Notes from the Chair
by John Kimble, RRT, RCP

I’d like to thank Larry Conway, from North Mississippi Medical Center in Tupelo, for serving as guest editor of this issue of the Bulletin. I’m sure you will enjoy Larry’s insight into several of the topics concerning us all in respiratory care management as much as I have.

Sharing information through the Bulletin is one of the primary ways we all have to stay abreast of changes in respiratory care management. Another is participating in our section’s listserve on the AARC web site (www.aarc.org). I have learned a great deal from all the members of the listserve over the past months. You truly represent some of the best and brightest among us, and your ideas for improving clinical care delivery, streamlining operations, and/or reducing costs should be recognized and shared with other members of the section and Association.

To that end, Garry Dukes, Bill Dubbs, and I are asking members to e-mail their improvements to the list (visit the Management Section area of the web site for instructions on signing up for the list) or fax them to Bill Dubbs using the form that appears in this issue. These ideas will then be archived and posted on the Management Section area of the web site. If possible, please include your contact information so that your fellow managers can get in touch with you for additional information when the need arises. The ideas will be rotated so that the site will remain current. I hope you will find this process both helpful and rewarding, and I encourage you to participate.

In the meantime, I look forward to seeing everyone at the Summer Forum in Vail.

I am very happy to be serving as guest editor of this edition of the Management Section Bulletin. More years ago than I care to acknowledge, I was chair of the Adult Acute Care Section and editor of that newsletter. The professionalism and content of the section newsletters have certainly grown since that time.

As an editor, I am supposed to seek others to contribute material, and, of course, to editorialize. Rita Curbow, who manages a home care operation, provided an article focusing on management in that setting. I sought articles from a variety of other sources, as well, but it is budget time in the great southeast, and my other contributors were unable to provide completed articles by the deadline. However, they each provided the kernel of an idea for an article, and I have done my best to prepare brief articles based on the inspiration they provided.

It also struck me that we often think that managers spring, fully trained and prepared, into that role. So, I have included a short piece targeted mainly at newer managers as well.

The risk of writing is that others may think that in doing so you are implying that you know more than they do. I think this is why so many people are reluctant to write articles for these kinds of publications. So, please take my submissions in the spirit in which they are intended: as an effort to share a little of what I have experienced in the hope that it will assist others or foster discussion that will advance our goals.

As of this writing in mid-April, there have been many news reports on the efforts of various nursing organizations to have minimum acceptable nurse-to-patient ratios established by law. Many have hailed this as a major step toward curbing the abuses of the “slash and burn” management techniques that have been practiced to the detriment of patient care. While I applaud the intent of this effort, my concern is that even good initiatives tend, in the end, to produce negative results. Let me explain.

There is only so much money in the health care system. For better or worse, and for reasons I cannot fully accept, the payers are in control. The payers have decided that we can know more than they do. I think this is why so many people are reluctant to write articles for these kinds of publications. So, please take my submissions in the spirit in which they are intended: as an effort to share a little of what I have experienced in the hope that it will assist others or foster discussion that will advance our goals.

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Notes from the Guest Editor
by Larry Conway, RRT, director of respiratory care, neurodiagnostics, and sleep services at North Mississippi Medical Center in Tupelo.

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“Guest Editor” continued from page 1

provide the care they demand for less money. Despite pay raises for health care workers and the cost of new technology, each year they decide that the amount should be lower than the year before. Translation? The pressure on hospitals to reduce costs will not go away; it will only get worse.

So, suppose you are an administrator needing to reduce costs (or increase profits). The legislature has told you that you cannot cut the level of nurses below a specific point. What do you do? You cut personnel from all of the other professions that DON’T have a mandated minimum level. That includes respiratory care. Since respiratory is among the newest and most misunderstood professions, it is a likely hot target.

The concept of minimum staffing levels is not a bad thing. However, unilateral minimum staffing levels are a disaster looking for a place to happen. My fear is that respiratory will bear the unintended negative fallout of this movement. We need to be there WITH nursing, promoting OUR minimum staffing ratios as well, or opposing the concept until it encompasses all critical members of the health care team.

Vital Data
by Larry Conway, RRT

It happens all the time. A hard-working respiratory director gets the call: consultants are on their way and will arrive in one or two weeks. What can the director do to prepare?

I have faced multiple consultant challenges over my 20 years in management and have lost only 1.25 FTEs to their claims. From those experiences, I have derived a number of strategies. They are probably not unique, may not be all-inclusive, and may not be the best, but they have been effective for me. I share them here with you because, with a predicted “second wave” of reductions facing health care, we need all of the ideas we can muster.

The first and most important strategy is to operate each day as if consultants could arrive tomorrow. Always have the data you would need at hand. Establish time standards and benchmarking strategies NOW that administration endorses. It will be too late to do that when the consultants are at the door.

Second, share productivity and time management data with your boss. When the consultants have you in their crosshairs is not the time to try to build credibility with your VP or assistant administrator. Positive data taken out of context could simply look like a predictable reaction to a threat. However, consistent positive data that the VP has been seeing for months or years may cause consultants and administrators alike to pause when pulling the trigger on reductions, allowing you time to formulate a credible response to specific allegations. In my experience, this provided the means to refute and defuse the allegations.

Third, there is some information every department needs to have ready at all times. This includes:

1. Medical staff- and administration-endorsed minimum staff levels, based on the geography and needs of the facility
2. Productivity data — the more precise the better — that compares:
   • weekday to weekend day
   • shift-to-shift
   • days of the week to each other
   • unit-to-unit
   • (you get the idea)
3. Independent time standards upon which the productivity is based
4. Benchmark data (formal data is best, but even informal data may be useful)
5. Cost data
6. Standard of care information (your own, local, regional, national)

Having this information available in the hospital systems is good, but having your own database is best. In the days leading up to the arrival of consultants, or when a hospital is planning for a redesign, many people will be making demands on the hospital systems, and you may not be able to access the data you need. Also, if you have your own database, you can play with the data, finding trends and information that you might never think to ask for in a request to the MIS department.

The fourth strategy is to contact others who have experience with the specific consultants you are expecting. Knowing their biases and strategies will be beneficial in determining where to spend your energies in preparation.

The fifth strategy is to learn the system the consultant uses, if possible. Several years ago, I tried to get a consultant to explain his system to me. He would not. However, his office shared that it was based on the Maryland RVU system. I contacted a friend in Maryland who faxed me the details of that system. Turned out, the consultant was not applying the comparative data correctly. That knowledge saved the department five FTEs.

The sixth strategy is to build your own database to parallel the information the consultants are modeling, if you can determine the model they are using. Surprise is never pleasant, so if you do know what system model they are using, running your own version can be very helpful in seeing trouble coming. In 1987, I was working with consultants and was running my own spreadsheet in parallel with theirs. After each session with them, I updated my model to reflect the changes discussed. This allowed me to see in advance that a modest change they had proposed would have catastrophic results for the department. I was prepared to oppose the change at the next meeting, with facts and projections to support my position. The change was avoided.

The final strategy is to be as nice as you can for as long as you can. In other words, be helpful and cooperative — until it is necessary to be less nice. There will come a time in most of these processes when a major disagreement over approach or data arises. If you have been hostile and confrontational from the very beginning, your opposition to a major issue will be dismissed as “more of the same.” However, if you have been cooperative and agreeable, your opposition is more likely to be taken as credible.

Of all these strategies, I believe the most important are the first two. After all, data drives these processes. The key is ongoing credibility with your administration and having and sharing credible data.
What New Managers Need to Know Most
by Larry Conway, RRT

The world has changed quite dramatically since I first took on the role of manager of a department. At that time, it was common for a therapist to get the nod to be manager simply because he or she had displayed strong capability in the clinical setting. Today, it is more common for the manager position to be given to someone with some management experience or training. But this is not always the case, especially in smaller or out-of-the-way facilities that have difficulty recruiting. It is still fairly common for facilities in this situation to tap a strong clinician to take the reins.

The most important thing for a new manager to know, especially in that situation, is what he or she does not know; in other words, to recognize that only part of what you learned in clinical leadership will transfer to actual department leadership. You cannot rest on your past successes or the skills that got you the opportunity. Management, like medicine, is an art and a science. There are well-documented principles, but their application is rarely precise. As in medicine, in management you are dealing with people. Each is different and may have a different response to a given action.

Further, you are dealing with a whole new realm of obligations, expectations, and pitfalls. For example, employment law is not always based on common sense. It is easy to make a mistake in decision-making, interviewing, or hiring that can place you and your facility at significant risk. Application of the Family Medical Leave Act or the Americans with Disabilities Act is not always easy to understand, but errors in these areas can lead to hefty fines or other actions.

If you are a newly-elevated clinician, be sure to invest in yourself with management training. You must learn those well-documented management principles. These, along with good interpersonal skills and fairness, comprise the bedrock of effective management. If you cannot get to a college or university for formal classes, take advantage of every management training session your facility or state society offers. There are many things yet to learn, even for those of us who have been doing this a few years.

One of the greatest disadvantages a respiratory department can have in this age of renewed redesign efforts, consultant challenges, and expanding opportunities is a manager who is unprepared. As a new manager — indeed, even as an experienced manager — you must take stock of your vision, preparation, and skills inventory. Work on those areas where you are weak. Your department, your facility, and your patients deserve a well-prepared director.

Y2K: Another Way to Spell PI?
by Larry Conway, RRT

So, we survived Y2K with barely a blip. What was the hubbub about? Was all that time and energy and money a total waste? Actually, it was not. Y2K made us think through many of our processes and systems from top to bottom. For many of us, it was the first time we ever had to do that. We had always been able to rely on basic services, like power and water. Various departments tended to look at disaster scenarios from “within their own walls.”

Y2K changed that. We had to look at our services all the way from their most basic supply sources. That raised a number of questions that we never had to address before, including the one discussed here.

Does your facility have independent electrical power backup for ventilators? Not just emergency wall power on a generator, but true, freestanding backup? Has your emergency power ever failed? It did in one of my prior facilities. Time sure drags as you try to make your way through darkened hallways to an intensive care unit that you know has ten ventilators running and only one therapist to try to get to them all.

Y2K got one of the department directors in Mississippi thinking about this scenario. His response was to have a single large Uninterruptable Power Supply (UPS) installed to handle all ventilator power in the intensive care units. Of course, there are a variety of ways to plan for this possibility.

Many modern ventilators come with built-in batteries that will maintain the unit for several minutes. However, many do not, even the more recent units. Do your infant ventilators in your NICU or PICU have this feature?

What about the old units in your fleet? How about that oscillator or jet ventilator? Look at them all. How comfortable would you be with a long-term (more than 5 minutes) loss of power to your ventilators? Perhaps you had already explored this issue prior to Y2K.

Therefore, Y2K could be considered a worldwide effort at performance improvement (PI). After all, the idea behind PI is to examine your systems and processes, detect any problems or opportunities to improve, and carry out that improvement. Maybe we should have Y2K every year. (NOT!) But we do need Y2K-like thinking every year.

DME Managers Face Special Issues
by Rita Curbow, CRT, field manager for North Mississippi, Health Management Services, Tupelo, MI.

Health care management, at all levels and in all settings, shares some of the same characteristics, such as budgets, financials, quality of service, and care and staffing issues. However, in the four and a half years I have spent as field manager for Health Management Systems, a durable medical equipment company specializing in sleep disorders and respiratory services in the home setting, I have learned that home care has its own set of requirements.

Durable medical equipment (DME) is a constantly changing and growing field for respiratory therapists. To be an effective manager of a DME company, one must keep up with the ever-changing Medicare guidelines. In a full line DME company, that means becoming familiar with guidelines outside of the respiratory care area, such as those governing beds, specialty chairs, etc.

DME managers must also be knowledgeable about the Medicare Certificate of Medical Necessity (CMN). This is the form that must be filled out correctly by someone in the physician’s office or by the physician himself, and then signed by the physician. If this form is not filled out properly, or if something is left out, Medicare will reject the CMN and no payment will be rendered. To complicate matters, Medicare frequently changes the format of the CMN, requiring managers to revisit the form on a regular basis to ensure compliance with all the requirements therein.

Private insurance and HMOs are hitting DME companies very hard, and managers are being forced to take a proactive stand to ensure adequate reimbursement for these...
“Special Issues” continued from page 3

patients. For example, a DME company must be in the HMO’s preferred provider organization (PPO) or take a loss when providing services for patients. Some HMOs will only allow certain companies to set up equipment for their patients. It is essential for DME companies to deal effectively with insurance companies, whether through a designated marketing person or manager.

In the world of DME today, respiratory therapists are being stretched very thin and usually not in the area of patient care. While many therapists serve in marketing and/or management capacities at these companies, a lot of companies today are hiring drivers to set up respiratory equipment in the patient’s home, then expecting the therapist to make a phone call to be sure everything is okay. Fortunately for me, Health Management Services does not employ drivers in this capacity. However, I do know managers at other DME companies who face this issue everyday. On paper, it makes sense to pay someone half of what you would pay a therapist to deliver the equipment. In reality, it is not good patient care. Managers should take a stand on this issue and not give in on the driver versus therapist argument.

Marketing and community involvement play a very important role in DME as well. As managers, we are always a marketing tool for our company, no matter where we are or what we are doing. We also have to stay updated on the new equipment available. Technology is always changing; some change is for the good and some is not. Just because a new concentrator or CPAP device has a lot of bells and whistles does not mean it is the best machine available.

Last, but certainly not least, we all must remember that patient care comes first, with no exceptions. Physicians, referral sources, and patients trust us with their care. It is the job of the manager to instill the importance of quality patient care in all employees.

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**Tales from the Front: Protocol Implementation**

**Editor’s Note:** Over the past few months, the AARC has been gathering information on the implementation of protocols in the nation’s hospitals. A recent Quick Poll, for example, found that protocols are a growing phenomena in departments across the country. Eighty-eight of 135 respondents reported having implemented these tools in their departments already, and another 19 were in the process of doing so. For most, overcoming physician resistance was the biggest barrier they faced in the process. Sixty respondents cited physician opposition as a major obstacle they had to overcome. Interestingly, 23 respondents named staff opposition as a major stumbling block, and ten had to overcome opposition from nursing.

To find out more about how these managers are successfully breaking down the barriers to protocol implementation in their departments, the Management Section email list has been soliciting first-person accounts from managers across the country. In this issue, we’d like to share three such “tales from the front” with our readers. If you have a protocol-related story to tell, sign on to the listserve and share it with your colleagues. We’ll be checking the postings periodically and may run selected stories in future issues of the Bulletin. Please note: if we do choose your story for the Bulletin, we’ll contact you to receive your approval first.

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**Persistence, Patience, and Education**

by Leigh Parker, manager, respiratory care, Washoe Medical Center, Reno, NV.

We are a 535-bed teaching facility with nine pulmonologists on staff (all in the same group). We’ve had our “Respiratory Care Protocol” program in place for approximately seven years. I can’t imagine any tougher physicians out there than a couple of ours, and there were times when I thought it was too much of a struggle to get their acceptance. Persistence, patience, and education were our keys to success.

In our program, we use designated assessors (senior RCPs) who take all the new starts/protocols, assess the patients, and implement the care plan. This helped many of the physicians accept the program, because they had already developed a respect for the knowledge and skill levels of these senior RCPs.

Prior to full implementation and approval of our protocol program, we conducted a daily review of all of our patients, compared what the doctor had ordered to what our protocol suggested, and called the physician for changes. After following this procedure for some time, the doctors decided that they didn’t want us to bother them with these minor changes (i.e., from QID to Q4 or vice versa). We explained that if they had their patients on protocols, we could make these changes and wouldn’t have to bother them.

Another selling point for our protocols were our “boundaries” – these are defined circumstances in which the physician must be notified (i.e., patient requiring QT therapy, increased O2 requirements, etc.) These boundaries add comfort and assurance to the medical staff that they are in the loop; we are not taking the control away from them.

We now have less than 2% of our patients on “No Protocol,” and the majority of those are pediatrics (an even bigger challenge). Our pulmonologists and trauma surgeons are giving us more freedom with our ventilator patients as well, and we are in the process of developing weaning protocols with them.

It was a struggle to gain physician acceptance for our “RCP Protocols,” but now they not only accept them, they are trying to get the other facilities in town to implement them as well so they can order them there. It doesn’t happen overnight, and it does take a team of dedicated professionals to make the program a success. Fortunately, we have a program that is very successful in many ways. We have decreased utilization and expenses while maintaining and/or increasing quality of care. Our department is recognized and respected by our medical staff, administrative staff, and other members of the health care team.

Respiratory care protocols are a “win-win” for everyone, and that is the message everyone needs to be giving. It’s about providing “appropriate” care to the patient, not about decreasing care.

Take a look at your protocols and make sure they are designed to provide “appropriate” care, then give that message to your physicians. Passion and believing in what you are doing is essential to your success.

If I can be of any assistance, e-mail me at Leigh_Parker@washoehealth.com, or call me at (775) 982-4460.
Worth the Investment
by Patty Munro, RRT, director, respiratory care services, Arkansas Children’s Hospital, Little Rock, AR

At Arkansas Children’s Hospital, we have had our protocols (respiratory care plans) in place since 1993. Two important factors in our success were: 1) bringing physician representatives from each service to the table during development of the care plans and 2) having a core group of therapists to “drive” the care plans. These “patient care coordinators” are a key to the success of these care plans. They are a respected group of therapists, trained and validated by our pulmonologists in assessment skills and care plan algorithms. They are viewed as an extension of our medical director (also a pulmonologist).

Additionally, our department had the support of the administrative staff during the 1993 development of our care plans. Implementation of protocols to ensure that only “appropriate” therapies would be carried out was an integral part of a departmental plan to decrease expenses (and FTEs). The whole process of development, approval (patient care committee, medical staff executive committee, etc.), and implementation of our care plans took a year of hard work.

Implementing protocols in a pediatric, teaching hospital was an uphill battle, to say the least. But the end result was well worth the time invested. If you’d like more information about our experience, contact me at (501) 320-3530 or pmunro@exchange.ach.uams.edu.

Section Seeks Cost Reduction Ideas

RC managers are no strangers to cost reduction efforts. After all, we’ve been dealing with demands to do more with less for over a decade now. So it stands to reason that in all that time at least some of us have come up with some unique and/or innovative ways to save money in our departments. Now we need to share those ideas with our colleagues. Remember: if we don’t all hang together, we will surely hang separately.

Use the following form to send us the cost reduction strategies that have worked for you, or better yet, simply post your strategies on the Management Section listserv on AARC Online (www.aarc.org). (If you have yet to sign up for the section listserv, go to the section homepage on the web site and follow the directions to sign up.) We’ll organize and archive the material on the web site so that everyone will have “one stop shopping” access to proven methods they can use when they get yet another request to “trim the fat.”

Cost Reduction Strategies

Name_________________________________________
Facility_______________________________________
Address_____________________________________ City___________________State______
Telephone________________________E-mail________________________

In our department, we have cut costs by:
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If necessary, please feel free to attach additional sheets. Please fax to: Bill Dubbs, AARC, (972) 484-2720.
Don’t forget to make your nominations for the 2000 Management Specialty Practitioner of the Year. This honor is given to an outstanding practitioner from this section each year at the AARC’s Annual Convention.

The recipient of this award will be determined by the section chair or a selection committee appointed by the chair. Each nominee must be a member of the AARC and a member of the section.

Use the following form to send in your nominations for this important award:

I would like to nominate ____________________________ for Management Specialty Practitioner of the Year because

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Mail or FAX your nominee to the section chair at the address/number listed on page 2 of this issue.