Notes from the Guest Editor
by George Gaebler, MSEd, RRT, director, respiratory care, and cardiovascular service line administrator, University Hospital, Syracuse, NY

I would like to thank all the guest editors who have preceded me in editing this Bulletin for their timely articles, which I have always found to be insightful and germane to the daily menagerie of tasks confronting the respiratory care manager. In this day of the hectic manager, the “state or regional guest editor” format seems especially useful. Not only does it spread the work between several volunteers, it also allows us to gain a bird’s-eye view of RT management as it is being carried out in different parts of the country. I’d like to thank John Kimble, our outgoing section chair, for providing me with another opportunity to share our experiences here in the North Country of New York.

The articles found herein cover a several key issues confronting new and not-so-new managers alike. If you would like additional information on the topics covered in this issue, please feel free to contact the authors at the email addresses and/or phone numbers listed at the end of each article.

For additional information, George can be reached via e-mail at gaeblerg@upstate.edu or phone at (315) 464-4490.

Specialty Practitioner of the Year:
Rick Ford, BS, RCP, RRT

This year’s Management Section Specialty Practitioner of the Year knows what it takes to succeed in our current cost-driven health care environment. As a director of respiratory services in one of the most capitated markets in the country, Rick Ford, BS, RCP, RRT, has had to squeeze inefficiencies out of his system time and time again. The fact that he and his department at the University of California, San Diego Medical Center are not just surviving but thriving is testament to his ability to work within the system to achieve positive results for his organization and the patients it serves.

Over the past decade, Rick has taken repeated directives from his administration to cut costs and turned them into opportunities to enhance the role of the RT in the institution. Chief among his achievements: development and implementation of systems and programs that ensure the delivery of only appropriate care administered by the most efficient use of hospital resources.

Rick, who has been an AARC member for the past 25 years and a member of the section for the past six, believes the AARC adds irreplaceable value to his role in respiratory care management. “Today’s RC managers need all the help they can get. Participation provides a means to stay informed and benefit from the expertise of others.” Congratulations, Rick!

More Thoughts on Managing:
The Multi-Departmental Challenge
by Claire Alman, MS, RRT, director, cardiopulmonary and sleep services, Samaritan Health Systems, Watertown, NY

About a year ago, I wrote an article for this newsletter on what it was like to be a new manager of a respiratory care department. Earlier this summer, George Garbler asked me if I would consider updating my thoughts. Thinking that I had plenty of time, I said yes. Of course, time flew by, and here I am, trying to put those thoughts into some coherent order while the deadline looms. So here goes...

When I started this job, I thought of myself as a respiratory therapist. I had held...
“More Thoughts” continued from page 1

acquainted with the chargemaster, CPT codes, APCs, LMRPs, fair hearings, and other wonderful things related to getting paid for what we do. I have learned to work with physicians on issues largely unrelated to clinical patient care: staff development, performance improvement, and development of new programs. I have learned to use my skills in the acute care setting, in outpatient testing, in skilled nurs- ing facilities, and in multiple clinics affiliated with the system in which I am employed.

I have also investigated the many possi- bilities and pitfalls of benchmarking out- comes and have learned to work closely with the marketing department to help build and maintain outpatient programs. Yes, they even talked me into being on television next week . . . at 6:30 a.m. no less! I have learned the value of networking with- in the institution to promote the profession- als in each of “my” departments. I have worked toward greater integration of these departments. My cardiac rehab nurses are now cross-training in echocardiography. The respiratory therapists working in pulmo- nary rehab now work in cardiac rehab as well. All of the sleep technologists are res- piratory therapists, and some staff are now cross-training to work in both departments. The RT staff backs up the EEG technicians when they are unavailable. It’s great to see these diverse professionals coming together and learning from one another.

Of course, there are days when I have second thoughts about all of this. After all, I spent most of my professional life work- ing as a respiratory therapist or teaching others to be respiratory therapists. In my home care career, I taught therapists about home care, supervised them in their daily performance, or introduced them to new respiratory care techniques. I even took care of a patient now and again. Since I have been here (about 18 months), I have performed care for a patient for a patient exactly once. For some reason, I happened to be in the ED (not one of my more frequent stops). It was frantically busy, and one of my newest therapists was trying to get a chronic lung patient started on non-invasive, pressure ventilation while also running around doing treatments and drawing blood. Knowing that it’s difficult to be successful with an anxious patient unless you can do some serious hand-holding, I offered to help. I did the whole thing, from fitting the mask to initiating the therapy, titrating pressures, and assessing patient response. When the therapist stepped back by, she found me grinning from ear to ear, as my patient gratefully averted with much improved gas exchange. (If I let her do the blood gas, though — I’m just a little rusty!) Caring for this patient was at least as satisf- ising as completing a variance report, getting a proposal for increased staffing approved, or working through a new pro- ject with my administrator. Yet I know that the opportunity to do this again will become less and less likely as I move fur- ther into the world of multi-departmental and multi-specialty management. While I can still fit a face mask that most unexpectedly previously was my hat so many times!

I’ve also worked hard to make my other departments know that even though my background is respiratory therapy, I am equally sensitive to the specific needs. I know that they are the experts in what they do, and I try to stop by regularly at shift change or have lunch with them periodically, but it’s just not the same. At first they felt like I had abandoned them, but now they seem to understand the change. They know I will be there for them any time they need me, but just not in the next room.

Keeping up with all of this is a contin- ual challenge, and I have learned that there are many new things that it would take me all day to list. Among the many, for example, I found myself running from a management meet- ing about billing for echos and EKGs, to the storage barn with my exercise physiologist to look at exercise equipment for our new location, and then back to my office to meet with the EEG staff and some vendors about a newly digital EEG system. After that, my sleep- respiratory medical director wanted to talk about our satellite sleep labs and a home care vendor called about problems with the discharge of a home oxygen patient. My head was spinning from chang- ing my hat so many times!

“More Thoughts” continued on page 3
This article is based on a talk I gave recently and a question asked during the discussion period at the end. Essentially, I was attempting to make the argument in my presentation that respiratory care leaders should be aggressive in seeking salary increases for staff, increasing FTEs, and seizing opportunities resulting from the chronic shortage of registered nurses. The question, paraphrased here, was: Did I really do not experience it first hand.

A little over a year ago I was asked to provide leadership for a service line within our institution which entailed the management of areas in nursing and intensive care units. I must admit that I really did not have a good sense of the magnitude of the problem related to nurse staffing on a macro level. We, as respiratory care leaders, hear about this problem anecdotally, but certainly do not experience it first hand.

Further, there is a trend — and I emphasize trend — in our profession towards manpower shortages of our own. The perception is that respiratory care is pulling up out of the destruction left in the wake of consultant pressures, which generally dictated that we were not needed. Whether you have all heard the clichés regarding the decreases in enrollment and applicants for school programs.

1. Respiratory care leaders be aggressive in their thought processes about adding services, increasing staffing, and increasing salaries for staff and others. Some of you may be wondering whether this makes any sense based on your local experiences. I would argue that all of the assumptions of the past several years must be thrown aside.

2. The applicant pool for respiratory care leaders has pulled us together and we are doing very well now. I don’t agree with every decision they make, but I know we are all singing in the same direction together, and I’m glad to be part of the team that’s making it happen.

3. We continue to have an ever-increasing aging population with more chronic diseases. Specific manifestations in my hospital include the following:

- Nursing has turned FTEs over in the budget process to the respiratory care department for the purpose of hiring more RNs to strengthen multidisciplinary teams.
- We have added more general FTEs for the respiratory care department.
- We received approval to reinstate a position for education and research coordination for respiratory care that had gone unfilled for five years.
- We received market-based salary increases for the first time in recent memory that averaged over 10% per individual.

Clearly, there is a change in the climate for our profession. It is not regional. It is, or soon will be, everywhere. Indeed, despite all the consultant-driven activities of the last several years, respiratory care has been and continues to be on the top 20 list for projected growth in workforce numbers over the next ten years.

We have all heard the clichés regarding the need for change and I will not repeat them here. However, we do have to think differently in order to meet the coming challenges. Therefore, I would propose that:

1. Respiratory care leaders be aggressive in their thought processes about adding services, increasing staffing, and increasing salaries for staff and others. Some of you may be wondering whether this makes any sense based on your local experiences. I would argue that all of the assumptions of the past several years must be thrown aside.
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The absolute worst-case scenario is that we have the opportunity to advance our profession, but the professional staff needed to accomplish this goal are not available.

3. We must find the time to actively involve ourselves in community, professional, and leadership activities designed to reverse the trends of decreasing enrollments and graduates. If you have been out of professional activities, re-involve yourself through local, state, and national AARC activities. And encourage your staff to get involved as well.

4. The provision of our services must be driven by evidenced-based practice, assessment, and patient/family education, and we must ensure that we only provide direct patient care for as long as is necessary to get the patient educated and stable enough to self-administer through facilitation by others.

5. Embrace new technologies that allow decreased therapeutic delivery times.

These activities will provide us with the extra time we need to get involved in the new opportunities that are knocking on our door. For example, there is no professional better prepared to be involved in conscious sedation monitoring than the respiratory therapist. From a practical point of view, the common practice of having two nurses be present for conscious sedation does not make sense, especially when our health care delivery system is suffering from worsening shortages of nurses and hospital beds are closing as a result. We should be one of those individuals.

The future of our profession is being charted right now. We have enormous opportunities that I personally believe rival those of the early days of our profession. We are in the driver’s seat, and the direction in which we will head is entirely up to us.

For more information contact George Gaebler via e-mail at gaeblerg@upstate.edu or phone at (315) 464-4490.
Cost Reduction Strategies

Jack Fried, MA, RRT, from St. Mark’s Hospital in Salt Lake City, UT, says that the following cost reduction strategies have worked in his department:

- Eliminating bubble humidifiers
- Extubating patients to nasal cannulas instead of aerosol masks
- Changing inline suction catheters every other day instead of daily
- Going from maintenance contracts to time and materials

Have you found effective ways to cut costs in your department? If so, please consider sharing them with the membership by filling out the following form and faxing it to the AARC or posting your comments on the Management Section listserve on AARC Online (www.aarc.org). If you have yet to sign up for the section listserve, go to the section homepage on the web site and follow the directions to sign up. We’ll organize and archive the materials 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.”

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 if we all hang together, we will surely hang separately.

Use the following form to send us the ideas with our colleagues. Remember: if we don’t all hang together, we will surely hang separately.

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JCAHO Site Visit Reports

As of the end of October, the section had received the following responses to its request for information about JCAHO site visits.

Pathology & Clinical Laboratory Services

Facility: Alamance Regional Medical Center
Contact: Karen Bartels, barkare@amc.com
Inspection Date: 8/2000
Score: 98% hospital wide; no deficiencies noted in cardiopulmonary blood gas lab
1. What was the surveyors’ focus during your last site visit?
   - Proficiency, staff competencies, policy and procedures, performance improvement, performance evaluations.
2. What areas were cited as being exemplary?
3. What suggestions were made?
4. What changes have you made to improve compliance with the guidelines?

Additional comments: Surveyors noted in cardiopulmonary blood gas lab.

Home Care

Facility: Advanced Healthcare of Fort Wayne, IN
Contact: Roger O’Connor, CRT, RCP
Inspection Date: 8/2000
1. What was the surveyors’ focus during your last site visit?
   - Charting, follow ups, MD’s orders, CMNs, plan of care, competency check offs (i.e., yearly), infection control, employee files, TB X-rays, physicals.
2. What areas were cited as being exemplary?

Additional comments: None noted.

Further comments: Educate all staff about the importance of charting and follow ups. We have flow sheets for each piece of equipment which services in follow up times. Also, having patient limitations in the plan of care.

More education for non-credentialed employees on documentation; monitor more closely the compliance of CMNs being returned within 30 days.

Additional comments: Surveyors are really looking at the following — documentation, for patient charts to tell a story; continuity of employee knowledge of policies and procedures; company equipment maintenance records to make sure manufacturer guidelines are being followed; education of patients, and safety policies in the home.

Long-Term Care

Facility: Glendale Care Center, 4704 W. Diana, Glendale, AZ 85302
Contact: Joy Haupt-Black, (602) 247-3949
Inspection Date: 2/1997
1. What was the surveyors’ focus during your last site visit?
   - Resident and staff education, resident education documentation by the multidisciplinary team, competencies for RT staff.
2. What areas were cited as being exemplary?
   - Rehab — PT, OT, ST, RT. No deficiencies.
3. What suggestions were made by the surveyors?
4. What changes have you made to improve compliance with the guidelines?

Additional comments: None noted.

If you would like to share your site visit experience with fellow section members, please fill out the following form and fax it to the AARC or post your comments on the Management Section listserve related specifically to the specialty (not to the AARC or the practice of respiratory care in general) to: Kelli Hagen, hagen@hageng.com, FAX (972) 484-2700 or (972) 484-6010. The Association will utilize our input in determining priorities for the coming year.
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?
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2. What areas were cited as being exemplary?
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3. What suggestions were made by the surveyors?
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4. What changes have you made to improve compliance with the guidelines?
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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