

“Monitoring” continued from page 7

procedures done by the department are also factored in. The hospital financial office sends us our official productivity reports 30-90 days after the end of each fiscal month.

While these reports can help identify long-term trends, they are less helpful in monitoring day-to-day productivity. In order to maintain our daily productivity goals, we found it necessary to monitor the work assigned, the work completed, the number of RTs scheduled, and their assignments. A quick and simple method to measure shift productivity and staffing requirements was needed.

Since the RC department had installed an information system, billable procedures completed could be closely monitored. Productivity standards were identified via an accessible and easy to understand method. Variables that affect productivity also needed to be considered. Each procedure has a designated time standard for each shift or for each occurrence. The system enables the department to generate reports on the work

units (minutes) performed per RT, per area, and per shift. The information that was readily available was monitored for several months and compared to the official productivity reports from management engineering.

Although having an information system to assist in this process is helpful, a similar tracking system can be accomplished manually. Each therapist can keep track of the procedures he or she has performed throughout the shift. These can be multiplied by the time standards and totaled in a spreadsheet program such as Excel.

To maintain positive productivity and also assign reasonable workloads to the RTs, there are many variables on each shift that need to be considered. Listed below are some of the variables we considered when assigning work and determining the ideal number of RTs needed per shift.

1. The amount of work assigned at the start of the day shift increases by an average of 100 work units (minutes) per practitioner working. This is the result of unscheduled work (i.e., airway emergencies, bronchoscopies, ABGs).

2. Sunday is the slowest day of the week and Wednesday or Thursday is the highest volume day. This is related to the surgery schedule and admission and discharge of surgical patients.

3. The work that is completed in the emergency room is higher (approximately 100 work units) on night shift.

4. Geographical locations and practitioner skill level are additional considerations.

Since the amount of work that was reasonable at the start of each 12-hour shift was determined, the number of required RTs was known in advance. Approximately 500 work units per RT are assigned. Remember that this is based on predetermined time standards for each procedure. If this productivity goal is not achieved, staff levels can be adjusted prior to the start of the shift.

Every respiratory care department will have different variables to consider when developing a productivity system, but all can benefit from knowing department productivity in terms that are definable and understandable to staff members as well as administrators. ■

Resource Panel Update: We Need You!

We will be mailing an updated version of our Resource Panel Directory with our January-February issue and would like to include as many new names as possible. If

you are interested in volunteering to serve as a resource for your peers in the section — or if you need to update your contact information from a previous listing — please fill out

the following form and send it to: Kelli Hagen, AARC, 11030 Ables Lane, Dallas, TX 75229. All information received by December 20 will be included in the new directory.

Resource Directory Sign-Up Form

Name _____
Title _____
Organization _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____
e-mail _____

The following are topics frequently requested by those who call the Executive Office. (Please check all that apply.)

Competency Documentation
 Performance Appraisals
 Respiratory Care Information Systems
 Benchmarking
 Case Management
 Other _____

Please list any materials (samples of contracts, business plans, etc.) you would be willing to share with others: _____



Management Bulletin

Nov./Dec. '99

2

Notes from
the Guest Editor

3

Keeping Interest High
While Salaries and
Benefits Decline

4

Ancillary Care
Coordination: *Staying
Alive as a Professional
Service in a Clinical
Business Unit Design*

5

How to Evaluate New,
Improved, or Less
Expensive Technology
and Supplies for your
Department

6

Starting a New Service

7

Monitoring Productivity
for Respiratory Care

8

Resource Panel Update:
We Need You!

American Association
for Respiratory Care

Restructuring's Next Wave: Perception is Reality

by William H. Dubbs, MHA, RRT, AARC associate executive director, and Sam Giordano, MBA, RRT, AARC executive director

Occasionally, AARC members forward news items about respiratory care that appeared in their local newspapers to our Executive Office in Dallas. Recently, we received a news item from the *Upper Keys Independent* written by a person who was frustrated by the bill he received from his hospital for treatment of injuries sustained in a traffic accident that occurred when another driver ran a red light. Part of this article hit home hard.

Here's what this individual had to say about our profession: "The 44, ten-minute visits to my room by a low-level person to place a mask over my nose, stand aside, and watch me inhale the medicine (or leave the room as they did on occasion) called *respiratory therapy* cost . . . \$4,518." Whether the "low-level person" described here was a respiratory therapist is unknown. What we do know is that this patient perceived respiratory therapy to be a treatment that cost a lot of money, was provided by someone who had limited skills, and was of little value to his recovery.

It starts at the bedside

We all know that therapist behavior in the workplace is a primary driver of patient perceptions of respiratory care. (It certainly made an impression on the patient who wrote to this newspaper.) Therapist behavior at the bedside also drives the general perception of the department by key decision makers. If therapists are delivering multiple therapies simultaneously to patients in separate rooms, leaving patients alone during their treatment, and speeding along to their next patient without communicating with other caregivers, those therapists are really saying, "you don't need me." Others who work in the facility and observe this behavior could fairly conclude that the services being provided do not require extensive knowledge and skills. Further, they could logically speculate that the required knowledge and skills could be gained with a minimal investment of time.

When the next wave of restructuring hits these facilities — something health care analysts believe is certain to happen over the next year due to Medicare cuts enacted by the

Balanced Budget Act of 1997 and other factors — those seeking ways to improve organizational efficiency may justifiably assume that an unlicensed nursing assistant could readily be trained to do this *respiratory therapy*. But imagine how different that perception would be if the therapist were observed to be coaching the patient, assessing his or her response to therapy, and making suggestions for changes in therapy based on the assessment. It is unlikely that anyone would consider transferring those responsibilities to lesser trained individuals.

Wouldn't it be more efficient if, for example, after an initial assessment by a therapist, patients who could self-administer treatment (as they do in their homes) were allowed to do so.(1) Wouldn't it be more efficient to have a therapist periodically reassess the competence of patients who are deemed competent to self-administer than spend time with a patient who needs no assistance? Therapists who provide care by following protocols are actively helping to control costs and minimize patient risk from unnecessary procedures. Therapists who treat without reassessing the status of patients and/or don't follow protocols promulgate misallocation and raise both the cost of care and risk to patients.

Key decision-makers

Positive perception of respiratory care services by organizational decision-makers will be critical to surviving the next wave of restructuring. During the last wave, consultants eager to recommend ways to cut costs frequently attempted to characterize respiratory therapy as a service that added little value to struggling organizations. In organizations where a similar perception was already shared by leading decision-makers, the consultants merely provided the validation that made the decision to downsize or eliminate respiratory care services easier. To survive the next wave of restructuring, our organizational leaders must believe that respiratory therapists make a significant contribution in holding down operational costs while maintaining quality of care for patients.

"Next Wave" continued on page 2

"Next Wave" continued from page 1

Which organizational leaders need to have a positive perception of your service? The person responsible for the *final decision* about changes to the service, along with those who provide *counsel* to that person, are the ones who count. By focusing on your immediate administrator, the vice president of patient services and/or director of nursing, and various department heads who are known to have influence with that final decision-maker, you can significantly influence the CEO or leading vice president's ultimate decision. Equally important is the medical staff. Top administrators rarely make significant decisions without checking with the physicians who staff the facility.

It is critically important that *all* these individuals have a positive perception of the respiratory care service. A pre-existing positive perception about your service will serve as a vaccine against negativity that may be broadcast by consultants anxious to apply their standard template to your organization.

Connecting with administrators

For your service to be viewed as an organizational asset by each of these decision-

makers it must somehow tie into their individual values. Your administrators will want to know what your service is doing to minimize costs and positively impact patient satisfaction. They will need information that ties adherence to clinical practice guidelines and the administration of protocols to low misallocation rates. They will also want assurance that your staff is efficient, as demonstrated by a productivity system that uses valid time standards and methodology they trust. Further, they will look for evidence that your service is entrepreneurial, willing to adapt to change, and dependable.

If you aren't using protocols to deliver a significant portion of your therapeutic services, if you don't have a credible productivity system, or if your service has not recently implemented any cost-cutting or revenue enhancing programs, it will not be difficult for consultants to convince your administration to make major changes in the way respiratory care services are being delivered.

Relating to the DON

A positive perception about respiratory services by the director of nursing is essential to convincing administration that RTs bring value to the facility. Are therapists viewed as cooperative and competent care delivery partners whose services enhance quality patient care? Or, are they viewed as low-skilled technicians who appear, do tasks, then disappear until they are called or a scheduled treatment is due, thus adding little value to quality patient care?

It is critical for these leaders to perceive the respiratory care department as a "can do" service that works cooperatively with other disciplines to implement system-wide change. Once again, without the support of these critical leaders, it will be much easier for consultants to convince top administration that the "cookie cutter" changes in respiratory care services will better serve the organization.

Physician alliances

During the last round of restructuring, many administrators did not seriously consider physician input in the planning process. When the organizational changes into which the docs had limited or no input

began to impact negatively on service delivery and patient satisfaction, the physicians made sure administrators were aware of their dissatisfaction. Administrators have learned from this mistake and are likely to include physicians to a much greater degree when discussions about restructuring begin again.

This can work to our advantage. Like most of us, if something is working, docs are reluctant to change it. If the medical staff perceives that therapists are contributing unique skills and knowledge that assist them in their diagnosis and management of cardiopulmonary patients and believe these skills and knowledge cannot be provided by others in the organization, it is unlikely that they will support any organizational change that would diminish that support. Conversely, if they barely notice the presence of respiratory therapists, they will probably be indifferent and will not oppose changes that diminish the role of respiratory therapists in the organization.

Actions speak louder than words

Key alliances between respiratory care services, administration, nursing, physicians, and other professionals must be solidly established long before the consultants arrive. If the key decision-makers and the medical staff are convinced that respiratory care services are a vital component of their organization, it will be much more difficult for consultants to convince them that a different organizational structure that worked somewhere else will be equally effective in their facility.

The moral of this story? Perception is reality. So, be sure your respiratory care service and all those who represent it demonstrate professional, customer-friendly behavior at all times. If any of your patients decide to write in to their local newspapers about the respiratory care they received in your hospital, let's hope it is only to report that the price they (or their insurance companies) paid was money well-spent. (And you can be sure your administrators will be reading the papers!)

Reference:

1. Giordano, Sam, What We Say versus What We Do, Respiratory Care, June '96, pp. 505-506 ■

Management Bulletin

is published by the
American Association
for Respiratory Care
11030 Ables Lane
Dallas, TX 75229-4593
(972) 243-2272
FAX (972) 484-2720
e-mail: info@aacrc.org

Kelli Hagen

AARC communications coordinator

Debbie Bunch

Bulletin managing editor

Edwards Printing

Bulletin typesetting

Section Chair and Bulletin Editor

John D. Kimble, Jr., RRT, RCP
Director, Respiratory Care Services &
Sleep Diagnostic Lab
Scott & White Memorial Hospital
2401 S 31st St.
Temple, TX 76508-0001
(254) 724-2179
FAX (254) 724-7630/724-7572
jkimble@swmail.sw.org

Medical Advisor

Martin Sheridan, MD (ACCP)
(410) 682-7626
FAX (410) 682-8044

Notes from the Guest Editor

by Susan Rinaldo-Gallo, RRT, MED, system manager, respiratory care services,
Duke University Medical Center, Durham, NC

This issue of the *Bulletin* is organized slightly differently than previous issues. The past few issues contained articles representing regions or areas of the country or entire states. This issue is a collection of articles from the managers I work with at Duke University Health Systems. When presented

with the idea of contributing to the *Bulletin*, they all agreed that it would be a worthwhile experience. Putting this together proved to be just that, and more. The individuals who contributed all have different focuses within

"Notes" continued on page 3

“New Service” continued from page 6

pressure breathing (IPPB) treatments, insert endotracheal tubes, and manage mechanically-ventilated patients. IPPB can serve as the “poster boy” for a service’s life cycle, as it grew to become a very popular modality before entering a decline phase when an alternative, equally effective method (hand held nebulizer) was identified. To sustain our department’s growth and help ensure the ongoing employment of our staff, we constantly monitor and evaluate the ordered frequency of each department activity and keep abreast of advances in technology and research that may affect our clinical practice.

Three decades ago, Frederick Herzberg proposed that workers are motivated by factors such as achievement, recognition, the work itself, responsibility, growth, and advancement.¹ Our experience with “job enrichment” tends to support Herzberg’s theory. Over the past 35 years, the role of our respiratory therapist has grown to include the delivery of complex technical services that are recognized by the other members of the health care team as adding value to the medical center’s mission of providing high quality patient care. Our practitioners are perceived as integral members of the health care team and take great pride in knowing that their contributions are appreciated.

How is a new service identified?

Paying close attention to our internal environment helps us anticipate and recognize opportunities. Our managers and clinical staff members participate on both hospital-wide and unit-centered committees. We monitor changes in hospital operations and physician practice and look for situations where we might apply our knowledge and skill.

For example, arterial cannulation had long been a critical care procedure performed by residents and medical students. Insertion of an arterial catheter as soon as possible after a patient is intubated and placed on mechanical ventilation is one of our main patient care standards. In 1996, the hospital decided to reduce the size of its residency programs. We thought that this decision would increase the resident’s patient caseload and place greater demands on their time. Since our staff was already skilled in arterial puncture, we felt radial artery cannulation was a service we

could effectively and efficiently provide with minimal education and training. Transferring the responsibility to the respiratory therapist has allowed the resident time to address other, more important, issues.

Is it something we want to do?

When it comes to new services, we try to “stick to the knitting.” This is an expression that simply means, “do what you do best.” Clinical services that directly relate to our professional education and training, as well as our department’s mission (i.e., services related to the diagnosis and treatment of cardiac and respiratory diseases), present the best opportunities for growth.

We need to answer a few important questions

We try to predict the impact the new service will have on our staffing and department operations by gathering enough information to answer the following questions:

How many of these procedures will we perform? To help predict the demand for the new service, we look at historical data. If data are not available we may ask our customers (physician group) how often they will request the service or simply make an educated guess based on our clinical observations.

How much time will it take to perform the new service? If the procedure is one performed by other respiratory care departments, a time standard may be found in the AARC’s Uniform Reporting Manual. In our institution, the management engineering department assigns time standards to clinical procedures.

Do we have enough staff to take on this new service? Once we have a volume estimate and a time standard, we can predict the impact the new service will have on clinical work assignments.

Is this a billable procedure or will we do it for free? Billable procedures are a good thing. But some new services add value to the department even though they may not be billable. We pursue services because they add value to our patient population and meet the “stick to the knitting” test.

Will this service be reflected in our productivity numbers? Our productivity is primarily based on billable procedures. We argue for productivity credit for non-billable procedures because they add value to patient care and support the mission of the

medical center.

What kind of equipment will be needed, how will it be purchased, and who will pay for it? We prepare a cost analysis of capital equipment, equipment rental, supplies, and the purchase of disposable items.

Test the waters

We try to determine if there will be physician support for our idea before we submit a written proposal for the new service. The idea is first presented to our medical director. We are fortunate enough to have a medical director who is actively involved in department activities and who supports and encourages our continued growth. Since his signature is on each of our policies and procedures, there isn’t any point going any further until he is on board.

After we have our medical director’s approval, we informally discuss our plan with the physicians who will be utilizing the service. We describe the problem, outline our solution, and emphasize the benefits that would accrue from having respiratory care provide the service. Once support is obtained we can proceed to writing the proposal.

A simple plan

Our proposals are generally brief and to the point. We outline the main points of the plan: the problem being addressed, our solution, and the expected outcome or benefits. We also include a section on financial considerations, as well as a section on implementation that identifies the personnel involved and the education and training that will be required. Although we want enough data to support our proposal, we try not to over analyze — we may miss the opportunity if we fail to act quickly.

Because of its continued growth, respiratory care is a more interesting, challenging, and satisfying profession than it was when I first donned a lab jacket some 25 years ago. As managers, we should continue to do all we can to foster its growth into the next century.

Bob Campbell can be contacted via email at campb003@mc.duke.edu

Reference:

1. Herzberg F. One more time: how do you motivate employees? *Harvard Business Review* 46(January-February 1968):53-62. ■

Monitoring Productivity for Respiratory Care

by Susan Rinaldo-Gallo, RRT, MEd, system manager, respiratory care services, Duke University Medical Center, Durham, NC

The current health care environment has caused changes in the way respiratory care departments operate. Departments are now held accountable for productivity as never before. At Duke University Health System,

the management engineering department monitors our productivity via a system that is primarily based on billable procedures completed. Travel time, documentation, breaks, report, physician rounds, education,

and other daily activities are factored into complicated formulas and called “fixed time.” The handful of non-billable

“Monitoring” continued on page 8

“How to Evaluate” continued from page 5

5. Reliability: Does the product have a track record of performance? Does the company offer product service and warranties?

The product champion may want to consult with other members of the department to answer these questions. An experienced clinical staff member might be the best resource to assess a product's clinical application. A short, controlled clinical trial might be the best method to determine how user-friendly the product is and how well the product performs. A clinical educator can provide the best estimate of training needs. The department manager may be able to justify the purchase of a more expensive product if it produces cost savings in other areas.

Functionality and reliability may be the most difficult areas to assess, and many departments stop short of investigating these aspects. This is particularly true if the department does not have the experience, time, or resources to carry out an effective investigation. Assessment in that case would be based on the product information provided by the manufacturer. There are several different sources of product information:

- **Independent Lab Testing:** An independent lab test report (i.e., ECRI) is least likely to be biased and therefore should be a reliable source. Usually, the report will quote ISO or other standards by which testing was regimented. Obtain as much information as possible about the specific test performed and standard used. Keep in mind that products are usually evaluated to minimum standards. All products should perform at minimum standards. However, is the minimum standard acceptable? Do other products perform better? Proceed with caution if you only receive a partial report. Sometimes the company has a reason for not wanting you to see the complete report — ask for a complete report anyway.
- **Manufacturer Testing:** Obviously, this type of testing has the potential to be biased and self-serving. But don't arbitrarily disregard the manufacturer's test results. Many times a company will not have a resource for independent testing, especially if the equipment or device is “cutting edge” technology.
- **Testimonials:** Learn to differentiate testi-

monials from reported clinical experience. Testimonials tend to make judgments and draw conclusions without backing them up with organized information or data collection. Many times they state the opinion of one expert or clinician. Ask if you can contact the individual for further questions or more specific information.

- **Journal Abstracts:** Journal abstracts are short, one-page summaries that may report preliminary data from a study or summarize a manuscript. If the abstract has no associated manuscript, the study or investigation may still be in progress, incomplete, or have resulted in data that were not strong enough to publish further. Do not base your decision on an abstract alone — seek out the associated manuscript.
- **Manuscripts:** Manuscripts from peer reviewed journals seem to contain the most compelling information. Though highly reliable, they are not faultless or without limitation. You should undertake your own critical review when considering the information. Things to weigh in the balance include the study design, human or animal population studied, power and statistical significance of the data, sponsorship, reputation of the investigator or the institution, and any references cited. You will also want to note the difference between comparative studies to predicate devices and evaluations focusing on a single device
- **White Papers:** White papers are documents produced by the company marketing the product. White papers usually contain a descriptive narrative, a list of functions and operational characteristics, and product specifications. A white paper may also include one or more references to other types of documents previously described. Consider that white papers are designed and constructed in a manner to market the equipment, so review them critically and ask lots of questions.

Once all the documentation has been reviewed, the product champion may decide to test some of the published characteristics. Many times a bench study can be easily set up and carried out. A clinical engineering or biomedical department may be able to provide some needed testing equipment. Although it may not be necessary to com-

pletely recreate an entire testing or study situation, your bench study should prove repeatability of specifications. A bench study that validates the product's test performance should add confidence to your ability to recommend the product for purchase.

After all the information and data are collected and analyzed, the product champion submits a written report to the committee for review. The report should include a summary of only the most relevant information; too many facts and figures may overwhelm the committee and bog it down in excessive discussion. The committee may ask the product champion for additional details as necessary for clarification and edification. The report must also include a recommendation that should take one of the following forms:

1. Information strong enough to warrant a decision to purchase.
2. Worthy of merit. Enough information to suggest a clinical evaluation for a specified period in a controlled environment.
3. Further information and investigation is needed (including suggestions on who could provide that information and how it might be obtained).
4. Not worthy of further consideration at this time.

If the recommendation is for further information or investigation, the committee should consider a trial of the device or product. Since this will consume resources, the group should agree that there may be some value in its pursuit. We suggest that the trial be done in a very controlled situation with specific goals in mind. Decide ahead of time the information you would like to collect, and provide a form or survey for feedback. A summary of the evaluation with recommendation should be presented to the committee for consideration.

Remember, the committee need not make all the decisions. Recognize the obvious, and don't waste time discussing or evaluating products that won't work for your service. Recognize your internal resources and utilize them. Organize your approach to evaluations in ways that make your department function more efficiently.

Bob McConnell can be contacted via email at mcon003@mc.duke.edu ■

Starting a New Service

by Robert B. Campbell, MBA, RRT, clinical educator, respiratory care services, Duke University Medical Center, Durham, NC

We are frequently contacted by respiratory care managers who request information about the clinical services that we provide to patients at Duke University Medical Center. Many of these managers are looking for information that will assist them in starting a new inpatient service at their institution. Although I'm sure we take a fairly typical approach to the subject, in this article I will review our philosophy and

highlight our process for evaluating the feasibility of, and gaining approval for, adding a new service to our scope of practice.

Why take on something new?

Promoting department growth and providing job enrichment are the two main reasons we have to add new services and expand our scope of practice. We view our

department as a company that offers a line of products, each having a life cycle of birth, growth, and decline. Born in the mid-1960s, we experienced a period of sustained growth that lasted for approximately two decades. This period of growth was driven by the hospital's need for skilled practitioners to administer intermittent positive

“New Service” continued on page 7

"Notes" continued from page 2

our department.

As respiratory care managers, we are often asked to take on new things, and occasionally we see things we would like to do or feel respiratory care could or should do. Bob Campbell (the AARC member from North Carolina, not Ohio) is our education coordinator, and he contributed an article about the things a respiratory care department should consider when taking on a new service or responsibility.

Janice J. Thalman has contributed two articles. The first is on methods to keep your

staff motivated and interested. This can be a challenge, particularly because most managers these days are dealing with more experienced staffs who need a different type of motivation. Jan's second article concerns a new restructuring concept that is taking place at Duke called Central Business Units (CBU). The CBU style of organization has been implemented in other institutions, although it has taken a slightly different form here.

Bob McConnell, our research associate, has written an article on things to consider when purchasing new equipment or switching manufacturers for existing equipment. He explains the process we use here and the

types of information that are available to facilitate the process.

Lastly, I have submitted an article on how we measure daily productivity.

I hope these articles are meaningful to Management Sections members. Although we are a large medical center, aspects from each of these articles can apply to any type of health care facility. I would like to thank my co-workers for their enthusiastic support in contributing to this issue of the *Bulletin*. They are all very busy, but somehow they managed to do one more thing. ■

Keeping Interest High While Salaries and Benefits Decline

by Janice J. Thalman BS, RRT

Health care hasn't been a picnic over the past few years. No new news there. Providing the motivation necessary for respiratory therapists to keep a positive attitude in a profession with dwindling resources has not been an easy task for managers. When you ask senior staff, "What keeps you here?" the answer is obviously *not* the money or the hours (night shift, Christmas Eve, etc.). The answers that do come out time and again have more to do with the "variety" in the job, the fact that RTs are "never bored," and the "respect" that RTs get from the physicians and other health care providers.

Variety: The spice of RT life

The routine scope of care at Duke University Medical Center is like that of many institutions: fully packed. Intubation, extubation, bronchoscopy, arterial line insertion, nitric oxide, heliox, and CO₂ gas therapies are the norm. So are mechanical ventilator management, oscillatory ventilation, trach weaning, ABGs, emergency care, hyperbaric medicine, NIV, bronchodilator therapy, ECLS, and neonatal and pediatric care and stabilization.

This traditional scope of practice requires a high level of skill and commitment. The variance in the daily routine ensures that none of it becomes "routine." However, as the profession matures, it is the non-traditional scope of practice that has served to retain staff and provide a key motivational source for the seasoned practitioner looking to add spice to his or her RT life. Some of these opportunities are "one time shots," while others lead to tradition. It is the ever-perceptive and alert staff that snags some of these opportunities. Here are just a few of the opportunities that we have taken advantage of at Duke:

Out-of-hospital care

Every year the Duke department of surgery goes to Nicaragua on a mercy mission to perform pediatric heart procedures.

For the last two years, RTs have been included as members of the care team. This is a two-week commitment. The RTs involved do a substantial amount of work to get ready, and they work long, hard hours while they are there. They are assisted with schedule considerations and given a few tuition dollars for Spanish classes that are offered within the health system.

Recently, another RT went on transport with a patient to Taiwan, the patient's homeland. The therapist was responsible for total ventilator management. Additionally, the RT provided training to the medical staff at the hospital in Taiwan.

Annually, Duke Pediatrics sponsors a camp for sick children. Most of these kids do not get an opportunity to stray far from their parents due to the severity of their disease. "Camp K" allows both kids and parents a much needed reprieve from each other. The level of health care providers needed to "man" the camp is extensive. Each year two RTs attend the camp. Their role is a combination of counselor and care provider.

Education

RTs who enjoy teaching others can take advantage of the department's active involvement in a number of educational endeavors that depend on the expertise of an RT. RTs are formally involved in orientation and skill workshops for physicians, nurses, the Life Flight transport team, the trauma team, and area hospital outreach programs. The appreciation they receive for these efforts goes a long way in providing a positive influence in their day.

Therapists from the department have also participated in training for the sales force of a mechanical ventilator manufacturer. This was a two-day program that tied together technical application from the manufacturer perspective to that of the actual clinical user. A spin off of this program has been a manufacturer-supported user training program, which focused on

RTs from other hospitals that were recent buyers of the technology.

Therapists from the department, along with the medical director, are part of the annual faculty for the American College of Chest Physician's (ACCP) two-day mechanical ventilator seminar as well. Spending two days at a great location teaching other professionals what we know best is quite an RT esteem builder.

Research

Opportunities are available to all RTs who are self-motivated enough to organize a study, collect the data, and write it up. The excitement that is generated by having an abstract published and/or presenting one at a national or state meeting is second to none. Abstract presentations usually lead to formal presentations at seminars and professional meetings. Duke RTs have presented several abstracts at meetings held by the AARC, ACCP, American Thoracic Society, Society for Critical Medicine, and the North Carolina State Society for Respiratory Care, as well as neighboring state and national functions.

Within the hospital

Our therapists are active in JCAHO peer review rounds, the information systems work group, the product standard and evaluation committee, hospital ACLS instruction, and the "Code 5" committee, to name a few. This exposure gives others an opportunity to get to know us, and the RTs involved become department resources.

Professional involvement

Encouragement and support for professional involvement is yet another means of keeping the interest ratings high for RTs. Our department has several RTs who are active on the committees of state and national organizations. Some have even served on the boards of directors or as officers of these organizations.

"Keeping Interest High" continued on page 4

"Keeping Interest High" continued from page 3

Go Blue Devils!

Advanced therapists are members of the emergency Code 5 team within the hospital. The Code 5 team supports the Duke athletic department by providing emergency coverage for all of the Duke University basketball and football games. Two RTs are selected to attend each home game (center court seats). To qualify for game coverage, one must be airway certified. As you might expect, we don't have to offer many other incentives to get our staff members to complete the airway certification requirements!

Just a little respect

Respect is a seven letter word that comes with a high price tag. You can't buy it, you can't mandate it, and you can't rest on your laurels once you have it. How do you get it? We have a motto: the three "A's" . . . availability, affability, and ability. We start by hiring smart RTs. Then we enforce high standards for attendance, response time, relationships with others, and clinical sophistication.

Specific attention is paid to fostering the RT-physician relationship. Part of our job is to "make the Doc look good." We begin that process by providing resident training on mechanical ventilation the first day the residents are assigned to the intensive care units. These are scheduled in small groups at the request of the

attending physicians (our past resident proteges). The resident begins to get comfortable with ventilation, yet realizes how much there is to learn. First contact has just been made with one RT resource that will surely help along the way.

"Core teams" of therapists are assigned to specific ICUs. People see the same faces every day, relationships develop, a team is born, and respect rallies. The core team selections are based on several considerations; one is matching the personality of the RT to the personality of the unit. The RT rounds with the physicians on the mechanically-ventilated patients. At this point, they work together to establish the game plan or protocol for the shift, and then the RT goes about the work of "making the Doc look good."

All physician orders are received as consults. A therapist then assesses the patient and does one of three things: enters the order to be done as ordered, implements a protocol, or customizes the order to better suit the patient needs. The physicians are very appreciative of this service because it makes them look good. As the residents go through their years at Duke, they remember their early interactions with the RTs. The level of support they provide in the years that follow is instrumental in our advances and opportunities.

Where do you get the resources?

How can you offer all of this excitement and career opportunity when payroll dollars are attached to productivity measures resembling those of a Chrysler auto plant? Dig around — you'll have to challenge the creative side of your brain.

Some of the training and offsite care provisions we have been involved with have had fees associated with them. Any profits from these endeavors are put into a department discretionary fund. These funds can be used to support travel for department members to present abstracts or attend seminars. Innovative scheduling can give staff "off" days without the use of paid time off. Activities are also scheduled during a 36-hour work week. This enables the department to pay for some RT participation without using overtime. Incentives for active participation and presentations have been built into the department performance evaluation process. Going the extra mile will generate an "exceeds expectation" rating, and that translates into a higher annual percentage pay increase. In addition, some individuals participate in extra activities on their own time for their own growth, experience, and marketability.

Build it and they will stay

Build a department on tradition and the basics, grow the department on venturing out from both of these, *and they will stay!* ■

Ancillary Care Coordination: Staying Alive as a Professional Service in a Clinical Business Unit Design

by Janice J. Thalman BS, RRT

Duke University Health Systems is developing a business design referred to as Clinical Business Units (CBUs). Nine business units have been identified: Children's, Heart, Transplant, Women's, Emergency Services, Medical/Surgical Critical Care, Neuro/Muscular Skeletal, Oncology, and Psychiatry.

The CBU structure was created with objectives *similar* to those of other health care redesign efforts in mind. The structure would:

- Create flexible systems and services that respond to the financial pressures of lower reimbursement from payers
- Create accountability at the department and business unit levels
- Align CBU patient population needs with services provided by ancillary professional services
- Develop consistent utilization management and discharge planning processes throughout the system
- Maximize efficiencies and care delivery systems

A *unique* twist to the CBU structure is how the ancillary professional services

fared in the clinical redesign. An ancillary care coordination team was launched. This team consisted of the department heads/managers of:

- Advanced Practice Nursing
- Case Management
- Discharge Planning
- Nutrition
- Pastoral Care
- Pharmacy
- Physical/Occupational Therapy
- Physician Assistants
- Respiratory Care Services
- Social Work

The coordination team identified a set of core values to adhere to during the change process. These core values included:

- Recognizing the contribution of each individual discipline
- Understanding that CBU patient populations may have different needs
- Viewing efficiency as *not* across-the-board cuts or uniform skill mix changes
- Supporting that certain business processes remain consistent across the organization

Numbers

Data were presented that reflected operational statistics for each CBU. The total number of FTEs involved from all ancillary professional services was 554. This information was further divided by specific service. Respiratory Care Services (RCS) represented 94 of the FTEs and 17% of the ancillary resources spread over all clinical CBUs.

Role delineation

Each professional service submitted discipline standards. The content included the:

- Type and scope of service
- Skills and availability of staff (i.e., advanced level practice, basic level practice)
- Technical support
- Educational/credentialing requirements.

References used to support the discipline standards included any applicable federal or state law, licensing specifics, JCAHO dictums, national and state clinical practice

"Staying Alive" continued on page 5

“*Staying Alive*” continued from page 4

guidelines, and department and hospital policy and procedures.

Contract negotiations

Each CBU was organized using the same leadership structure: a medical director and an administrative operating officer. The leadership of each CBU negotiated services (not FTEs) with each of the ancillary department directors. Considerations during the agreement process included:

- Adhering to discipline-specific standards
- Matching CBU clinical priorities and budget targets with professional roles
- Identifying any duplication of clinical services currently provided
- Identifying opportunities for cross-training individuals without “deprofessionalization” of clinical providers
- Using consistent human resource practices across professions
- Identifying education and training resources
- Maintaining department management structure

The agreement contract has specific clauses for ongoing dialogue between CBU and department directors, performance measurements, dispute resolutions, amendments to services (new clinical procedure requiring more resources), and termination or transfer of services.

Balanced scorecard

The overall performance of each CBU is based on the efficiency and contribution of all services within that CBU. This is measured through a “Balanced Scorecard,” a measuring matrix comparing four business perspectives: *financial perspective*, (operating margin adjusted cost and discharge), *internal business perspective* (medication safety, nosocomial infection rate, LOS), *customer perspective* (patient satisfaction, patient access and flow), and *internal growth/learning perspective* (absenteeism, staff satisfaction, employee suggestions implemented, publications).

Challenges for RCS

Our traditional department responsibilities remain centralized: human resources, professional development, productivity, technical support, capital selection, and accountability for the total revenue and expense budgets. Accurately identifying the resources that should be “charged” to a specific CBU is difficult. By using the RCS information system, we are able to identify the procedures performed on areas attached to each CBU. The procedures have time standards assigned to them so that the amount of the therapist’s time spent on each CBU can be identified. The average rate of RT pay is then used to put a human resource dollar figure to the CBU demands.

The ancillary department-CBU agreements are to supply services, not a specified number of FTEs. Key to the department budget success is using the staff to the most optimal scheduling capabilities. Key to the CBU success is assigning a consistent core team that can influence and participate in the overall success of the CBU.

The RCS scheduling process attempts to accomplish both consistency and efficiency. Core teams of RTs are assigned to each CBU. The number assigned is based on volume trends and *minimal* requirements. A centralized float group is then used house-wide to offset high volume areas and critical procedure times.

What is decentralized in this model is the input necessary to operate the individual departments. Each business unit administrator, as well as the unit medical directors, must participate in the overall planning, objectives, resource utilization, and clinical scope. Changes in CBU direction or priority can have a major influence on the individual department budgets and staffing allocation. This model is incredibly time-consuming for the ancillary department managers and requires sharp skills in negotiation and diplomacy.

The early phases are proving to be successful. The end results seem to be pointing to an organized approach to patient care, closer eye to detail before implementing change, and a true “team” structure in working toward common objectives. ■

How to Evaluate New, Improved, or Less Expensive Technology and Supplies for your Department

by Robert R. McConnell, Jr., BS, RRT, clinical trials/research specialist, respiratory care services, Duke University Medical Center, Durham, NC

Manufacturers’ representatives frequently meet with department managers to introduce supplies, devices, and equipment that are touted to offer potential benefits in terms of cost, improved patient care, or superior product performance. To support their claims, manufacturers often provide documentation of laboratory testing, user testing results, or research study results. Regardless of how impressive and persuasive the sales presentation, a manager needs to focus on real benefits to patients, the staff, and the department. How do you sift through all the information being presented? How do you compile enough evidence to make a case for including the product or device in your inventory?

In this article I will offer some suggestions for improving your department’s ability to make a purchasing decision in a timely and effective manner. Many departments already use one or more of these techniques. But even though some may be familiar, I hope others may be ideas you have not yet considered.

The methods you use and the extent to

which you evaluate new devices and supplies will depend on the size of your hospital and staff. It is important to organize your approach and develop a strategy that works for your institution. Many departments have an individual who serves as the liaison to all the manufacturers’ representatives and has the power to negotiate and sign contracts. While this is an important role, forming an equipment committee to review and make recommendations to this individual can be a very effective approach to product evaluation. To be effective, the committee should be relatively small (2-5 members). Committees that are too large sometimes have trouble reaching consensus. These committees should also be made up of individuals with different points of view. For example, the committee needs a representative from management to provide a financial and budget perspective. Another member should represent the educational and clinical point of view. And, whenever possible, the committee should include a representative

from the clinical engineering or biomedical division.

The committee should appoint an individual to review product literature and evaluate the product in terms of its application, impact, cost, functionality, and reliability. This “product champion” should have a high level of interest and motivation and should also have clinical experience with similar equipment. The evaluation process should address several critical questions:

1. Application: What features and functions improve or make patient care safer or more effective?
2. Impact: How will it affect your staff and department with regard to education, training, and productivity?
3. Cost: How can you justify making a recommendation to purchase a product that is more expensive than the competition?
4. Functionality: Does the product do what the company says it will do?

“How to Evaluate” continued on page 6