



# Management Bulletin

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## Notes from the Editor: The Three "R's" of Respiratory Care: Responsibility, Responsibility, Responsibility

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

I hate listening to the news these days. Almost every day you hear of some individual or group shifting the blame for their latest faux pas on someone or something else. If an elected official is caught in a compromising position with someone not necessarily his spouse, he blames the pressure of politics or the loneliness of the campaign trail. If a child is expelled from school for cheating, he blames the pressure of school or his parents. Does no one take responsibility for their own actions anymore? Responsibility is an easy term to define, but a difficult virtue to live up to.

I began my respiratory care education in 1979 at Saint Philip's College in San Antonio, TX. I started my first job in respiratory care that same year on Christmas Eve. Although I have held multiple positions in respiratory care, I am first and foremost a therapist. A respiratory therapist, in my opinion, has the following responsibilities:

1. To remain competent in the field of respiratory care. A respiratory therapist cannot stagnate; you cannot think that because you've graduated and gotten your credentials that learning is complete. A respiratory therapist must continue to educate himself through college courses, seminars, new and revised textbooks, medical journals, and inservices. If you work primarily with adults, increase your pediatric skills. If you are primarily a general care therapist, increase your knowledge of intensive care equipment and procedures.
2. To develop excellent "soft skills." By this, I mean communication skills, conflict management skills, team building and teamwork skills, presentation and public speaking skills. We work with people, on people, and through people. These people have faults, perceptions, misconceptions, prejudices, and altering viewpoints. Sometimes these people are our patients, sometimes they are our co-workers, sometimes they are our

bosses. We can't let these people ruffle our feathers. We can't respond in kind in any situation.

3. To develop a service attitude. We need to be ever mindful that we must do what is necessary to improve the health status of our patients, the operational efficiency of our departments, and the financial standing of our institutions. This is achieved through service. Our main goal needs to be not just meeting, but exceeding the expectations of our patients and employers.
4. To become comfortable with change. New drugs, new procedures, new equipment, and new regulations call for new ideas, new processes, new ways of thinking. If we are stuck in the "good old days" mindset, we will not be able to meet the expectations of the change. When faced with what may seem like impossible tasks, we have to resist the temptation to succumb to the "it's not fair" syndrome and look for ways to succeed with change. As Eleanor Roosevelt said, "You must do the things you think you cannot do."
5. To be able to separate from a work setting that either is not meeting your needs or is one in which you are not meeting the needs of the work setting. I get very tired of hearing, "same s\_\_\_, different day," when I ask people how it's going. If you feel this way at work, you need to consider changing your position, your department, or your hospital. Let's face it, we work for a multitude of reasons. Most therapists will say they got into the field to help people, but we also work for a good salary, for a sense of belonging, for promotion, etc. If your individual needs are not being met, you can become bitter, resentful, and uncooperative. You need to find a setting where your needs can be met OR you need to reevaluate your needs. ■

## **In My Opinion: The Impending Human Resource Crisis in Respiratory Care**

by Tom Johnson, MS, RRT, director, division of respiratory care, Long Island University, Brooklyn, NY

According to AARC President Kerry George, the Human Resource Survey determined that 7,797 budgeted staff therapist positions are currently unfilled. This implies that new graduates of the nation's respiratory care programs are having little difficulty finding jobs. Conversely, respiratory care managers are competing with each other for this limited pool of new employees and working hard to retain the staff they currently have. As we proceed into the new decade, new grads will be happy to learn that they can expect more of the same. Unfortunately, the situation for managers is only going to get worse. Respiratory care programs are experiencing a serious downturn in enrollment. Some programs are closing and others are in the process of closing.

Within two years, the human resource shortage will really hit managers hard. Staff overtime (mandatory and voluntary), agency pools, and creative scheduling

will again be the norm. It is "Back to the Future" all over again. As a manager who could not find replacement staff during the last manpower crisis in the 1980s and early 1990s, I know firsthand the nightmares that personnel shortages can cause. The profession weathered the "Perfect Storm" of the 1980s staffing shortage; however, this new one is more powerful than the last. This shortage comes about without a clear causality. There is no AIDS-like disease scaring young people out of a career in health care. There is only low unemployment (unemployment was high in the late 1980s) and a booming economy. The source of this manpower shortage is multi-factorial.

We all learned LaPlace's Law. Now, our profession may become a victim of that law. The larger alveolus of nursing may finally absorb respiratory care. After all, how many people, other than those who have actually had a respiratory therapist care for them or a loved one, have ever even heard of "respiratory therapy"? And how many of those may have assumed those therapists to be nurses anyway?

At the Summer Forum in Vail, CO, Dr. William Turner, Dean Emeritus of Michigan State University, noted that only 5,000 high school students even know what a respiratory therapist is. It is difficult to sell a profession that most people are not aware exists. He says, "There is a high level of invisibility that is a serious marketing problem for respiratory care." In preparing for his presentation at the Summer Forum, Dr. Turner learned that two programs recently closed due to low enrollment. Respected programs in the New York City region will close by June 2001. There will be fewer programs, and the existing programs will be producing fewer new graduates to fill staff positions.

All you have to do is read the want ads to see evidence of this condition. There are sign-on bonuses. Agency and pool work are being offered. The facts are clear. What can be done to forestall or at least soften the punch of this crisis? I believe we need to increase our visibility among our patients, our peers, and our public.

How many of our staff therapists have been misidentified as nurses or doctors? Our badges have also been mistaken for those worn by physician assistants or

physical therapists. Our profession needs a clear and recognizable logo. It worked for Nike and Reebok – why not respiratory care? The color and logo design must be nationally coordinated and implemented. We will need professional marketing assistance in this endeavor. A patient and his supporters should be able to recognize a respiratory therapist at a distance and not have to squint at small print on a name badge. The term registered respiratory therapist should be as familiar as that of registered nurse.

The staff respiratory therapist must become a walking billboard for the profession. He should be wearing an embroidered lab coat or scrub top with appropriate patches, e.g. RRT or CRT. This increased visibility should engender some esprit de corps. Of course, it will be up to each manager to assure job satisfaction to the best of his ability. The test will be for managers to resolve conflicts and motivate their staff. Managers must make their staff multi-skilled. Use TQM/CQI data to show the staff therapists their successes. This is the way to build morale. Show them that they have been successful. Success breeds success.

The AARC and its local chapters can help by sponsoring sporting events and supporting public radio or TV programs. TV audiences should hear that, "Sesame Street is sponsored in part by a grant from the American Association for Respiratory Care." Radio spots must be supported in every major demographic area. Radio messages could say something to the effect of, "This respiratory therapist saved a life last night while you slept." We need a media campaign designed on Madison Avenue to reach out to the public at large. The public has to learn about our profession. We have counted on our asthmatics, COPDers, and CF patients to inform others about us. Evidently, we have asked these sick people to do what we were unprepared to do for ourselves. How many of us have been to a social function, and when asked about what we did, we said, "I am a respiratory therapist." What was the response? The person to whom we were speaking probably never heard of respiratory care or respiratory therapists. This is the reason we need a nationwide advertising campaign. No more small measures; we must finally take bold action.

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The AARC, NBRC, and CoARC will have no reason to exist if there is not a clinical therapist to service. The parents of every high school senior in America who takes the SAT should receive a letter from the AARC addressing the profession and listing the nation's respiratory care

programs. RC educational programs must send letters to every high school student who has his College Board scores sent to the college. The AARC has developed a marketing letter template for programs to use in this regard. Educators need to copy it onto the letterhead of their programs and get it into the mail.

Respiratory care vendors have gone through considerable pain to develop,

produce, market, and improve their products. They must be brought into a strategic alliance with our Madison Avenue advertising, the AARC, clinical therapists, managers, and educators. This will be the surfactant that will stabilize our alveolus and improve our function. We must begin immediately. ■

## Call for Comments on NCCLS Quality System Model for RT Services

by Susan Blonshine BS, RRT, RPFT, FAARC

AARC encourages respiratory therapists to comment on the National Committee for Clinical Laboratory Standards (NCCLS) document, HS4-P, A Quality System Model for Respiratory Services.

In May of this year, the NCCLS published the first in a series of discipline specific documents based on GP-26, A Quality System for Health Care; Approved Guideline. The first in the series is HS4-P, A Quality System Model for Respiratory Services. Members of the working group include Garry Kauffman, MPA, RRT; Carl Mottram, BA, RRT, RPFT; Karen J. Stewart, MS, RRT; and Marta Tingdale, BCA, RRT, RN. The guideline provides a structure for a comprehensive, systematic approach to build quality into the respiratory service's processes, assess its performance, and implement quality improvements. Respiratory therapeutics and pulmonary diagnostics are used as specific examples, with the understanding that this system can be implemented in any service area.

The Institute of Medicine report listing "medical errors" as a major cause of mortality and morbidity in today's health care system should prompt all health care professionals to assess their systems. Building a quality system has been discussed previously in Edward Deming's work and is the cornerstone of the Malcolm Baldrige award. Several years ago, the Joint Commission on the Accreditation of Healthcare Organizations began changing its focus to one of quality improvement. Despite all of these efforts, medical errors remain a significant concern. The NCCLS document provides guidance very specific to respiratory services, with the intent of achieving the third of five stages of a quality hierarchy. The third stage of the quality hierarchy is defined as the development of com-

prehensive and coordinated efforts to meet the quality efforts.

Before implementing HS4-P, one should be familiar with GP-26. The Model for Respiratory Services builds on this model (GP26-A), which was previously described for health care. A basic understanding of the International Standards Organization (ISO) quality system may also be beneficial. The two primary components of the quality system include quality essentials and the path of workflow. The ten quality essentials as described in GP26 are:

- documents and records
- equipment
- process control
- personnel
- purchasing and inventory
- occurrence management
- internal assessment
- process improvement
- organization
- customer service and satisfaction

These essentials apply to all health care areas. The path of workflow is specific to the service. The pulmonary diagnostic path of workflow as described in HS4-P includes these major areas:

### Pre-test

- patient assessment
- test request process
- patient preparation
- equipment preparation

### Testing Session

- patient training
- results review and training
- patient assessment for further testing

### Post-test

- results report
- interpretation

### Information Management

- information system
- clinical consultation

The respiratory therapeutics path of workflow is described in HS4-P as follows:

### Pre-analytical

- information gathering
- patient assessment
- equipment preparation
- request for therapeutic intervention
- patient preparation

### Analytical

- evaluation of data gathering
- determination of therapeutic goals
- equipment preparation
- patient preparation

### Post-analytical

- institute or suggest an intervention
- outcome assessment

### Information Management

- information system
- clinical consultation

The application of the quality system essentials as a management tool defines the operational philosophies and framework for the quality plan. Defining the path of workflow for each service area builds the framework for defining processes, developing procedures, defining quality indicators, and establishing comprehensive training programs. The document provides a plan for implementation of each phase of the quality system. Multiple references and appendices are included to provide examples for the user.

The NCCLS consensus process allows a proposed document to be open for comment for a six-month period. These comments are essential to the consensus process, and users are encouraged to submit comments. The comment period on HS4-P ends in December 2000. The original working group will reconvene and address all comments, which will be published as an appendix to the approved document. The document may be obtained from NCCLS, 940 West Valley Road, Suite 1400, Wayne, PA 19087-1898, (610) 688-0100. ■

## **Congress Symposium Sheds Light on Quality Systems in RC**

To assist its members in gaining a greater understanding of the application of quality systems in respiratory services (see previous article), the AARC International Congress, held in Cincinnati, OH, in October, featured a symposium entitled "Moving Up the Quality Hierarchy: Applications in Respiratory Care." Speakers and topics

included the following:

- Quality System Essentials that Support Effective Management and Clinical Practice of Respiratory Care, Susan B. Blonshine, RRT, RPFT, FAARC, TechEd, Mason, MI
- Enhancing Clinical Effectiveness Through the Application of a Quality Plan, Marta Tingdale, BCA, RRT,

RN, Baylor University Medical Center, Dallas, TX

- Easier Management Through the Cultivation of Quality, Karen J Stewart, RRT, Charleston Area Medical Center, Charleston, WV

If you missed the session, tapes are available through the AARC office, (972) 243-2272. ■

## **Web-Based Benchmarking Tool Now Available**

by Rick Ford, RRT

While respiratory care managers welcome improvement opportunity, external benchmarking data have not been that useful for many RC departments. Although there are several proprietary benchmarking systems in the marketplace, the respiratory therapy component of many of these systems provides a very limited number of financial and operational indicators. In addition, such components often ignore key clinical quality indicators required to demonstrate the value added by respiratory services, and most do not gather respiratory care demo-

graphic data that are specific enough to enable "like" comparison. RC managers must work collaboratively to ensure that the data are understood, that units of service are comparable, and that information related to the structure of the participating departments is available.

In light of these important issues, the CliniVision Users Group has provided a forum to define benchmarking elements. Through the resources of the University of San Diego California Medical Center respiratory care department, a web-based benchmarking tool has been developed.

This tool allows managers of respiratory care departments to enter information into a comparative database. Participating managers will then have access to the entire database to identify improvement opportunity. This project is in the early stages of development, and you can participate in the first trial of data collection. If you are interested go to: [www-cvusers.ucsd.edu](http://www-cvusers.ucsd.edu) or [www-respcare.ucsd.edu](http://www-respcare.ucsd.edu) and follow the links. (Please note the hyphen rather than a dot after the www - this is correct for UCSD-based web sites.) ■

## **The OPPS and Pulmonary Rehab**

by Trina M. Limberg, BS, RRT, FAACVPR, chair, Continuing Care and Rehabilitation Section

The new outpatient prospective payment system (OPPS), which went into effect in August, divides all patient services into 451 Ambulatory Payment Classifications, or APCs. Services grouped under each APC are intended to be clinically similar and require comparable resources. However, since there are no payment codes that directly relate to pulmonary rehabilitation, the implementation of the OPPS is making it difficult to maintain access to pulmonary rehabilitation services for our patients. As you can see from reviewing the partial APC and CPT code list included in this *Bulletin* (see following article), the CPT codes do not reflect the components of assessment, skill, and supervised exercise training.

Some rehab programs are attempting to cope with the new system by using existing codes, but with limited results. For

example, the CPT code 94799 (unlisted, pulmonary service/procedure) is currently being used by Florida and Arizona in policies put forth by their fiscal intermediaries to bill for pulmonary rehab services. In the APC list, this code appears under the grouping, Level I Pulmonary Tests, which is listed at a payment rate of \$40.24. But because the APCs are based on CPT codes and the CPT codes were lacking in the first place, it is unlikely that rehab programs will fare any better under this code. In my opinion, if rehab programs are going to be instructed to use 94799 under the new APC listings for Level I Testing, payment will be far too low. The other problem I see is that the listing implies that this code will only be billed once for the date of service. If so, that would mean a payment rate far below the cost of delivering the service.

I have also received a number of phone calls from therapists who are billing for rehab services with the 94760 and 94761 CPT codes for oximetry. A word of caution: you must be certain that there is clinical indication to use these CPT codes. Good documentation is always necessary. In addition, please be aware that the Health Care Financing Administration (HCFA) is proposing to eliminate payment of the single and multiple oximetry and will only pay for overnight monitoring as an inpatient.

The AARC is working to develop comprehensive codes that would improve the ability of rehab programs to bill more appropriately under the OPPS. For more timely information, visit the AARC web site at [www.aarc.org](http://www.aarc.org). ■

### **Bulletin Deadlines**

<b>Issue</b>	<b>Date editor must have copy</b>	<b>Date AARC must have copy</b>
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

## Ambulatory Payment Classifications (APCs)

*Editor's Note: The following partial list of APC and CPT codes was provided by Jill Eicher, AARC director of state government affairs.*

The new outpatient PPS divides all outpatient services into 451 groups called Ambulatory Payment Classifications (APCs). Services grouped under each APC should be clinically similar and require comparable resources. Respiratory therapy related services are grouped as follows:

APC	HCPCS	HCPCS Description	Payment Rate		
0031	Hyperbaric Oxygen		\$145.46	94010	Breathing capacity test
	99183	Hyperbaric oxygen therapy		94200	Lung function test (MCB/MVV)
	G0167	Hyperbaric oz tx; no md reqrd		94250	Expired gas collection
0077	Level I Pulmonary Treatment		\$20.85	94375	Respiratory flow volume loop
	94640	Airway inhalation treatment		94400	CO2 breathing response curve
	94650	Pressure breathing (IPPB)		94450	Hypoxia response curve
	94651	Pressure breathing (IPPB)		94680	Exhaled air analysis, O2
	94664	Aerosol or vapor inhalations		94690	Exhaled air analysis
	94665	Aerosol or vapor inhalations		94720	Monoxide diffusing capacity
	94667	Chest wall manipulation		94770	Exhaled carbon dioxide test
	94668	Chest wall manipulation		94799	Pulmonary service/procedure
	0078	Level II Pulmonary Treatment		\$64.97	0368
94642		Aerosol inhalation treatment	\$80.49		
0080	Ventilation Initiation and Management		\$154.19	94060	Evaluation of wheezing
	94656	Initial ventilator management		94240	Residual lung capacity
	94657	Continued ventilator management		94260	Thoracic gas volume
	94660	Positive airway pressure (CPAP)		94350	Lung nitrogen washout curve
	94662	Negative pressure ventilation (CNP)		94360	Measure airflow resistance
0213	Extended EEG Studies and Sleep Studies		\$540.63	94370	Breath airway closing volume
	95805	Multiple sleep latency test		94620	Pulmonary stress test/simple
	95807	Sleep study, attended		94681	Exhaled air analysis, O2/CO2
	95808	Polysomnography, 1-3		94725	Membrane diffusion capacity
	95810	Polysomnography, 4 or more		94750	Pulmonary compliance study
	95811	Polysomnography, w/CPAP		0369	Level III Pulmonary Tests
	95812	Electroencephalogram (EEG)		\$113.46	
	95813	Electroencephalogram (EEG)		94014	Patient recorded spirometry
	95827	Night electroencephalogram		94015	Patient recorded spirometry
	95951	EEG monitoring/videorecord		94016	Review patient spirometry
	95953	EEG monitoring/computer		94070	Evaluation of wheezing
	95954	EEG monitoring/giving drugs		94621	Pulmonary stress test/complex
	95958	EEG monitoring/function test		94772	Breath recording, infant
0367	Level I Pulmonary Tests		\$40.24	95070	Bronchial allergy tests
				95071	Bronchial allergy tests

## Hospitals Continue to Shut Their Doors

Citing severe financial losses and market pressures, 20 acute inpatient hospitals have closed in the United States since January 1 and four more plan to close by year's end, according to a report released late last summer by Dynamis Healthcare Advisors.

The report reveals that 12 of the closed hospitals were non-profit and eight were for-profit. St. Louis leads metropolitan areas with four hospital shut-downs, and Ohio leads the states with four hospital closings. The report defined closure as ceasing to provide acute inpatient health care services. The 20 hospitals collectively had 2,606 staffed inpatient beds and more than 7,500 employees. The majority, 18, were located in urban areas; two were rural-based. Four of the former hospitals still provide some type of outpatient service. Four were part of a hospital network, and their operations and employees were consolidated with fellow network hospitals.

All hospitals in the report publicly cited severe financial losses, the impact of reduced reimbursements, the 1997 Balanced Budget Act (BBA) cuts, and low occupancy as the primary reasons for closure. The highest losses were posted by

Bethesda Oak Hospital of Cincinnati, OH, with a \$19 million loss in 1999, and Mt. Sinai Medical Center of Cleveland, OH, with more than \$24 million in losses in 1999. Only one hospital in the report filed for bankruptcy.

The largest hospitals to close were Cleveland's Mt. Sinai Medical Center (344 beds), Franciscan Medical Center of Dayton, OH (321 beds), and Mercy Medical Center of Detroit, MI (268 beds).

So far, the number of hospitals that have closed in 2000 is reflective of current trends in hospital closings. According to the most recent data from the Department of Health and Human Services' Office of Inspector General, 43 acute care hospitals closed in 1998, which was the highest number since 1992, when 50 hospitals shut down.

"The impact of the 1997 BBA cuts, the 44 million uninsured, and the high cost of rebuilding America's inpatient hospitals to meet outpatient needs are just some of the pressures facing hospitals today," says Scott Keller, president of Dynamis Healthcare Advisors. "For now, financial performance is the most important measure of a hospital's true health. At some point, national, state, and local governments will

have to work together to develop social policies that streamline how health care is paid for and how it will be delivered. In the near future, we won't have full-service hospitals in every neighborhood and in every town. We will have care, (but) it will just be delivered differently."

In the meantime, some ailing hospitals are finding new and innovative ways to avoid shutting their doors and abandoning their communities. "Struggling hospitals are sitting down with their neighbors and discussing what services or programs might be transferred to their hospital campus. This way, no building gets boarded up and new services are brought in. It's definitely a win-win alternative to closing up a hospital and walking away," says Keller.

Dynamis Healthcare Advisors is a Cleveland and Washington, DC-based firm that provides community relations, governance education, real estate management, funding, and request for proposal services to hospitals faced with the dilemma of having to close or eliminate services. For more information on the hospital closure report, visit the company's web site at: [www.dynamis-hc.com](http://www.dynamis-hc.com). ■

## 1999 a Bad Year for Non-Profits

According to median financial ratios released last August by the international rating agency Fitch, an alarming 63% decrease in profitability is one of the many financial statistics outlining a profoundly difficult year in 1999 for non-profit hospitals and health care systems. What's more, Fitch expects most operating and balance sheet ratios to be even weaker in 2000, forcing hospitals to manage expenses more closely, consolidate services where appropriate, and divest of

unprofitable business lines.

"By every financial measure – liquidity, profitability, and capital structure and cash flow – 1999 was a very challenging year for non-profit hospitals and health care systems," says Richard Szalkowski, Fitch associate director. "Fitch anticipates more of the same for 2000, as the transition to Medicare Ambulatory Payment Classifications, coupled with the Health Insurance Portability and Accounting Act of 1996, will exacerbate

pre-existing negative pressures of the Balanced Budget Act of 1997, increasing pressures from managed care payers, sustained losses on employed physicians, and rising expenses."

For a copy of the company's *1999 Median Ratios for Nonprofit Hospitals and Health Care Systems*, contact Fitch Market Services at (800) 853-4824. ■

## Cost Reduction Idea

When Scott Pettinichi, MEd, RRT, RCP, respiratory care director at Cincinnati Children's Hospital in Cincinnati, OH, faced the problem of not having regulators and flowmeters on the portable oxygen tanks stored in various locations around the hospital, he turned to new technology for an answer. He resolved the problem with a

new device that combines a pressure regulator and a flow meter into one unit. This new device has now been attached to all tanks stored in remote locations.

Although he has yet to conduct a full cost analysis, Pettinichi believes he has reduced his overall regulator and flowmeter expense by switching over to this system. If

you'd like more information about this cost reduction idea, you may contact him by e-mail at [Petts0@chincc.org](mailto:Petts0@chincc.org). If you have a cost reduction idea to share with members of the section, read the following article on how to submit such ideas for publication. ■

## 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 in all that time at least some of us have come

up with some unique and/or innovative ways to save money in our departments. Now we need to share those ideas with our colleagues. Remember: if we don't all hang together, we will surely hang separately.

Use the following form to send us the cost reduction strategies that have worked for you, or better yet, simply post your strategies

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"Cost Reduction Ideas" continued from page 6

on the Management Section listserv on AARC Online (www.aarc.org). (If you have

yet to sign up for the section listserv, go to the section homepage on the web site and follow the directions to sign up.) We'll organize and archive the material 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." ■

### Cost Reduction Strategies

Name \_\_\_\_\_  
Facility \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Telephone \_\_\_\_\_ Email \_\_\_\_\_

In our department, we have cut costs by:

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If necessary, please feel free to attach additional sheets.

Please fax to: Bill Dubbs, AARC, (972) 484-2720.

## JCAHO Site Visit Reports

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

### Hospital

St. Joseph's Hospital  
Janet Pangborn

Inspection Dates: July 17-21, 2000

*What was the surveyors' focus during your site visit?*

MD bylaws and practices, restraints, ease in finding things in charting, scopes of care and interdisciplinary focus, and turnaround time of transcribed reports, especially diagnostic.

*What areas were cited as being exemplary?*

Environment of care, living our Mission, our system approach to PI and to HR practices.

*What suggestions were made by the surveyors?*

Assure compliance to licensure requirement, refine criteria concerning behaviors for restraints, assure H&Ps done in timely fashion, keep OP orders for diagnostic studies.

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

In progress.

### Home Care

Apria Healthcare  
Alison Murray  
Alison\_Murray@apria.com

Survey Dates: Multiple survey dates/states from March 2000 to present

*What was the surveyors' focus during your site visit?*

Lots of chart review – complex respiratory patients (vents), O<sub>2</sub>, NPPV. Personnel file

review (looked for license, CPR, orientation documentation, and competency verification), home visits to O<sub>2</sub> and vent patients, staff interviews, equipment processing procedures (cleaning, PM, etc.), performance improvement.

*What areas were cited as being exemplary?*

Performance improvement, home visits to the vent patients, equipment maintenance.

*What suggestions were made by the surveyors?*

Better system to verify that patients are compliant with their therapy – mainly hours of use for O<sub>2</sub> patients.

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

Patient file audit process to verify that the MD orders match what the initial referral source requested and that the patient is using equipment as ordered.

### Home Care

Valley Medical Supply, Inc.  
Deborah Fitzsimons, CRT  
Inspection Date: 11/12/99

*What was the surveyors' focus during your site visit?*

Clinical respiratory services, infection control, documentation, home visits with respiratory therapists and oxygen drivers, prescription compliancy.

*What areas were cited as being exemplary?*

Follow-up care to our patients. The surveyor was impressed with our service and visits to patients (every three months).

*What suggestions were made by the surveyors?*

To improve our care plan and obtain pre-

scriptions from MDs. We were cited for not having a script for a cascade on a vent patient; also for prescriptions that didn't include frequency and route of administration of O<sub>2</sub>.

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

Revised our care plan to include height/weight of patients; home safety assessment; psychosocial concerns; and a new medication record sheet. Also, new standards for obtaining prescriptions from MDs.

### Home Care

Acadia Home Care  
Tom Derchaine  
acadiahc@mf.net  
Inspection Date: 9/98

*What was the surveyors' focus during your site visit?*

Policy and procedures, staff competency.

*What areas were cited as being exemplary?*

Management, staff knowledge of respiratory therapy.

*What suggestions were made by the surveyors?*

Getting certificates of medical necessity returned by MDs in a more timely manner. Placing defective equipment in a separate area.

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

Chase CMNs aggressively, improve communications with MD staff.

If you would like to share your site visit experience with fellow section members, please fill out the following JCAHO Accreditation Report and fax it to the AARC Executive Office. ■

**Management Bulletin**

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**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](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 email address.)

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

2. What areas were cited as being exemplary? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. What suggestions were made by the surveyors? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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