American Association for Respiratory Care's

Management Bulletin

September / October 2002

Notes from the Chair

by Karen J. Stewart, MS, RRT, LRTR

As I write this column in late summer, many of us are getting ready to head to the 48th AARC International Respiratory Congress in Tampa, FL, this October. The meeting promises to be an exciting event for managers - not only because of the wealth of information that will be presented but also because the AARC is once again hosting a "Buying Show." Having the opportunity to strike deals on the floor of the Exhibit Hall definitely adds to the overall value of the convention. I am also looking forward to two sessions in particular: "Getting Hip On HIPAA" and "Patient Safety: Better Safe Than Sorry."

I am also looking forward to meeting many of you at the section meeting. Hopefully, we'll be able to get a lot of new ideas for section programs and benefits for the coming year. However, if you aren't able to attend, rest assured your input can still make a difference. Just email me your suggestions at the address listed on page 2.

I want to take this opportunity to thank those of you who took the time to nominate a peer for Specialty Practitioner of the Year. We received many excellent nominees and selecting the winner was a difficult process. However, we are proud to honor Frank Miller, from the Mayo Clinic, with this year's award. Congratulations Frank!

One note: some of the individuals who were nominated this year were either not AARC members or were not members of the section. These worthy individuals were not considered for the award, because the criteria

Continued on page 4

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). To change your option to the electronic Bulletin, send an e-mail to: 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.

SECTION LISTSERVE:
Start networking with your colleagues via the section listserve. Go to the section homepage on www.aarc.org and follow the directions to sign up.

Management Specialty Practitioner of the Year: Frank Miller, RRT

Frank Miller has come a long way in a short period of time at the Mayo Clinic Hospital in Phoenix, AZ. Initially hired four years ago as a respiratory therapy team lead, he has since risen through the ranks, first becoming supervisor of respiratory care and then adding the cardiodiagnostics area to his title.

Co-workers credit his rapid advancement to his skills as a clinician and his leadership potential, noting that he works to maintain his clinical skills while managing diverse functions in two different work units. He continues to promote the expansion of services involving his respiratory staff as well, demonstrating his understanding and commitment to John Maxwell's Third Law of Leadership, "The Law of Process." He recognizes that "Leadership Develops Daily, Not in a Day." Frank is known as a rock of composure and realizes that his biggest success is the success of his staff.

Frank also demonstrates leadership by volunteering to serve his professional organizations. In addition to serving as president of the Arizona Society for Respiratory Care (AzSRC) and AARC-PACT co-chair, he has served on numerous AzSRC committees and on the Gateway Community College Respiratory Therapy Advisory Board. ◆

JCAHO site visits

Manager #1: I've been an RT director for over 20 years and this is the first time in many, many years that the RT department is on the schedule for the JCAHO survey. We have been allotted 1.5 hours. Does anyone have any recent experience with a visit directly to the department by the physician surveyor? If so, what kinds of questions were asked? What was he/she looking for?

Manager #2: I, too, have not had a departmental visit in years. But my guess would be that they will be looking at all the hot topics we have heard about for the last year or two - stacked treatments, staffing patterns, safety issues, missed treatments, etc.

Manager #3: During our survey in April, the meeting was pretty informal. The physician surveyor asked how many staff members we had. When I told him we had 45-50 (at 400 beds, we get a lot of pulmonary patients) he said, "I have never heard of a respiratory department having that many employees." Sure enough, a few weeks after the survey my staffing was questioned by my CEO, who was present at the time of the survey. The surveyor did not ask to see any employee files. The surveyor also suggested we should start outpatient services, such as IPPB treatments, HHN treatments, etc. He also toured our bronch and PFT lab. He asked my RNs questions about conscious sedation, etc. He was easy to talk to, not pressuring like some others. It was pretty painless. He stayed about an hour. But I agree that JCAHO is really going drill down on respiratory therapy for the items mentioned by (Manager #2). The days of surveyors bypassing RT departments are coming to an end.

Manager #4: We were surveyed this year, and the physician sat down with the staff. He questioned them on our orientation process, their competencies and also about their role in the code responses. He was concerned about their education and training more than anything else.

Manager #5: We just experienced a Mock Joint Survey from corporate. Be prepared, they are hitting hard on staffing issues, concurrent therapy, missed medications, medication storage, documentation on MARS, interdisciplinary team work, and process improvement activities within the department and other hospital PI committees. I gather that all ancillary departments and their efforts to assist in providing patient care is one of the top issues. I suggest you go to the JCAHO web site and review the standards of care and plan of care. ◆

Leapfrog is Having an Impact

Are big hospital chains responding to the goals outlined by the Leapfrog Group earlier this year to reduce medical errors?

You bet. The Sutter Network recently invested $50 million in medical technology and other improvements aimed at following the guidelines set forth by the national consortium of health care purchasers. Among the items on the list: electronic monitoring equipment linking off-site critical care specialists to ICU patients and bar code technology for patient identification bracelets to match and monitor medications.

The original set of recommendations from Leapfrog called for hospitals to implement a computerized system for placing medication orders, use critical care physicians to manage their ICUs and meet high-volume requirements for high risk procedures. ◆

NOVEMBER IS COPD AWARENESS MONTH

Management Bulletin

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

Chair
Karen Stewart, MS, RRT
(304) 348-4367
karen.stewart@camcare.com

Editor
John D. Kimble, Jr., RRT, RCP
jkimblerrt@aol.com

Ventilators outside of the ICU

Manager #1: We are looking at our practice of transferring stable patients who require mechanical ventilation out of the ICU and up to the tele/medical floors. We don't have a subacute facility within our institution, so we simply transfer them out of the units and place them on the floors, as near to the nursing stations as possible, while we wait for placement in a subacute facility. In light of the Sentinel Event Alert issued by JCAHO recommending direct observation of these patients we are reexamining our current practice. How are some of you handling this issue? Do you get sitters to observe? Do you have remote alarms? Please share some of your practices.

Manager # 2: We identified eight beds on our telemetry unit for a step-down unit. Besides placing our patients as close to the nurses' station as possible, we are training the nursing staff on how to handle alarm situations. Training was mandatory for charge nurses and nursing supervisors. They must complete a ventilator familiarity competency that includes airway management. As far as observation is concerned, we purchased remote baby monitors with video (available at any store selling baby products) for about $100 apiece. The small TV monitors will be placed in the telemetry control room where the monitor technicians can monitor the patient visually and audibly. They will then call the nurse's cell phone for any alarm situations. The monitors are inexpensive and perform well in low light environments. So far this has worked out well for us.

Manager #3: We use the Lifecare remote alarm system, which is interfaced into the nursing call system and placed on the highest priority code. It rings right behind the bathroom fall button alarm. A call to see a nurse would be preempted by the vent alarm should both requests come in at the same time. We also have a red light outside of the vented patient's room that lights up whenever the alarm goes off. The alarm cannot be silenced by anyone at the desk until the problem is corrected. We put the vented patients outside the nurses' station. If the alarm goes off and the problem isn't obvious (i.e., high pressure due to coughing or needing suctioning) we direct the nurses to call their therapist and to bag the patient until we get there. We have been using this system for approximately nine years and it has worked very well for us. We also hold informal mini "crash" vent classes for the nurses whenever a vent is sent to their floor unit to help ease their anxiety - and ultimately save ourselves a lot of time as well! ◆

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@aarc.org. ◆

What's On Their Minds?

What are the top concerns of your hospital CEO? According to a recent survey of 629 hospital executives taken during the first half of the year, labor/staffing and payment issues top the list. Nearly 70% of CEOs tagged labor/staffing as a major concern, down slightly from 75% in 2001, while 65% said reimbursement from government sources was a big problem. That's up slightly from a year earlier, when 61% of CEOs cited reimbursement woes.

These two issues continue to far outpace other concerns among top executives. The next most often cited problem was regulatory/compliance issues, at 22%. No other problem was mentioned by more than 20% of the respondents.

Participants in the American Hospital Association survey were allowed to mention up to four concerns. ◆

CMS Leaves Transfer Rule Alone

The Centers for Medicare and Medicaid Services (CMS) has decided not to expand the post-acute care transfer policy to additional diagnosis related groups in fiscal 2003 as earlier planned. According to AARC Associate Executive Director Bill Dubbs, MEd, MHA, RRT, FAARC, "This transfer policy was set up when CMS found that hospitals were keeping some patients only two or three days, then transferring them out to other places - mostly nursing homes - but still collecting the full DRG." In order to curb the practice, CMS instituted the policy on ten DRGs, at least one of which pertained to RT, limiting hospitals to a per diem of the full DRG for every day the patient remained in the hospital, rather than the full DRG itself.

The decision not to expand the transfer rule to include additional DRGs is seen as a victory for hospitals. The American Hospital Association applauded the decision, saying that it would ensure hospitals are able to provide "the right care at the right time in the right setting."

The expanded list of DRGs originally slated to go under the transfer rule included several involving respiratory care. ◆

HIPPA Regulation Finalized

After several years of debate, a final rule governing the privacy of medical records was published in the Federal Register August 14. The regulation, established by the Health Insurance Portability and Accountability Act, includes the following provisions:

- Patients must give specific authorization before entities covered by this regulation could use or disclose protected information in most non-routine circumstances - such as releasing information to an employer or for use in marketing activities. Doctors, health plans and other covered entities would be required to follow the rule's standards for the use and disclosure of personal health information.
- Covered entities generally will need to provide patients with written notice of their privacy practices and patients' privacy rights. The notice will contain information that could be useful to patients choosing a health plan, doctor or other provider. Patients would generally be asked to sign or otherwise acknowledge receipt of the privacy notice from direct treatment providers.
- Pharmacies, health plans and other covered entities must first obtain an individual's specific authorization before sending them marketing materials. At the same time, the rule permits doctors and other covered entities to communicate freely with patients about treatment options and other health-related information, including disease-management programs.
- Specifically, improvements to the final rule strengthen the marketing language to make clear that covered entities cannot use business associate agreements to circumvent the rule's marketing prohibition. The improvement explicitly prohibits pharmacies or other covered entities from selling personal medical information to a business that wants to market its products or services under a business associate agreement.
- Patients generally will be able to access their personal medical records and request changes to correct any errors. In addition, patients generally could request an accounting of non-routine uses and disclosures of their health information.

The regulation will go into effect for most entities on April 14, 2003. ◆

We're Going Electronic!

The Management Bulletin is getting ready to fully enter the electronic age. Beginning in 2003, our newsletter will be published exclusively via an e-mail newsletter format. The change, approved by the Board of Directors this 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 e-mail address please do so ASAP. Send your address to: mendoza@aarc.org. ◆

2003 JCAHO National Patient Safety Goals

In the last issue of the Bulletin, we outlined the new patient safety goal from Joint Commission on Accreditation of Healthcare Organizations dealing with alarm systems. Here are the remaining five goals making up the initial six National Patient Safety Goals that health care organizations will be surveyed on beginning in January:

Improve the accuracy of patient identification.

- Use at least two patient identifiers (neither to be the patient's room number) whenever taking blood samples or administering medications or blood products.
- Prior to the start of any surgical or invasive procedure, conduct a final verification process, such as a "time out," to confirm the correct patient, procedure and site, using active - not passive - communication techniques.

Improve the effectiveness of communication among caregivers.

- Implement a process for taking verbal or telephone orders that require a verification "read-back" of the complete order by the person receiving the order.
- Standardize the abbreviations, acronyms and symbols used throughout the organization, including a list of abbreviations, acronyms and symbols not to use.

Improve the safety of using high-alert medications.

- Remove concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium chloride >0.9%) from patient care units.
- Standardize and limit the number of drug concentrations available in the organization.

Eliminate wrong-site, wrong-patient, wrong-procedure surgery.

- Create and use a preoperative verification process, such as a checklist, to confirm that appropriate documents (e.g., medical records, imaging studies) are available.
- Implement a process to mark the surgical site and involve the patient in the marking process.

Improve the safety of using infusion pumps.

- Ensure free-flow protection on all general-use and PCA (patient controlled analgesia) intravenous infusion pumps used in the organization. ◆

Word on the Web

This issue, we feature sound bites from two recent discussions conducted via the AARC web site. The first, on JCAHO site visits, took place on Helpline. The second, dealing with ventilators outside of the ICU, occurred on the Management Section listserve. Postings have been edited slightly for space and style considerations. ◆

American Association for Respiratory Care
11030 Ables Lane
Dallas, Texas 75229-4593

Continued from page 1

NOTES FROM THE CHAIR

state that the honoree be both a section and AARC member. The question is, why aren't they members? Certainly, anyone deserving of a nomination for Specialty Practitioner of the Year is just the kind of person we need and want in our Association and section. If your nominee fell into this category, I would encourage you to ask him or her to join the AARC AND the section. These folks have a great deal to offer.

Lastly, if you haven't visited the section homepage on www.aarc.org lately, please do so. We recently added a patient satisfaction survey to the Swap Shop area, along with a training and competency program for the handling of e cylinders. The latter is ideal for non-respiratory therapists who may be handling cylinders. ◆

Report Outlines Hospital Closures in 2000

The latest report on hospital closures from the Office of the Inspector General finds that 64 general, short-term, acute care hospitals closed in 2000, amounting to 1.4% of all hospitals nationwide. The same number of hospitals closed in 2000 as in 1999; however, 29 hospitals opened or reopened in 2000, seven more than in 1999.

Rural hospitals that closed were similar in size to hospitals that remained open, but had slightly lower occupancy rates. Closed urban hospitals, however, were smaller and had lower occupancy than urban hospitals overall. The average daily patient load in the year prior to closure was 23 in rural hospitals and 69 in urban hospitals.

Although residents of a few communities had to travel greater distances for hospital care after the closures, for most, emergency and inpatient medical care was available within ten miles of a closed hospital. After closure, 31% of the hospitals were being used for other health-related services, such as outpatient and long-term care facilities. ◆