitutes for the respiratory therapist wouldn't be the issue it is today, because only respiratory therapists with documented competency have the combination of psychomotor skills and cognitive ability to assess the patient at each encounter and influence appropriate changes in physicians' orders. It is only by using respiratory therapists that misalloca-

tion will be marginalized.

During the height of hospital restructuring in the mid-'90s, AARC Executive Director Sam Giordano, MBA, RRT, wrote an editorial in *Respiratory Care* titled, "What We Say Versus What We Do." In this editorial, Giordano addressed an issue that continues to rear its ugly head today — the simultaneous delivery of therapies to multiple patients in separate rooms. The editorial described a better way to use the unique skills possessed by the therapist to improve both productivity and patient care quality. Because reimbursement to facilities is still diminishing, cost-control pressures continue to demand maximum productivity as a means of achieving or maintaining profitability; hence, the approach described in the editorial continues to make sense today.

In our increasingly cost-conscious environment, the services we provide must add value. The ideas described in the following editorial present a practical solution — one that uses our knowledge and skills as assessors and helps us better apportion our time by spending it with the patients who need our expertise. It is clearly a key strategy in minimizing misallocation. ■

### Management Bulletin

is published by the  
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## What We Say Versus What We Do

by Sam Giordano, MBA, RRT, AARC executive director

*Editor's Note: The following editorial is reprinted from the June 1996 issue of Respiratory Care.*

I'm sure that it's not exactly "hot" news that the health care industry is in a state of incredible change. (1) While we acknowledge countless examples of different approaches to re-engineering, restructuring,

"downsizing," vertical integration, horizontal integration, and on and on and on, we must never forget that the prime catalyst is the need for our health care delivery system to make the transition from a cost-plus or fee-for-service payment system to a capitated or risk-related payment system. If such a

"What We Say" continued on page 3

“What We Say” continued from page 2

transition were not called for as part of an effort to control health care expenditures, then I feel it’s safe to assume that restructuring, re-engineering, and downsizing would be no more popular in the ‘90s than they were in earlier decades.

Many health care providers have witnessed elimination of their jobs. No category of health care worker, from CEO on down (even including chaplains), has failed to experience some degree of job elimination in acute care settings. Certainly, respiratory care practitioners are no exception.

Our profession has resisted efforts to eliminate jobs because we believe that we are best able to render respiratory care procedures. Many of us believe that restructuring and re-engineering are the major culprits driving job elimination, but this simply isn’t true. We often draw the comparison between disease and symptoms, and I think it’s appropriate to recognize the “disease” as an ever-decreasing utilization of services offered by hospitals. The symptoms of the disease are downsizing, restructuring, and re-engineering. Put another way, if hospital utilization continues to decrease, jobs of all types will be eliminated. Even if there were no efforts to restructure and re-engineer, put simply, it’s a matter of supply and demand. As demand for services decreases, if nothing else changes, then it follows that fewer human resources will be needed to meet the reduced demand. (2) This will happen with or without restructuring or re-engineering.

I’m sure that many of you realize the true dynamics of change in health care. But what we seem to be struggling with, in some instances, is a difference between what we say and what we do. I believe that one particular activity needs immediate attention because many of the conceptions regarding respiratory care practitioners and what we do seem to flow from this activity. Let’s call it the treat-and-leave scenario.

Have you ever watched a respiratory care practitioner enter a patient’s room, start the patient on a small-volume nebulizer treatment, and then leave the room, perhaps to start another treatment? Have you ever watched one of your colleagues initiate an aerosol treatment, remain in the room (physically), but seem to notice everything in the room except the patient?

I’m sure this is a rarity throughout the United States. The reason I know it must be flows from the fact that we, as a profession, consistently argue against downsizing. We consistently argue against transferring so-called routine respiratory care treatments to non-respiratory care practitioners, and we support both arguments by saying that we

are the only profession trained and qualified to render respiratory care procedures. We know how to operate the equipment, instruct the patient, coach the patient, and constantly evaluate and assess the patient on behalf of the attending physician.

We then convey our findings to the attending physician through appropriate communication channels. We also aggressively seek order changes when, in our opinion, after performing appropriate assessment, we believe that the current order does not match the patient’s needs. We thereby influence use of services, in addition to rendering the care itself, and we most certainly have strong communication ties with nurses and other members of the multidisciplinary team in order to keep them abreast of the patient’s progress from the perspective of the respiratory care practitioner.

That’s what we like to say (3-5), but every time a respiratory care practitioner starts a treatment and leaves the room, he or she is saying, “You don’t need us to perform this task.” Every time a respiratory care practitioner stands idly by the patient’s bedside without relating to that patient other than to take an occasional pulse and consult the clock, we’re telling all who “buzz” in and out of that room that they don’t need us. Do you ever wonder why some hospital executives and nurses and management consultants believe that respiratory care practitioners are not needed for routine services? It’s because they have observed such behaviors in respiratory care practitioners, and they believe what the behaviors are saying rather than what the respiratory care profession is saying in terms of their being indispensable to successful respiratory care interventions.

A few hospitals have effectively transferred responsibility for routine respiratory care procedures to non-respiratory care practitioners. Those non-respiratory care practitioners include registered nurses, licensed practical nurses, unlicensed assistive personnel, and others. To my knowledge, the training provided to these substitute caregivers is marginal at best. Training seems to encompass the motor skills necessary to render routine treatments and information about operation of the devices. Very little, if any, training addresses the reasons why patients are receiving treatment, appropriate assessment, the role of coaching to optimize therapeutic results, or the ongoing evaluation of the appropriateness of the procedures in light of the patient’s condition. Ultimately, these efforts will fall short of the mark in terms of decreasing costs, if for no other reason than the

absence of adequate utilization control.

Bear in mind that one of the “assumptions of convenience” that is at work in this scenario is that all orders for respiratory care services are appropriate and remain appropriate for the duration of the order. Now, we all know this simply isn’t true. Indeed, in some institutions efforts have been made to measure the percentage of inappropriate orders. (6) Yet, when we start a treatment and leave the room, or when we fail to interact constantly with the patient throughout the therapy, we are saying that meaningful assessment, coaching, and continual evaluation of the appropriateness of the order are not important. We, therefore, make it easy for some “downsizer” to come in, identify routine respiratory services as clinical responsibility that can be shifted inexpensively, and have such a recommendation readily accepted.

Many of our colleagues recognize the need to provide treatments correctly. They want to instruct, they want to coach, they want to assess, they want to evaluate, and they want to make recommendations concerning appropriateness of respiratory care orders related to patient condition, but they are “under the gun.” Many top decision makers in hospitals have conveyed by edict that staffing be fixed at a certain level. In many instances, staffing levels do not permit respiratory care practitioners to render all treatments in the hospital on a one-on-one basis. I have the feeling that this trend is growing, and if it is, perhaps now is a good time for us to move toward creating a system that allows us to “downshift”

certain patients within the hospital. I propose that we develop a system that relegates patients requiring respiratory care treatments to one of two categories — Category A: those who require the services of a respiratory care practitioner; and Category B: those who, after appropriate instruction from a respiratory care practitioner, (4,5,7-9) can self-administer their therapy.

I believe that it’s better that we formally recognize that many patients receiving respiratory care treatments are, in effect, self-administering “by default.” (What would you call it when someone starts a treatment and leaves the room?) Why don’t we recognize this fact? After all, the days of cost-plus reimbursement are ending. Why not redesign our delivery systems to be compatible with the new system?

Here’s how it would work. When patients are initially ordered on respiratory care treatments, a qualified respiratory care practitioner visits the patient and performs an in-depth assessment. This assessment

“What We Say” continued from page 3

not only addresses the more obvious physical and disease-related aspects of the patient’s condition but also seeks out information concerning chronicity and the potential for the patient to require therapy after discharge. Patients who have chronic pulmonary diseases or conditions and who self-administer therapy at home are ideal candidates for such a self-administration program.

Once the care team agrees that a particular patient should and could self-administer treatment, then a program of instruction is undertaken by the respiratory care practitioner. During the instruction, the patient’s ability to self-administer treatment is assessed, with both physical and psychological factors considered. Once the patient

has “graduated” from the instruction phase, then responsibility for physician-ordered compliance is shared by the patient, the nurse, and the respiratory care practitioner assigned to the patient. The patient, of course, must undertake the treatment consistent with physician orders. The nurse (because he or she is the person in contact with the patient for the greatest number of hours) can offer reminders and make the respiratory care practitioner aware of non-compliance with physician orders. The respiratory care practitioner monitors the patient’s self-treatment, offers tips regarding technique, and, of course, performs daily assessments of the patient’s condition and the appropriateness of the respiratory care order. This information, plus whatever suggestions and recommendations may be warranted, is fed back to the ordering physician.

Of course, the patient in Category A will be treated in a more traditional fashion, utilizing the full range of services of respiratory care practitioners who have enough time to instruct the patient concerning the procedure, coach the patient during the procedure, and evaluate the patient’s progress and condition on behalf of the ordering physician. These interventions, coupled with a well-trained respiratory care practitioner who is committed to making a positive difference with each and every patient he or she encounters, will go a long way toward alleviating the disparity between what some members of our profession say and what they do. Such an approach must recognize “up front” and honestly that not all patients under today’s conditions can expect to receive services in some hospitals from respiratory care practitioners. Shuffling tasks to others who are not prepared by education, training, and competency testing is not the answer, and treating and leaving is most certainly not the answer. But by using our knowledge and recognizing that not every patient needs a respiratory care practitioner every time a treatment is needed, we can move forward as part of the change process in health care delivery today, rather than continuing to sometimes send a message that has and can

continue to hurt patients, nurses, physicians, hospital administrators, third-party payers, and respiratory care practitioners.

I believe that we do have an opportunity to make an important difference, without compromising the quality of care. What do you think?

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<b>Bulletin Deadlines</b>	
<b>Issue</b>	<b>January/February</b>
<b>Date editor must have copy</b>	December 1
<b>Date AARC must have copy</b>	December 10
<b>Issue</b>	<b>March/April</b>
<b>Date editor must have copy</b>	February 1
<b>Date AARC must have copy</b>	February 10
<b>Issue</b>	<b>May/June</b>
<b>Date editor must have copy</b>	April 1
<b>Date AARC must have copy</b>	April 10
<b>Issue</b>	<b>July/August</b>
<b>Date editor must have copy</b>	June 1
<b>Date AARC must have copy</b>	June 10
<b>Issue</b>	<b>September/October</b>
<b>Date editor must have copy</b>	August 1
<b>Date AARC must have copy</b>	August 10
<b>Issue</b>	<b>November/December</b>
<b>Date editor must have copy</b>	October 1
<b>Date AARC must have copy</b>	October 10

**FYI . . .**

**New Lewin report figures BBRA into predictions**

Last spring, the Lewin Group prepared a report for the American Hospital Association on the impact that the Balanced Budget Act of 1997 was having on the nation’s hospitals. That report indicated that

BBA payment reductions would reduce total Medicare margins to a negative 3.9% by 2002, assuming that costs grew at the market basket rate minus 1% (about 2% each year). By 2004, these margins were expected to increase to a negative 2.6%. If

“FYI” continued on page 5

“FYI” continued from page 4

costs grew at the market basket rate (about 3% each year), the margins were predicted to fall to a negative 7.3% in 2002 and to a negative 7.7% in 2004.

Of course, since that time, Congress has passed, and President Clinton has signed, the Medicare Balanced Budget Refinement Act of 1999 (BBRA). While the BBA would have reduced total Medicare payments to hospitals by \$76.7 billion from 1998 to 2002, with additional reductions of \$42.2 billion through 2004, for a total reduction of \$118.9 billion over the entire 7-year period, the BBRA is projected to restore approximately \$8.4 billion between FYs 2000 and 2004, representing 8.6% of the \$97.6 billion payment reduction that would have occurred for this period.

This sounds like good news, but Lewin advises caution. Even though the BBRA raises total Medicare margins by approximately 1.5% in 2002 and by about 1% in 2004 under both cost growth assumptions, the report says that margins for outpatient, hospital-based home health, and PPS-exempt services will still be negative. Inpatient margins, while remaining positive, will fall under the BBRA as well, especially if costs increase at the full market basket rate. (American Hospital Association)

### **Survival rate rising for lung cancer patients**

Dutch researchers report a significant 41% five-year overall survival rate among 2,263 patients who had surgery for non-small cell lung cancer (NSCLC). Jules M.M. van den Bosch, MD, PhD, FCCP, and colleagues showed that survival in patients with complete resection was significantly better; five-year survival was 44.3% in patients with complete resection versus 16.2% for incomplete surgery.

“For patients with NSCLC,” says Dr. van den Bosch, “surgery and complete removal of the primary tumor and its involved lymph nodes remains the most effective mode of treatment.” He adds, “Lung cancer staging . . . is an important aid to determine the clinical course of the patient and the success of treatment.” Staging is based on the anatomic extent of the disease as defined by the grade of the primary tumor, any regional lymph node involvement, and whether distant disease is present.

According to the investigators, who used the 1997 staging criteria, there were significant differences in survival between tumor stages 1A (63 five-year survivors) and 1B

(46 five-year survivors); 1IA (52 five-year survivors) and 1IB (33 five-year survivors), and 1IIA (19 five-year survivors).

The researchers note that during the last decade more aggressive surgery has led to more liberal inclusion of patients with advanced disease. They also point out that the number of patients with advanced lung cancer in this study was slightly higher than average.

The investigators considered resection to be complete when the surgeon was certain all known disease had been removed, resection margins from removed tissue were free of disease on pathologic examination, and the highest lymph node was free of disease in a pathologic examination utilizing microscopy.

The researchers focused on patient data from 1970 to 1992, studying 2196 men (93%) and 165 women. Deaths within 30 days of the operation were excluded from the study. Tumors were classified as squamous cell carcinoma in 1607 patients (68.1%), adenocarcinoma in 542 (23%), adenosquamous in 88 (3.7%), and undifferentiated large cell carcinoma in 124 (5.2%).

According to the researchers, survival was significantly better in patients who had squamous cell lung carcinoma compared with patients who had non-squamous cell carcinoma, based on one estimate of disease extent from pathologic examination of resected specimens. They also point out that until four years after surgery, age at operation did not influence survival; however, after five years, patients over age 65 had a significantly lower survival rate.

In this cohort of patients, reanalysis of data showed no relationship between lymph node involvement and histology or tumor size. (Chest, 2/00)

### **Respiratory virus infections lead to hospitalization**

Respiratory virus infections commonly trigger serious acute respiratory conditions that result in hospitalization of patients with chronic underlying conditions, say investigators from Texas.

W. Paul Glezen, MD, from Baylor College of Medicine, Houston, and colleagues conducted a study to determine the frequency of specific virus infections associated with acute respiratory tract conditions that lead to hospitalization of chronically ill patients. According to the authors, while hospitalization rates have declined overall, hospitalizations for acute lower respiratory tract infections have increased steadily since 1980.

The study included 1029 patients from four large clinics and related hospitals serving diverse populations representative of Harris County, TX. The patients were hospitalized for pneumonia, tracheobronchitis, croup, exacerbations of asthma or chronic obstructive pulmonary disease, and congestive heart failure.

The authors found that 93% of patients older than 5 years had a chronic underlying condition; a chronic pulmonary condition was most common. The study also noted that low-income patients with chronic pulmonary disease were hospitalized at a rate of nearly 400 per 10,000, almost 8 times higher than the rate for patients from middle-income groups, which was approximately 52 per 10,000. Of the 403 patients who submitted convalescent serum specimens for antibody testing, respiratory tract virus infections were detected in 181 (44.9%). Influenza, parainfluenza, and respiratory syncytial virus (RSV) infections accounted for 75% of all virus infections.

According to background information cited in the study, the number and rate of hospitalizations for persons with acute lower respiratory tract infections has increased steadily during the last 20 years. Almost 1.5 million persons were hospitalized in 1995, an average increase of more than 28,000 per year since 1980.

The authors state that, “efforts to prevent respiratory virus infections should be focused on prevention of the infections that result in hospitalization in high-risk patients. Our studies suggest that vaccines for RSV and parainfluenza viruses should be added to the currently available vaccine for influenza.” They speculate that such a vaccine “could potentially reduce hospitalizations of high-risk patients by at least 50%,” but emphasize that the development of the vaccine alone won’t be enough to solve the problem. “Developing effective vaccines for these viruses . . . will not be sufficient; improved delivery of vaccines to patients at risk is essential.” (JAMA, 1/26/00)

### **Spontaneous movements common after brain-death**

Argentinean researchers have found that spontaneous movements such as the jerking of fingers or bending of toes, which can be disturbing to family members and health care professionals alike, causing them to question the brain-death diagnosis, occur in 39% of brain-dead patients.

“FYI” continued on page 6

“FYT” continued from page 5

The study examined all patients in a hospital who had a diagnosis of brain death during an 18-month period. Of the 38 patients, 15 exhibited these motor movements. In all cases, the movements were seen in the first 24 hours after the brain-death diagnosis, and no movements were seen after 72 hours. Some of the movements occurred spontaneously, but others were triggered by touch.

Examiners used tests designed to elicit motor movements, such as lifting the arms or legs or touching the palm of the hand. EEG tests did not show any brain activity in any of the patients with movements.

“If the lack of understanding of these movements leads to a delay in the brain-death diagnosis or questions about the diagnosis afterwards, there can be important practical and legal implications, especially

for organ procurement for transplantation,” says study author Jose Bueri, MD. “Family members and others need to understand that these movements originate in the spinal cord, not in the brain, and their presence does not mean that there is brain activity.” (Neurology, 1/11/00)

**Efficiency ideas could pay off**

Medicare is currently offering monetary awards to individuals and others who can supply the Health Care Financing Administration (HCFA) with original suggestions on ways to improve Medicare efficiency. The newly created program is part of a final rule that implements Sec. 203(c) of the Health Insurance Portability and Accountability Act of 1996.

A description of the program, including

information requirements and eligibility criteria, lower and upper limits for payments (\$1,000 to \$25,000), and the process and time limitations HCFA will follow in issuing a reward, is provided in the final rule. The program is open to individuals, groups of individuals, or legal entities, (e.g., corporations, partnerships, or professional associations). Federal employees, contractors, grantees, and their family members are not eligible. To qualify for a reward, the suggestion must be original and result in a net savings of at least \$1000.

The guidelines are listed in the November 26, 1999, Federal Register, Volume 64, No. 227, page 66396. You can also learn more at the following web site: [www.access.gpo.gov](http://www.access.gpo.gov) (type “Medicare Efficiency” in the search space for more details). (HCFA) ■

**Diversity Workshop to Expand Sensitivity, Awareness**

Many of you are probably thinking, “So, what is all this talk about ‘diversity,’ and is it really all that important?” Come find out immediately following Summer Forum: Sunday, June 4, 1 - 4 pm, in Vale, Colorado. Join AARC Cultural Diversity Committee Chair Janyth Bolden and her special guest Joseph Ponds, PhD, for a special workshop on the basics of diversity awareness.

- Recognize your level of sensitivity as well as your prejudices

- Learn how to determine if your patients’s noncompliance is culturally based
- Improve your communication skills with people of other cultures

Do you know which group is likely to be offended by being handed a gift from your left hand?... What about being turned off by seeing the soles of your shoes?... And did you know that an affectionate pat on the head can be quite an insult to people from

some cultures?...

You’ll discover interesting facts like this and much more, so make plans now to attend the AARC’s Diversity Workshop!

Workshop is free of charge. For more information contact Janyth Bolden by phone 530/926-6073 or email [rcp-granny@jps.net](mailto:rcp-granny@jps.net) ■

**Save These Dates!**

**AARC Summer Forum**  
Vail, CO  
June 2-4, 2000

**46th International  
Respiratory Congress**  
Cincinnati, OH  
October 7-10, 2000

**AARC Asthma Disease  
Management Course**  
Vail, CO  
June 4-5, 2000

Atlanta, GA  
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