Management Bulletin
May/June '01

Notes from the Chair

by Karen Stewart, MS, RRT

Well, it has finally happened: the Management Section has officially gained a seat on the Board of Directors. I recently attended the spring meeting, where I got a feel for what the Board is all about.

One of the primary issues and concerns facing the Board today is membership. I know I am "preaching to the choir," but we all need to become more involved in recruiting and maintaining members. Let's face it — membership brings in the funds that allow the AARC to fight for reimbursement in Washington or assist the states in legislative issues. So we need to increase our numbers. In all likelihood, only about 25% of the therapists practicing in the United States today are members of the AARC. Let's get out there and talk to others and encourage them to join.

In addition to recruiting new members for the AARC, we also need to become more involved in recruiting new therapists into the profession. One of the other issues that has become apparent to the Board — and should be apparent to you, as managers, as well — is the decreasing numbers of individuals who are entering RC programs. This is causing colleges and universities to reevaluate the need for such programs. At my facility, we have begun a workforce development program. We will be working with kids as early as middle school to teach them who and what a respiratory therapist is. Our goal is to raise awareness of the profession so that respiratory care becomes one of the careers that is considered by our young people. I am really interested in hearing how other facilities are handling workforce development as well, so if you have things you are doing, by all means, please email me at: Karen.stewart@camcare.com. If you do have a program up and running, you might also consider sharing it with your peers through an article in this *Bulletin*.

Last of all, thanks for the emails you've sent concerning the Swap Shop. By the time this publication is out, we should be up and running. Keep those ideas coming. ■

Notes from the Editor

by John D. Kimble, Jr. , RRT, RCP

As I write this column in early April, spring is here and so is Daylight Savings Time, so we all have more time for non-work activities. But somewhere out there, your fellow directors are concerned about cutting costs, improving efficiency, or deciding what new technology to implement. "What can I do to help them?" you ask. Submit your success stories, equipment reviews, or other news of interest to the *Bulletin*! Copy deadlines for upcoming issues are: June 1, August 1, and October 1. The Management Section needs you! ■

The Cost of Training New Respiratory Therapy Personnel

by James K. Stoller, MD, Lucy Kester, MBA, RRT, FAARC, and Douglas Orens, MBA, RRT, Cleveland Clinic Foundation, Cleveland, OH

Employee turnover is an undesirable phenomenon that has an impact on every employer in terms of costs, disruption of services, and the ability to maintain a cohesive work group. The "cause and effect" of employee turnover has been reported in the business world, but has not been well-studied in the health care environment.

A descriptive study was undertaken to assess the results of employee turnover within the respiratory therapy areas of nine member hospitals of the Cleveland Clinic Health

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System. The member hospitals represent a range from private, community-based institutions, to large tertiary care institutions (Table 1). A survey was conducted both in person and by written questionnaire to assess the annual rates of turnover among respiratory care practitioners.

A specific question was posed asking the representative from each institution: "Over the last three years, what was the annual rate at which respiratory care practitioners left employment at your institution?" The survey was initiated in October of 1999 and finalized by February 2000. To calculate the costs of training (Table 2), we utilized the orientation schedule for a respiratory care practitioner joining the Section of Respiratory Therapy at the Cleveland Clinic Foundation (Figure 1). Direct and indirect costs were calculated during the orientation period. This included costs of training provided by various members of the staff and materials provided for training (e.g., policies, procedures, handbooks, etc).

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Table 1: Respiratory Care Practitioner Turnover Rates Over the Past Three Years in Cleveland Clinic Health System Hospitals

Hospital	Number of Beds	Number of RCP Staff	Ratio of Beds/RCPs	Annual Turnover Rate Averaged Over 3 Years	Average Number of Staff Leaving per Year
Lutheran	204	12	17.3	3%	0.3
Marymount	279	32	8.7	NA	NA
Hillcrest	360	34	10.6	3%	1.3
South Pointe	364	22	16.5	10%	2.3
Euclid	371	20	18.6	15%	3.0
Huron Road	379	13	29.2	18%	2.3
Lakewood	400	23	17.4	9%	2.0
Fairview	478	35	13.7	5%	1.7
Cleveland Clinic	1192	96	12.4	9%	8.2

NA — Not available

Table 2: Cost Per Therapist at the Cleveland Clinic Hospital

Day	Activity	Personnel	Wages ($)
1	General hospital orientation	New orient	$188.48
2	Hospital tour & Section policies	Orient, Supervisor, Education Coordinator	$431.04
3	CliniVision training	Orient & Education Coordinator	$431.04
4-8	Training with an RCP	Orient's wages x 1/3 RCPs wages x 5	$1,523.39
9-11	Orient takes 1/4 workload	3/4 orient's wages x 3	$424.08
12-14	Orient takes 1/2 workload	1/2 orient's wages x 3	$282.72
15-17	Orient takes 3/4 workload	1/4 orient's wages x 3	$141.36
	Written education materials		$25.00
		Total Costs	**$3,447.11**

Figure 1. Schedule and Activities in Training a New Respiratory Care Practitioner at the Cleveland Clinic Hospital

Week one

1st day: Hospital orientation
2nd day: Hospital tour, review of Respiratory Therapy Section policies
3rd day: CliniVision training, review of Respiratory Therapy Consult Service
4th day: Work with Therapist and practice using CliniVision

Week two

Work with a Therapist. Begin entering and uploading patient data. Complete orientation skills check sheet.

Week three

Carry limited work assignment. Spend one week in each of the areas listed below: (Any combination of the floors listed in each area may be assigned according to the number of work units the orient is able to carry.)

Floor	Specialty	Date
H 50, 51, 60, 70	Med/Surg	_____
H 80, 81, &/or G 80, 81	Kaiser, Pulmonary	_____
H 61, M 53	Neuro, Rehab	_____
M 70, 71, & M 50	Palliative Care/Oncology	_____
M 30, 33	Pediatrics	_____
G 110, 111, & G 90, 91	Thoracic/Cardiac	_____

There should always be a preceptor assigned to the orient who will be working in a nearby area to answer questions and help with unfamiliar situations.
A new orient will NOT carry the triple beeper or the E.D. beeper.
A new orient will NOT carry a full workload.
NO exceptions please!

Table 1 presents the rate of RCP turnover from the participating hospitals. Turnover rates had a range of 3% to 18% per year. Five of the eight institutions reported rates of >8% per year. The rate of annual turnover correlated significantly with the ratio of hospital beds to RCPs (Pearson r = 0.784, r2 = 0.61, p=0.02), suggesting that higher workloads may contribute to turnover of RCPs. The moderate but incomplete degree of correlation between the annual turnover rate of RCPs and the ratio of beds to RCPs suggests that the ratio partially explains turnover, but that other factors, (e.g., salary, benefits, proximity of workplace to home) also influence turnover.

Table 2 shows that the cost of training each new RCP at the Cleveland Clinic Foundation

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totaled $3,447.11.

In this study of the nine member hospitals of the Cleveland Clinic Health System representing both community-based and tertiary care academic hospitals, the main findings regarding respiratory therapist turnover are:

1. Annual rates of turnover are high, exceeding 8% per year in five of the eight hospitals from which rates were available.
2. The estimated cost of training a new respiratory therapist is high ($3,447.11 per therapist), suggesting that the aggregate cost of turnover can be significant.
3. The rate of turnover correlated with the ratio of hospital beds to RCPs, suggesting that greater coverage demands (workloads) contribute to turnover.

Our analysis reveals that turnover among respiratory care practitioners poses a significant problem because of its frequency and expense. Our findings recommend efforts to enhance retention of respiratory care practitioners. ■

Cutting Costs: *Memorial Hospital, Chattanooga, TN*

Changes in some clinical procedures and purchasing arrangements have led to reduced costs in the respiratory care department at Memorial Hospital in Chattanooga, TN. According to manager Jim Wells, BS, RRT, the department was able to minimize the cost involved with portable "E" cylinders by purchasing rather than renting all the cylinders used in the hospital. The bottom line also got a boost when the department decided to alter the change out time for inline suction catheters from daily to weekly and as needed, discontinue the use of jet nebulizers and face tents on post extubation CABG patients (patients are now extubated directly to NC, Venti-mask, etc.), and use HMEs almost exclusively for humidification of patients on ventilators (external humidfication is now used only on an as needed basis).

If you have cost cutting ideas you'd like to share with the section, please go to the following link on the AARC web site: http://www.aarc.org/sections/mgmt_section/cost_reduction/. All ideas will be archived there, and some will be featured in future issues of the *Bulletin* as well. ■

Grants Available for Research on Working Conditions and Quality Care

In an attempt to determine how working conditions impact quality of care in our nation's health care facilities, Congress set aside $10 million for initiatives targeting health care workforce and quality improvements in the Agency for Healthcare Research and Quality's (AHRQ) FY2001 budget.

According to the AHRQ, recent efforts to reduce costs and streamline the delivery of care have led to significant changes in the health care workplace that may be affecting health care workers and impacting the quality of care they are able to provide. However, research is needed to understand if those effects on quality actually exist, what they are, and how successful interventions can be encouraged.

To that end, the AHRQ has issued a Request for Applications (RFA) for research grants that will examine the effect of working conditions on health care workers. Specifically, the Agency is seeking applications that will: 1) explore the relationship between working conditions that affect health care workers and the safety and quality of care they provide and 2) test innovative approaches to working conditions that have been effective in improving the quality of a product or service in industries other than health care.

For more information on this and other RFAs available from the AHRQ, go to: http://www.ahrq.gov/fund/funding.htm. ■

How to Securely Terminate Employees

Editor's Note: *The following article is being reprinted with permission from Opus Communications. It originally appeared in the March 12 issue of* Accreditation Connection.

What should be included in termination policies and procedures? When you fire or lay off employees, you need to do more than take their keys and escort them to the door. Having the correct termination policies and procedures in place is key. They help to make the termination process efficient, consistent, and secure.

If that isn't reason enough, termination policies and procedures are required under HIPAA. Your organization must have these administrative guidelines in place, and you must be sure that the policies and procedures are followed.

"These procedures are important to prevent the possibility of unauthorized access to secure data by those who are no longer authorized to access data," the proposed security rule states.

Further, the proposed rule says that termination procedures should include the following mandatory implementation features:

- Changing combination locks
- Removing the employee from access lists
- Deleting the employee's user account(s)
- Turning in keys, tokens, or cards that allow access

A closer look at the benefits

It's hard to say how big the risk is that terminated employees will retaliate by causing harm to their former employer, says John Christiansen, JD, partner at Stoel Rives LLP, in Seattle, WA.

All the same, termination policies and procedures are beneficial because having the process in writing helps organizations apply practices more consistently, he says. And in being consistent, organizations have more power to fight discrimination claims.

Moreover, when organizations don't have termination guidelines in place, they may be more likely to inaccurately track their actions to be sure that they have done everything necessary (i.e., the changing of combination locks, the removal from access lists, etc.), Christiansen says.

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In other words, without having a detailed guide to follow, procedures may not be properly conducted — steps may be skipped and procedures may be completed in the wrong order.

Also, if there's no step-by-step process that clearly indicates what department is responsible for what activities, inadequate communication between human resources and systems administration could cause elimination of the terminated employee's remote access privileges to be incorrectly timed, he says.

Overall, termination policies and procedures are important because they help your organization remain as secure as possible, says Holly Ballam, corporate privacy officer and physician liaison for Beth Israel Deaconess Medical Center in Boston, MA.

The policies and procedures help to guard against a terminated employee's potential to damage or erase data or cause harm to your organization in other ways, she says. For instance, terminated employees have planted logic bombs (malicious codes) which are set to execute when their termination is official, Christiansen says.

In one situation, a terminated employee's access privileges were turned off, but the employee had the time to prepare the logic bomb beforehand. Upon the system's registration of his terminated access privileges, $12 million worth of data was lost, Christiansen says.

Without termination policies and procedures that are strictly followed, you leave yourself vulnerable, Ballam says. Terminated employees, "could walk back into the office two, three years later, and (their) password could still work and they could get information on their neighbor, a relative, anybody."

Keys and combinations

When it comes to dealing with the different requirements of the proposed rule's termination procedures, Christiansen says to approach them all in the same manner: "Don't give people time to plan to cause you problems."

Your organization should do its best to not give an employee any warning that he or she is about to be terminated. This is particularly important for employees in sensitive positions, such as information security officer or system administrator, he says.

In general, to determine the severity of the measures you should take to maintain security when terminating an employee, "you need to scale it to the sensitivity" involved in the employee's position, Christiansen says.

When changing combinations and taking back employees' keys, tokens, or cards, "you need to know what it is they've got," he says.

It's important to track what access tools employees receive so that if you must terminate them, you collect everything they have received.

Assume that your employees have these items on them at work, Christiansen says. You should collect the keys, tokens, or cards upon giving them their notice to be sure that they have no time to make any plans to cause harm with them.

However, if a terminated employee does not have these items on him or her, you should go with the employee to his or her workstation to gather them.

User accounts and access lists

Removing the employee from user accounts and access lists, "is always a hard and sensitive situation," Christiansen says.

You need to make sure that all access privileges on the network are terminated with minimal warning, but "you don't want to suddenly freeze the person out of their workstation without them knowing what's going on," he says.

The preferred way to handle this situation is to call the person in for the exit interview while, at the same time, the system administrator is shutting down the employee's access privileges, Christiansen says.

This includes access to the PC terminal itself, he says. "It's not just the network. You don't know what they might have on the hard drive." You have to "treat the terminal as a part of the network" and not allow the employee back on it.

If the employee has personal data on the PC, you may allow that employee to retrieve this data, but only under supervision, Christiansen says. Of course, the severity of these measures depends on the person's position and the level of sensitivity.

Lastly, another good practice is to develop a checklist as your organization goes through the termination procedures, Ballam says. The checklist will help you to be certain that everything is done before the employee leaves the building.

Who's in charge?

The information security staff should coordinate with human resources to write these policies and procedures, Christiansen says. More interaction between human resources and information security is needed in general for HIPAA-compliance, he adds.

The information security employees should follow through with everything on the technical side, while human resources staff should oversee the process — including the information security aspects — to make sure that the termination procedures are followed as a whole.

Therefore, human resources should have the ultimate responsibility for termination, Christiansen says. ■

Hospitals Call In Turnaround Experts

What's a hospital to do when the doors are on the verge of closing? These days, they're calling in "turnaround experts" — firms such as Cambio Health Solutions, the Hunter Group, and Wellspring that sweep into institutions and take over the reins, often bringing the facility back from the brink of financial disaster. According to an article in the April 9 issue of *Modern Healthcare*, some of these companies have seen their business double in the past year. While the reasons for calling in the troops vary greatly, the article cites the following as prime instigators:

- Mismanagement
- Lack of governance
- Business expansions that go sour and devour cash
- Overstaffing resulting from uncontrolled hiring over a number of years
- Lack of standardization in purchasing
- Over-cautious coding resulting from a fear of fraud crackdowns
- Medical staff members whose patients consistently cost more to treat than similar patients cared for by other staff members.

How do these experts get control of a bad situation? The article says the work typically begins with a top-to-bottom examination of operations, followed by construction of an operational assessment and plan of action. Among the components of the plan: cutting jobs, renegotiating contracts, improving bill collections, changing coding methods, and overhauling purchasing. The typical turnaround takes about eight months to a year and can cost the facility anywhere from $300,000 to $1 million. ■

Benchmarking Leads to Recentralization of Department

Many facilities have found benchmarking to be a useful way to uncover areas ripe for process improvement. That was certainly the case for the respiratory therapy department at McKay-Dee Hospital Center, a 310-bed facility in Ogden, UT, that had decentralized as part of a hospital-wide reorganization. According to a recent article on the Healthcare Management Council web site, a comparison of McKay-Dee and four other hospitals not only found that the RT department had the highest cost per procedure, it also identified the department's current staffing model as the primary driver of the cost variation. Specifically, the study revealed that McKay-Dee had the lowest number of procedures per FTE and the greatest number of worked hours per admission and per patient day of any of the facilities — factors it attributed to a disproportionate amount of non-clinical time spent by therapists and ineffective staffing patterns due to the previous effort at decentralization.

With these statistics in hand, the department director, Dr. Gary Clawson, and his team went to work on a comprehensive plan to reorganize the department. First and foremost, the department was recentralized. The team then created a minimal staffing model utilizing staff scheduling software that could be managed by a single individual. They also eliminated duplication of non-core RT functions and decreased overtime and call backs by cross-training staff for more flexible coverage. In addition, the team:

- Streamlined the supply inventory and tracking process.
- Decreased supply costs by modifying the frequency of vent circuit changes, changing all open-heart circuits from heated wire to HME, and changing in-line suction catheters prn rather than Q3 days.
- Eliminated the practice of having a dedicated bronchoscopy team.
- Reviewed existing protocols for appropriateness; developed new protocols where needed.
- Altered hours of operation, scope of service, and staffing for the pulmonary function lab.
- Explored revenue enhancement opportunities in the PFT lab, sleep lab, and other outpatient areas.

The result of these efforts? McKay-Dee achieved 34% of the savings opportunities identified through the hospital's benchmarking program. ■

Ventilator-Dependent Patients on the Rise

Improvements in ventilator technology have significantly increased the number of ventilator-dependent patients in America over the past couple of decades. According to a report in the *New York Times* last April, the number has risen from about 6000 in the mid-1980s to at least 12,000 — and maybe even as high as 20,000 — today. The number of long-term care centers dedicated to the care of these patients has grown as well. There were about 100 such facilities in 1990, says the newspaper. Today that number stands at 240.

Less clear is what is going to happen to these patients and the facilities that care for them now that the Health Care Financing Administration has decided to switch long-term care hospitals from a cost-based reimbursement system to a diagnosis-based system similar to that which went into effect in acute care hospitals in 1983. The hospital PPS, says the *NY Times*, is largely credited with creating a need for long-term vent units because it did not adequately cover the cost of caring for vent patients much beyond a three week period. ■

Section Membership: *Each Voice is Important*

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 Taskforce for Organizational Restructuring, past-speaker of the AARC House of Delegates, and current AARC Transition Committee member, I thought I might offer some thought-provoking insights about the role of the AARC Specialty Sections with respect to the Bylaws changes enacted by the Board of Directors (BOD). The ratification of these very significant Bylaws changes in late 1998 brings us to a point where membership in the Specialty Sections should be desired by all members of the AARC.

One of our major objectives in restructuring the BOD membership was to streamline the connection of the profession to its members. The Bylaws now stipulate that the BOD shall include "a Section Director from each Specialty Section of at least 1000 active members of the Association." While the Bylaws are a living document, responsive to change by the membership, this new provision indicates a new commitment on the part of Association leaders to include greater diversity of opinion in the decision-making process at the highest level of the organization.

The new role of the section chairs places them at the apex of communications, where they can serve as a defined, direct voice for the specialty practitioners of any section meeting the 1000 member requirement. Never before have specialty practitioners from the grassroots within respiratory care practice had such a clearly defined voice at the AARC Board level. This allows any specialty practitioner a clear path for communications directly to the BOD, unencumbered by the affiliate communications pathways that may unintentionally filter a message so that it loses significance or relevance to the original perspective of the section member. Likewise, it provides the Board with a clear message, direct from specialty practice grassroots members, about issues confronting them in their everyday practice.

I am sure many AARC members and nonmembers alike have asked themselves how their voices can be heard, especially concerning their area of practice. Joining one or more of the AARC Specialty Sections is the solution, thanks to this new allowance in the AARC Bylaws.

The future growth and direction of the profession depends on consistent input and feedback from AARC members. The Specialty Sections provide the best opportunity for that feedback. You could think of the sections as "mini-associations" representing specially focused practitioners across the breadth of the Association. Your membership in the section provides the opportunity to directly impact the activities and direction of the profession in a way never possible before this change occurred. Indeed, a simplified and multi-directional membership voice in the

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Association was a baseline assumption by the Taskforce for Organizational Restructuring.

I invite all of you to seek out section membership in your chosen area of practice, pull others in to augment your collective voice, and help the profession move in the direction needed for the future. The emphasis on clinical activities in the Specialty Sections prompts the BOD to pause and listen to members who live the profession, teach the profession, and care for the profession. After all, our profession belongs to the folks in the trenches, and the future depends on your involvement and insight.

All of the sections probably include members who were part of the HOD and BOD process that brought the Specialty Sections to prominence. I challenge them to step up and lead the transition process. ■

Experience the Best of the Science, Tradition, and Future of Respiratory Care

28th Annual Donald F. Egan Scientific Lecture

COPD — On the Exponential Curve of Progress

John Heffner, MD, of the Medical University of South Carolina will the address COPD and its growing significance for respiratory therapists.

16th Annual Phil Kittredge Memorial Lecture

Mechanical Ventilation: How Did We Get Here and Where Are We Going?

Among therapists, Rich Branson, RRT, FAARC, of the University of Cincinnati Medical Center, is well recognized as an authority and visionary when it comes to mechanical ventilation.

27th Annual OPEN FORUM

Hundreds of original research papers will be showcased over the four days of the Congress, reviewing the latest in pediatric, adult, critical care, home care, and education. (You can still submit your research project — deadline July 31). Learn about cutting edge research in the OPEN FORUM and see the latest technology in the Exhibit Hall.

17th Annual New Horizons Symposium

This year the topic is airway clearance techniques. This featured symposium attracts an audience of hundreds who come to immerse themselves in the most thorough review of a clinical topic.

Secure your early bird low-cost registration fee now! Register online at www.aarc.org. Also, continue checking the AARC website for the latest information on the Congress.

The AARC's International Respiratory Congress is the gold standard of respiratory care meetings. The Congress boasts:

- The lowest cost of continuing education per credit of any show, any where.
- The largest and most impressive exhibit hall with the most vendors, where you can make you best deals on major purchases AT THE SHOW!
- The largest gathering of respiratory care experts and opinion-makers in the world.
- The most diverse and most dynamic series of lectures.
- The most opportunities for YOU to participate in your profession through research and networking. ■

ARCF Receives Endowment from VIASYS Healthcare

The American Respiratory Care Foundation (ARCF) and VIASYS Healthcare* are pleased to announce the VIASYS Healthcare Fellowship for Neonatal & Pediatric Therapists.

This fellowship is designed to recognize outstanding original research in the field of neonatal and pediatric intensive care. Special focus will be on bench studies, clinical research studies, and other qualified studies that involve mechanical ventilation. Recipient will be selected by the ARCF Board of Trustees based on abstract submission (final deadline July 17, 2001).

The recipient of the VIASYS Healthcare Fellowship for Neonatal & Pediatric Therapists will be presented a $1,000 cash award, a plaque, registration and airfare to the American Association for Respiratory Care's (AARC) International Respiratory Congress and one night's lodging in the convention city. They will receive their cash prize and plaque at the 2001 AARC Congress Awards Ceremony, which will be held December 1-4 in San Antonio, Texas.

ARCF Chairman Mike Amato is very pleased with the new addition to the Foundation's line-up of respiratory therapy research awards. "As the respiratory therapy profession continues to grow, many therapists have devoted their careers to working with neonates and pediatric patients," he said. "It's time these therapists were encouraged to further advance their specialty field-this fellowship does exactly that.

Amato said donors establish endowments with the ARCF to recognize achievements made by individuals working in specific areas of research. He said endowments not only encourage furthering education and research in the field of respiratory care but also bring recognition to the named donor supporting the respiratory profession.

"The Foundation, and most importantly the profession, is grateful to VIASYS Healthcare for its continued support of respiratory therapy," Amato continued. "We look forward to a long and mutually beneficial relationship with VIASYS. This corporate group and the Foundation's other industry partners make everything we do possible." he said.

If you would like more information on the ARCF awards program, visit our website at www.aarc.org/arcf/awards.html or call Diane Shearer at 972/243-2272.

The American Respiratory Care Foundation is dedicated to furthering the art, science, quality, and technology of respiratory care. It is a not-for-profit organization involved in supporting research, education, and charitable purposes. The Foundation seeks to ensure a better, healthier future for all by promoting quality treatment and prevention of a variety of respiratory and related diseases.

* Bear Medical Systems, Bird Products Corporation and SensorMedics Critical Care are subsidiaries of VIASYS Healthcare ■

***Bulletin* Deadlines**

Issue	Date editor must have copy
January/February	December 1
March/April	February 1
May/June	April 1
July/August	June 1
September/October	August 1
November/December	October 1

JCAHO Accreditation Report

The AARC is currently seeking information on JCAHO accreditation site visits. Please use the following form to share information from your latest site visit with your colleagues in the Association. The information will be posted immediately on the AARC web site at http://www.aarc.org/members_area/resources/jcaho.html and will also be featured in the *Bulletin*.

Accreditation visit you are reporting (choose one):

❏ Home Care
❏ Hospital
❏ Long Term Care
❏ Pathology & Clinical Laboratory Services

Inspection Date: _____

Facility Name: _____

Contact: _____
(Please provide name and e-mail address.)

1. What was the surveyors' focus during your site visit? _____

2. What areas were cited as being exemplary?

3. What suggestions were made by the surveyors?

4. What changes have you made to improve compliance with the guidelines?

Additional comments:

Mail or fax your form to:
William Dubbs, RRT
AARC Associate Executive Director
11030 Ables Lane
Dallas, TX 75229
FAX (972) 484-2720

Specialty Practitioner of the Year

Don't forget to make your nominations for the 2001 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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Nominee	***Your Name***
Hospital	Hospital
Address	Address
City State, Zip	City State, Zip
Phone	Phone

Mail or FAX your nomination to the section chair at the address/number listed on page 2 of this issue, or submit your nomination online at http://www.aarc.org/sections/mgmt_section/mgmt.html.