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American Association
for Respiratory Care

Notes from the Chair

by John Kimbal, RRT, RCP

Greetings to all members of the Management Section!

This issue of the *Bulletin* features articles from four therapists who are very involved in state and/or national respiratory care activities. They include the past president of the Kansas Society for Respiratory Care, the past chair of the Management Section, the speaker of the House of Delegates, and the president elect of the AARC. Since these people also have REAL JOBS and families, I really appreciate their submissions to the *Bulletin*.

Hopefully, everyone has responded to the AARC's request that we all write letters to Bill Thomas, chair of the House Ways and Means Subcommittee on Health, regarding the role that RTs play in skilled nursing facilities. Chairman Thomas was not

inclined to increase funding to SNFs, partially because he had not heard from health professionals who have been negatively affected by PPS (i.e., respiratory therapists!). If you have yet to send your letter to Chairman Thomas, please do so ASAP. SNF patients deserve the best respiratory care they can receive, and respiratory therapists should deliver that care.

A team is being assembled to plan, design, and manage a Management Section web site. If you have ideas, suggestions, or knowledge and experience in web site development, please e-mail me at jkimble@tucomm.net or post a message to the Management Section listserv.

Until next time, be well, be happy, and be involved in the AARC and your state societies. ■

Book Review

by Garry W. Kauffman, MPA, RRT, 1999 AARC president-elect, director, operations support, York Health System, York, PA

Reengineering the Corporation: A Manifesto for Business Revolution

by Michael Hammer and James Champy

Publisher: HarperCollins division of HarperBusiness

Publish date: 1993 (hardcover), 1994 (softcover)

During a recent conversation with a physician concerning how one might go about reengineering clinical processes (with a decided focus on "rationale reengineering"), I was asked if I had read one of the seminal works on thoughtful reengineering. Given that my schedule, like everyone else's, allows me precious little time to read for pleasure, I indicated that not only had I not read this text, but that I had never heard of it – even though it was published in 1993.

Within a couple of days, a present of this text arrived on my doorstep from the doc. Feeling a new sense of obligation, I set about to read what I figured would be yet another "slash and burn" diatribe focused on reducing FTEs (particularly those so licensed) and replacing them with lower skilled and task oriented folks. Retiring to my reading room (which also serves so admirably as my tool shed, exercise

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room, and ping pong area), I quickly engrossed myself in what I regard as a fresh approach to the subject. Here is my synopsis:

This text is unusual in several ways. It made the *New York Times* bestseller list and stayed there for over six months, which is fairly wild considering it's a book on business as opposed to one of the romance varieties. Secondly, it has since been published in softcover version (i.e., more readily purchasable by RC managers) and in 14 languages, thus allowing it to become a bestseller around the world.

I found this text to be useful, particularly because the authors eschewed the traditional “slash and burn” modus operandi so common to the health care reengineering efforts seen in many places in favor of creating an entirely new approach to the process of reengineering. I won't go into detail, but suffice it to say that their approach is both far more practical and thus more useful

to those of us struggling to stay alive in the new health care world.

One of the most interesting chapters for me was Chapter 4: The New World of Work. I'll give you a morsel to whet your appetite for more. The authors propose that the following issues will be critical to our success in achieving higher quality at manageable costs. (Note: You'll really have to read the full text to appreciate each point. Otherwise, this just sounds like Karnak.)

- Work units change from functional departments to process teams
- Jobs change from simple tasks to multidimensional works
- People's roles change from controlled to empowered
- Job preparation changes from training to education

At this point, I feel compelled to add a couple of sentences of my own: Training increases skills and competence and teaches employees the “how” of a job. Education increases their insight and understanding and teaches the “why.” In this age of attempted/planned replacement of licensed caregivers with others, this hit the mark with me.

- Focus of performance measures and compensation shifts from activity to results
- Advancement criteria change from performance to ability

- Values change from protective to productive
- Managers change from supervisors to coaches
- Organizational structures change from hierarchical to flat
- Executives change from scorekeepers to leaders

In conclusion, I would highly recommend this book for your personal digestion and likewise recommend it as a present from you to your boss. In addition, I had the opportunity to discuss this book with our RC operations manager, who informed me that not only had he already read this book, but he had also read the book by the same authors that followed this one (I really gotta get out more). A quick perusal of this text reaffirmed that I have another text to add to my reading plate.

If anyone would like to discuss this book or the principles contained within, particularly as they relate to our practice, please feel free to contact me via the method of your choice. I've listed my vital statistics below.

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Emergency Preparedness: More Than Just a Drill

by *Debbie Fox, MBA, RRT*

Would your department be prepared if an emergency forced the immediate evacuation of an entire building of your hospital? What if the neonatal intensive care unit was included in the evacuation?

On Friday evening, July 17, 1998, a fire started in a linen cart in the basement of Wesley Medical Center in Wichita, KS. The corridors rapidly filled with smoke. The overhead sprinkler system was activated and the smoke traveled up the elevator shafts to other floors in the building. Within minutes, a decision was made to evacuate all patients on the second, third, and fourth floors of the Women's Hospital building. The NICU is located on the second floor. Thirty-four infants were in the NICU that evening.

Fourteen patients were on ventilators, eight on nasal CPAP, and ten others were receiving oxygen. All patients were safely evacuated within approximately 20 minutes from the time the evacuation order was given. The other areas evacuated included the labor/delivery rooms, a maternity unit, and a women's medical/surgical unit.

Our internal evacuation procedure directs the evacuation of NICU patients horizontally to SICU, PARU, or the delivery rooms. Staff made the decision to move the critical infants to the operating suites and the PARU since most surgeries for the day were completed. Few beds were available in the 16-bed SICU and the delivery

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area was also being evacuated. The first immediate needs were for additional oxygen e-cylinders for transport and for additional personnel. The NICU RTs called the shift supervisor. He immediately called all available therapists to locate e-cylinders and to report to NICU to assist. An overhead page requested other hospital staff to report to assist with patient transport. Despite the initial confusion, the hall was soon filled with a parade of patients, IV pumps, ventilators, and supplies. Remarkably, all 34 critical infants were safely transferred without incident.

We learned several lessons from this experience that we would like to share. On a hospital-wide basis, the need for improved communications between security, the fire department, the hospital administration command post, and the patient units was emphasized. The hospital later purchased additional alpha pagers and a second radio to improve future communications. The OR personnel were not informed prior to the arrival of the evacuees, but were very accommodating. The hospital’s wireless telephone system proved invaluable. Luckily, the incident occurred at shift change time when additional personnel were available. Some difficulty was experienced adapting to the OR/PARU monitoring system. The hospital plan was revised

to keep family members with patients. Some staff expressed concern for the potential of an infant abduction during this type of situation.

From the respiratory care perspective, we valued a previous decision to maintain consistent medical gas outlets throughout all areas of the hospital and connected clinics. All the OR suites and the PARU have compressed air available, but only one outlet per bed. Some of the NICU ventilators required two air outlets to operate. A shortage of air “wye” connectors was experienced as well. As a result, some babies remained on 100% oxygen as long as 30 minutes. Following a previous disaster (tornado), our department established an emergency supply of e-oxygen regulators, which are maintained in a separate storage area in the department to ensure availability. However, these regulators were not used because the relief supervisor in charge that evening was unaware of the location.

Not all respiratory care staff are cross-trained to the NICU, so some were not familiar with the neonatal ventilators. Although manual resuscitation bags are available in the area, flow-inflating bags were used to manually ventilate the babies during transport. We also found that ventilators/CPAPs and other equipment need to be marked with patient’s names. After confirming that all the infants had been transferred, the respiratory care staff closed the oxygen

zone valves.

Obviously, this real-life experience provided valuable insights that are difficult to mimic during required quarterly disaster drills and safety insertives. The need for thorough orientation and annual review for all employees is essential for the timely and safe evacuation of critical patients. Supervisors must be able to respond immediately and take charge of the situation. The location of oxygen zone valves, oxygen e-cylinders, air compressors, and back-up equipment must be readily accessible. Written plans for evacuating an ICU must include steps to provide care to patients with IV/arterial lines, chest tubes, dialysis, tube feedings, NG drainage, cardiac monitors, and other supportive equipment. For an expeditious evacuation, the plan needs to identify what equipment and supplies are considered essential and what can be obtained later. Equipment compatibility between units is advantageous.

Approximately two hours after the fire, the “all clear” was called. The transfer of patients back to the unit was more organized and accomplished quickly. The hospital commended the personnel involved in the evacuation. Under difficult circumstances, within a very limited time frame, the staff performed a phenomenal job. Arson was later indicated as the cause of the fire. ■

Zero-Based Budgeting

by Karen J. Stewart, MS, RRT, LRT, director respiratory care and sleep disorders,
Charleston Area Medical Center, Charleston, WV

Zero-based budgeting is a method of budgeting used to eliminate complacency in ongoing programs. When an industry is changing it is necessary to eliminate assumptions that are built from historical data. In most cases budgets are built from historical trends. It is important that changes are recognized and decisions are based on the changed conditions and markets rather than history. Zero-based budgeting is most frequently used in existing programs to ensure that new conditions are anticipated and appropriate decisions are made.

In zero-based budgeting cost estimates are built from scratch rather than from a current level of historical cost.

Typically, zero-based budgeting is not conducted for every department every year. Zero-based budgeting is time consuming and requires additional resources. When discretionary costs are large, zero-based budgeting is the tool most frequently used.

There are a number of questions one should ask when preparing a zero-based budget, including:

- Should this activity be performed?
- Is too much or too little being done?
- Is there an activity that could be contracted or outsourced?
- Is the most appropriate person doing the activity?
- Is there a less expensive supply or resource that can be utilized?

- Is there a more efficient method to obtain results?
- How much should it cost? (Benchmarking)
- What is the demand?

Frequently, in traditional budgeting one glitch in expenses can inflate or deflate the budget. A good example is when an invoice for a high dollar supply item is misplaced at the end of a fiscal year and the posting occurs in the new fiscal year. At the end of the year that same payment is made, doubling the budget line item. This information becomes part of the historical information that becomes part of the

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udget for the following year.

When completing a zero-based budget leave no stone unturned. Remember the subtle costs when calculating the budget.

If you were budgeting the cost of an aerosol treatment and forgot to include the cost of \$.02 for medical gases and your department completed 130,000 treatments per year you would have missed your budget by

\$2,800. It doesn't take too many mistakes like that to put you in the administrator's office explaining budget variances.

Until next time – happy calculating! ■

The Six-Cell Balancing Tool: A Tool for Understanding Behavior

John Kimble RRT, RCP

How many times in your day do people come to you with, “Do you know what so and so did?!” How many times do you say it? What is the usual response? “They're just lazy!” “They're so stupid!” “Where did they go to school?!” It seems as though the normal response is to place the blame on the individual. To be more specific, what is attacked is the individual's motivation or intelligence. It's as if this alone explains an individual's behavior. There are no outside sources driving an individual's behavior. Or are there?

Think back to when you were ten. You are at the pool. Your friends are jumping off the high diving board, but you are way too smart to do that. Admit it, you're scared to death. Your friends begin to taunt you. “Chicken.” “Big Baby!” You begin to think, “Is it better for me to risk death by jumping off that diving board or to have to face being called Chicken until I'm 30?” You decide to jump. You hit the water at 20 mph, hurry to the surface, and get it grinning from ear to ear. You race your friends back to the board.

What happened here? Was this a change in heart due to a totally internal decision, or were you driven by outside sources (in this case, peer pressure)? If your friends had said “okay” when you didn't want to jump from the high board, chances are you would not have attempted it.

Let me give you one more example, this one from respiratory care. You are aged to a med-surg floor to start BiPAP on a patient. It is departmental policy to use the mask template to properly fit the mask. You tear the supply room up trying to find a template, but none are to be found. You call all your co-workers and they don't have one either. So you grab four different sizes of masks and go place the patient on BiPAP. What caused you to

not follow instruction? A blatant disregard for departmental policy or an organizational problem with supplies? Can you see where I'm going?

One of the most enlightening management books I've ever read is titled *The Balancing Act: Mastering the Competing Demands of Leadership*, by Joseph Grenny, Al Switzler, Ron McMillan, and Kerry Patterson. Each of the authors is a co-founder and partner in The Praxis Group, an organizational development consulting and training firm. In the book, the authors offer a novel way of understanding human behavior and a tool managers can use to change from “Look what they did!” to “I wonder why this happened?”

Human behavior is guided by a system of checks and balances. On the one hand, you have ability. If faced with a decision on what action to take, you wonder, “Can I do what is asked of me?” If the answer is yes, then you will do what is asked. If the answer is no, then you will not. On the other hand, you have motivation. If faced with that same decision, you wonder, “Will I gain something of value to me (or avoid something negative) if I do what is asked?” If the answer is, “yes, I will gain something (or avoid something),” you will do what is asked. Putting these two hands together, when faced with a decision on what to do humans analyze 1) their ability to do what is asked; and 2) if they will gain something from the activity, or put more simply, their motivation to do what is asked.

Now let's discuss the impact others have on human behavior. The authors say that when an individual is faced with a decision, after he has analyzed his own ability and motivation he looks to his peers. From a social ability standpoint, the question is, “Will others provide me with the help,

authority, information, and resources I need?” From a social motivation standpoint, the question is, “How will others respond to my efforts?”

Finally, we look at the organizational impact on behavior. What we mean here are the “three M's” from TQM training: methods, machines, and materials (we looked at the “fourth M,” man, in the previous paragraph). From the motivation standpoint, the organization's pay structure, benefits, or evaluation process may affect the individual's choice in doing what is expected. From the ability standpoint, the way work assignments are made, availability of equipment, or physical layout may affect the individual's ability to do what is expected.

In guiding human behavior then, the individual must be willing *and* able. Affecting these two facets are three sources of influence: individual, social, and organizational. Each one has a different effect on the behavior you, as a manager, expect. The authors call this the “Six-Cell Balancing Tool.”

Let's apply these concepts to a real-life situation, one that recently occurred in my hospital. You are analyzing departmental costs and find that you have purchased 700 spacers year to date. You review how many spacers you have billed to patients and can account for 350. You check your present stock and find 150. You have 200 spacers that are unaccounted for! Immediately you call for heads to roll! But, after you calm down you work through the Six-Cells.

• Cell 1: Individual Motivation

This is where most managers begin. They blame the employees, label them as lazy or stupid, or say that they do not care about the quality of the work they do.

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- Cell 2: Individual Ability
Is it possible that therapists do not know how to use or teach patients how to use spacers? Not in this day and age.
- Cell 3: Social Motivation
Do “seasoned” therapists who grew up before the era of spacers feel they are unneeded? Are they affecting the use of spacers?
- Cell 4: Social Ability
Has our staff forgotten about using and billing for spacers? Are our preceptors instructing new staff on the use of spacers?
- Cell 5: Organization Motivation
With our department’s concern on

costs, does staff feel spacers are a waste of money? Are they just taking them somewhere and stashing them?

- Cell 6: Organization Ability
Do we have spacers on supply carts in areas that are unmonitored and are they just “disappearing?”

After reviewing the Six-Cell Balancing Tool, we discovered that our staff had actually forgotten to charge for spacers. We have a respiratory care MIS, and they thought the spacers were being automatically billed. Just-in-time inservices and posted memos corrected the problem.

I have just touched the tip of the iceberg regarding *The Balancing Act*. The book is easy to read and full of

clear examples that can easily be adapted to respiratory care. I highly recommend it. Many management books give you theory and lofty words but no substance. This one provides suggestions you can put to use immediately.

I hope this information has been helpful. If you have questions or comments on this article or the book you can e-mail me at jkimble@tucomm.net. I close with a quote. ■

The cause of all human evils is not being able to apply general principle to specific causes.

– Epictetus

Black’s Law Dictionary: A Reference Underused By Managers

by Pat Munzer, MS, RRT, chair, allied health department, director, respiratory care, Washburn University

As a member of the Management Section, I have gotten many ideas from the Management Bulletin. I would like to return the favor now by relating to others a “good idea” that I have found very useful.

About eight years ago I was asked to give a presentation on professionalism. In my research it became apparent that many groups had their own definitions of that term. I looked at the question from a legal standpoint and asked one of the law faculty at my university if she had a textbook that would help me. She loaned me her *Black’s Law Dictionary*. I have used this reference on many occasions since then when developing curriculum and presentations. I highly recommend this resource as an adjunct to your medical dictionaries.

Here are some words and definitions

from *Black’s Law Dictionary* that I have found to be most helpful:

- **Profession:** A vocation or occupation requiring special, usually advanced, education, knowledge, and skill; e.g., law or medical professions. Also refers to whole body of such profession.
- **Professional:** One engaged in one of the learned professions or in an occupation requiring a high level of training and proficiency.
- **Legal Ethics:** Usage and customs among members of the legal profession, involving their moral and professional duties toward one another, toward clients, and toward the courts. That branch of moral science which treats of the duties which a member of the legal profession owes to the public, to the court, to his professional brethren, and to his client. Most

states have adopted the Model Rule of Professional Conduct of the American Bar Association.

- **Death:** The cessation of life; permanent cessation of all vital functions and signs. Numerous states have enacted statutory definitions of death which include brain-related criteria. For example, many states have adopted, sometimes with variations, the Uniform Determination of Death Act definition: An individual who has sustained either (1) irreversible cessation of circulatory and respiratory function, or (2) irreversible cessation of a functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards. ■

FYI . . .

Sleep apnea report available

MetaWorks, Inc., one of 12 evidence-based practice centers (EPCs) under contract to the Agency for Health Care Policy and Research (AHCPR), has released its summary and report of a systematic review of the research literature on the accuracy of sleep apnea screening and diagnosis.

The EPC conducted the review and

analysis to determine if there are tests for accurately screening and diagnosing sleep apnea that are simpler and less expensive than the current gold standard – the overnight, full-channel polysomnography (PSG). MetaWorks research found that the full PSG still appears to be the most effective test, although several less expensive and less time-consuming tests appear promising.

For more information or the full report, *Evidence Report on Diagnosis*

of *Sleep Apnea* (AHCPR99-E002) visit the AHCPR’s web site (<http://www.ahcpr.gov>) to access the National Library of Medicine’s HSTAT information retrieval system.

Printed copies are also available from: AHCPR Clearinghouse, P.O. Box 8547, Silver Spring, MD 20907 (800) 358-9295.

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1999 Summer Forum

The 1999 AARC Summer Forum will take place at the Pointe Hilton Resort at Squaw Peak in Phoenix, AZ, July 16-18. The program focuses on lectures and workshops aimed at helping managers and educators perform their jobs better.

For the first time ever, book publishers will be showing their publications at an exhibit during the meeting. Immediately following the Forum, RTs can participate in a patient assessment course designed to hone their skills in

managing service utilization (participants must register prior to July 1 for this program).

For detailed program and registration information, refer to your April issue of *AARC Times* or visit the AARC web site at www.aarc.org.

Possible scheduling change for Summer Forum 2000

Next year, the AARC International Respiratory Congress will be held the first week of October in Cincinnati, OH. The AARC Summer Forum is usually presented in July; however, we recognize that this might cause some

conflicts because it is so close to the Congress in October. In an effort to avoid as many problems as possible, the AARC is considering holding Summer Forum 2000 in either May or June.

Please take a few moments to cast your vote on when to schedule the Summer Forum in the year 2000: May, June, or July?

Please e-mail your vote to masferrer@aarc.org or fax it to Ray Masferrer’s attention at (972) 243-2272. Thank you in advance for your input. ■

Bulletin Deadlines

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

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Top manufacturers in the industry will fill the Congress Exhibit Hall ready to teach you about – and now, sell you – the latest in respiratory technology.

Make plans now to attend the December meeting in Las Vegas and take advantage of special show discounts – this could be the most cost-effective meeting you’ve ever attended!

Don't Miss It!