



## Notes from the Chair

by Karen J. Stewart, MS, RRT, LRTR

The coming year promises to be full of challenges and opportunities for the Management Section. Here are some of the goals that have been charged to the section:

- Develop a model career ladder program for posting on the AARC web site as a resource for respiratory care departments and department managers. The program should include rewards for credentials (RRT and specialty) and education (BS in respiratory care, graduate education, other), as well as advanced levels of practice, such as arterial line insertion, intubations, ECMO, aortic balloon pump, protocol implementation, patient assessment and care plan development, diagnostic testing and implementing and/or coordinating disease management programs.
- Develop a proposal for a two- or three-day "Management Institute" to train respiratory care managers in essential survival skills for their departments. Topics may include:
  - Hospital finance and reimbursement (Medicare, Medicaid, MCOs, etc.)
  - Staffing, productivity and "real" income
  - Protocol implementation for demand management to reduce or eliminate unnecessary care, maximize care given and control costs
  - Maximizing relationships with physicians, nurses and administration
- Employee recruitment, retention, and job satisfaction

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## Recognizing Quality: A New Program from the AARC

by Karen J. Stewart, MS, RRT, LRTR

The AARC introduced a new program at the International Respiratory Congress aimed at increasing recognition for your respiratory care service and hospital. "AARC Recognition of Quality Respiratory Care Services in Hospitals" is the first step in a multi-tiered effort that will work toward a more comprehensive program titled "Centers of Excellence for Respiratory Care." Details on how to apply will be mailed soon to all managers and hospital CEOs.

To qualify for recognition by the AARC, the hospital must provide documentation that:

- All respiratory therapists employed by the hospital to deliver bedside respiratory care services are either legally recognized by the state as competent to provide respiratory care services or hold the CRT or RRT credential.
- Respiratory therapists are available 24 hours.
- Personnel qualified to perform specific respiratory procedures and the amount of supervision required for personnel to carry out specific procedures, is designated in writing.
- A doctor of medicine or osteopathy is designated as medical director of respiratory care services.

Departments/hospitals that qualify will benefit from several AARC recognition mechanisms. The AARC will:

- Provide a database containing names and locations of qualifying hospitals which can be searched by state or hospital name.
- Remove from the database any hospital that no longer upholds the respiratory standards set forth by the AARC.
- Provide a certificate suitable for framing to qualifying hospitals.
- Provide a logo that qualifying hospitals can use to promote their recognition. ♦

## Top Hospitals Leading the Way in CPG-Based Care

by Bill Dubbs, MHA, MEd, FAARC, AARC associate executive director

Last fall, a supplement to Modern Healthcare reported that the nation's top 100 hospitals incorporate the use of clinical pathways or clinical practice guidelines (CPGs) at a rate 15.2% greater than their peers.

The take home message for respiratory care department managers is clear. Respiratory protocols based on the AARC's Clinical Practice Guidelines can contribute to a hospital's success. Hospital leaders will be placing increasing value on the contribution protocols make to improved clinical and economic outcomes. Those who have yet to ask their clinical service department directors about how they are incorporating CPGs into the delivery of their services will most likely be doing so very soon. RT departments using protocols today need to continue their development. More importantly, departments that are not yet using protocols need to quickly move in that direction.

The AARC's Clinical Practice Guidelines can be found at: [http://www.rcjournal.com/online\\_resources/cpgs/cpg\\_index.asp](http://www.rcjournal.com/online_resources/cpgs/cpg_index.asp). The Management Section home page on [www.aarc.org](http://www.aarc.org) features a wealth of information - including a protocol article bibliography - aimed at helping managers institute these guidelines into their departmental operations. ♦

## Section Connection

### GET IT ON THE WEB:

Help the AARC increase its efficiency by signing up to receive the Bulletin via the section homepage on the AARC web site ([www.aarc.org](http://www.aarc.org)). To change your option to the electronic Bulletin, send an e-mail to: [mendoza@aarc.org](mailto:mendoza@aarc.org).

### JCAHO ACCREDITATION REPORT:

Please consider sharing information about your most recent site visit by filling out the form on the AARC web site found at the following link: [www.aarc.org/members\\_area/resources/jcaho.asp](http://www.aarc.org/members_area/resources/jcaho.asp).

### SECTION LISTSERVE:

Start networking with your colleagues via the section listserv. Go to the section homepage on [www.aarc.org](http://www.aarc.org) and follow the directions to sign up.

## We Have Their Support

The percentage of Americans who believe hospitals are going through tough economic times is on the upswing. New figures from a poll of 800 voters finds 53% are aware of the industry's financial woes, half again as many as held the same view a year ago. About 80% of those questioned also believe the federal government should provide extra funds to safety-net hospitals to ensure those without health coverage receive necessary services.

The survey was conducted by Public Opinion Strategies last July on behalf of the National Association of Children's Hospitals and published on the organization's web site in October. ♦

## We Need Your Email Address!

Beginning next year, the Management Bulletin will be published exclusively via an email newsletter format. The change, approved by the Board of Directors last summer, will be more cost effective for the AARC, thus freeing up funds for other efforts important to managers and will also result in more timely delivery of news to section members.

So, if you have yet to supply the AARC with your email address please do so ASAP. Send your address to: [mendoza@aacrc.org](mailto:mendoza@aacrc.org). ♦

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## Quick Poll: Pulse Oximetry

by Gary J. Turner, White County Medical Center, Searcy, AR

In response to questions from the nursing and physical therapy departments concerning pulse oximetry use at White County Medical Center, I decided to perform an impromptu survey on the section listserv. Specifically, I wanted to determine whether or not pulse oximetry is being used in a consistent manner across the country. At our hospital, we have three different disciplines using pulse oximetry, and a physician's order is only sometimes required. In addition, I recently received a newsletter from the Joint Commission on Accreditation of Healthcare Organizations (dated March 15, 2002) containing a statement from the Food and Drug Administration conveying that a physician order is required for pulse oximetry in the home care setting.

Nineteen managers responded to the survey, with the following results:

PULSE OXIMETY SURVEY				
	YES	NO	For RT to Perform	For Continuous
Do you require an order for pulse oximetry?	4	3	6	6
Is pulse oximetry performed by nursing with normal vital signs?	14	2		
Does any other discipline use pulse oximetry in your institution?	12	3		

These results indicate most hospitals are treating pulse oximetry the same way. If it is a one-time saturation that is charged, it has to have an order. If it is used as a continuous monitor, it has to have an order. Most respondents indicated that nursing is performing pulse ox sats with routine vital signs and rehabilitative therapists are also using pulse oximetry. ♦

## Experts Question Breathing Devices

Self-contained breathing devices designed for use by hospital employees in the presence of unknown respiratory hazards could stand some improvement, report safety experts. The devices, which hospitals must have on hand to comply with OSHA standards, often cause overexertion, general discomfort, claustrophobia and limited vision, thus interfering with the ability of employees to do their jobs.

Alternative devices might better serve the purpose. Experts recommend supplied air respirators, which provide an outside source of air through a hose-and-hood/mask combination connected to a wall manifold, small pump, or system of air cylinders. The devices are more comfortable, provide better vision, and offer more splash protection. Powered air-purifying respirators that sift out specific contaminants via battery-powered blowers that pull air through a filter or cartridge and into a facemask or hood are another good choice, as they are lightweight and easier to move around in than conventional respirators. ♦

## Leadership Shortage

A new poll conducted among health care CEOs finds a dearth of potential leaders for the industry's future. Sixty-six percent of those surveyed said there aren't enough health care leaders today to fill all the key executive positions that will be opening up in the future.

Why the shortfall? The CEOs believe the industry itself is to blame. Over half said health care drives potential leaders away, noting in particular that the long hours needed to build a successful career take potential executives away from their personal lives.

Still, CEOs in the survey are quick to support their own career choices. Most felt that college students should be encouraged to pursue health care careers because of the immense personal satisfaction inherent in the job.

The poll was conducted among about 180 CEOs by health care executive firm Witt/Kieffer. ♦

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## Shared Visions - New Pathways

Significant changes are underway at the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Over the next couple of years, a new JCAHO initiative called “Shared Visions - New Pathways” will progressively sharpen the focus of the accreditation process on care systems critical to the safety and quality of patient care.

“Shared Visions” represents agreements among the Joint Commission and health care organizations as to what a modern accreditation process should be able to do and achieve as a constructive driver toward the provision of safe, high quality care. “New Pathways” represents a new set of approaches or “pathways” to the accreditation process that will support fulfillment of the shared visions.

### The new pathways include:

- A required mid-cycle, self-assessment during which the health care organization will evaluate its own compliance with the applicable standards and develop a plan of correction for identified areas of non-compliance. Validation of corrections and other randomly selected self-assessment findings will occur during the onsite survey at the end of the triennial period.
- A pre-survey review of organization-specific information, such as ORYX core measure data, sentinel event information and MedPar data, through an automated process to identify critical processes relevant to patient safety and health care quality for evaluation during the onsite survey.
- Substantial consolidation of the standards to reduce the paperwork and documentation burden of the survey process and increase its focus on patient safety and health care quality.
- Onsite evaluation of standards compliance in relation to the care experience of actual patients.
- Revision of individual organization performance reports to provide performance information not portrayed in the current reports.
- Active engagement of physicians in the new accreditation process.

“‘Shared Visions - New Pathways’ represents the next step in the evolution of accreditation,” says JCAHO President Dennis S. O’Leary, MD. “It shifts the focus from survey preparation to focusing on operations and internal systems that directly impact the quality and safety of care.”

An in-depth look at the new accreditation process is available online in a special 16-page edition of Perspectives, the Joint Commission’s official newsletter: [www.jcrinc.com/perspectives](http://www.jcrinc.com/perspectives). Questions may be emailed to [sharedvisions@jcaho.org](mailto:sharedvisions@jcaho.org). ♦

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## Good Practices Found Here

Joint Commission Resources (JCR), a subsidiary of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is sponsoring a new online database that offers hospitals practical examples to meet accreditation requirements related to patient assessment, patient care, staff competency, performance improvement, environment of care, pain management and patient rights and responsibilities.

The good practices database is intended to help health care organizations improve services by learning from the practical successes of others. The subscription service (\$199 per year) contains five examples in each of the seven topic areas. Examples include forms, checklists, policies and procedures. The database will be updated quarterly.

“This database facilitates the process of sharing examples of good practices by accredited health care organizations. And users can have confidence that each of the examples has been reviewed by JCR experts for compliance with standards, clinical accuracy and usefulness,” says Karen H. Timmons, CEO, JCR.

While the database is currently limited to hospitals, a pilot project for ambulatory, long-term and home care organizations is in the works. JCR also continues to seek good practice examples from JCAHO-accredited hospitals regarding patient safety, staffing effectiveness, medical staff and medication processes. Organizations interested in submitting good practice examples may find specifications and submission forms on the JCR web site, [www.jcrinc.com](http://www.jcrinc.com). ♦

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## Shorter Stays/ Higher Costs

According to new data from the Agency for Healthcare Research and Quality, average hospital stays have dropped for many high-cost conditions. But that doesn’t mean hospitals are saving money. The same research shows average hospital costs for these conditions - including several common respiratory diagnoses - are going up. Consider the following comparison of costs and LOS:

- Blood poisoning: costs rose from \$17,909 to \$24,365; LOS declined from 10.0 days to 8.2 days.
- Cardiac dysrhythmias: costs rose from \$10,152 to \$14,213; LOS declined from 4.7 days to 3.6 days.
- Stroke: costs rose from \$15,365 to \$19,956; LOS declined from 9.5 days to 6.7 days.
- Diabetes: costs rose from \$11,021 to \$14,779; LOS declined from 7.4 days to 5.6 days.
- Pneumonia: costs rose from \$12,860 to \$15,104; LOS declined from 7.8 days to 6 days.
- Congestive heart failure: costs rose from \$11,995 to \$15,293; LOS declined from 7.4 days to 5.6 days.
- Nonspecific chest pain: costs rose from \$5,135 to \$7,543; LOS declined from 2.5 days to 1.8 days.
- COPD: costs rose from \$11,263 to \$12,491; LOS declined from 7.2 days to 5.3 days.

The report attributes these discrepancies to new technologies and rising medication costs, which have increased average hospital charges while economic pressures have shortened the average patient stay. ♦

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## Improving ICU Care

A new report details efforts by some of the leading hospitals across the nation to improve care delivered in the ICU.

“Care in the ICU: Teaming Up to Improve Quality” profiles 11 institutions that have introduced innovations in ICU care which have dramatically improved quality of care and can serve as models for the rest of the nation. Among the initiatives: systems approaches to improving patient safety, bridging the use of technology with “caring” components, addressing environmental issues, and the use of telemedicine. The report notes that if these standards were implemented in all non-rural hospitals, they would prevent 54,000 deaths and save \$5.4 billion annually.

The institutions highlighted in the report are: Johns Hopkins University, Baltimore, MD; St. Vincent Hospital, Worcester, MA; St. John Medical Center, Tulsa, OK; The Stamford Hospital, Stamford, CT; LDS Hospital, Salt Lake City, UT; Lehigh Valley Hospital, Allentown, PA; Rhode Island Hospital, Providence, RI; Mission Hospital Regional Medical Center, Mission Viejo, CA; Memorial Medical Center, Johnstown, PA; Duke University Medical Center, Durham, NC; and Sentara Healthcare, Norfolk, VA.

The report was sponsored by the National Coalition on Health Care and the Institute for Healthcare Improvement, with funding from the federal Agency for Healthcare Research and Quality and The Robert Wood Johnson Foundation. ♦

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## New Bulletin Editor

George Gaebler, MEd, RRT, FAARC, from University Hospital in Syracuse, NY, has agreed to serve as Bulletin editor for 2003. Please send your contributions to George at the addresses/numbers listed on page two. ♦

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## Health Care Spending Linked to Hospital Utilization

A new report from the Centers for Studying Health System Change indicates increasing hospital utilization is at the root of the recent rise in health care spending, which went up 10% in 2001. Spending on hospital and outpatient hospital care rose 12% that year, accounting for just over half of the total increase in health care spending overall.

The American Hospital Association attributes the rise in hospital utilization to several factors, including an aging society, advances in technology and the easing of restrictions on medical care by managed care organizations. Also playing a role: increasing labor costs fueled by workforce shortages, higher prescription drug costs and increasing numbers of uninsured patients. ♦

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### NOTES FROM THE CHAIR

- Patient service delivery, quality markers and patient satisfaction
- Outcomes measurement and documentation, including essential measures such as length of stay, readmission rates and effective care delivery

The Swap Shop on the section homepage already includes a couple of clinical ladders which can serve as great examples and provide us with the foundation to create a new model. Additionally, work has already begun on the Management Institute. If you have needs beyond the description above, or would like to see more refinement, please let me know so we can incorporate your ideas - after all, it will be your program.

On another note, there was a challenge issued at the International Respiratory Congress regarding membership. The dollars from membership dues help all of our state societies, as well allow our AARC staff to represent our interests in Washington. There are a number of lobbying efforts underway to improve reimbursement and foster greater recognition of respiratory care. If every current member recruited one new member our voice would carry farther on Capitol Hill. I challenge each of you to recruit at least one new member into the AARC in 2003. And most certainly, if you know managers who are not members, please encourage them to join both the Association and the section.

The International Respiratory Congress was a winner, but now it's time to begin thinking of the Summer Forum and the next Congress. Your input is needed. You may submit your ideas for topics and speakers via the Association web site ([www.aarc.org](http://www.aarc.org)), but please email them to me as well (see contact information on page two). As your chair, I will also be submitting program proposals, and if you have identified a hot topic I can add it to my list or combine it with similar topics to create a symposium. This not only assists the Program Committee, but topics incorporated into symposiums often have a better chance of being accepted because symposiums sometimes carry more weight with the committee. ♦