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American Association for Respiratory Care

Restructuring's Next Wave: The Time to Prepare Is Now

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

Respiratory care managers remember all too well the restructuring frenzy that took hold of the nation's hospitals earlier in this decade. Things have settled down in the last year or two — indeed, in many cases coming full circle as hospitals watched such initiatives fail to live up to expectations — but recent developments suggest that they are heating up again. The general failure of health care reforms to contain costs, along with new provisions in the Balanced Budget Act of 1997 aimed at cutting another $115 billion out of Medicare spending by 2002, virtually guarantee a second wave of restructuring in hospitals. If you haven't heard rumblings along these lines in your hospital yet, expect them at any time.

What can RC managers do *now* to prepare for the inevitable onslaught of consultants likely to be in their futures? Fortunately, we have learned some important lessons from the first wave of restructuring that can help us position our departments for success during the second.

In the absence of competency, misallocation occurs

The most important lesson we learned is that unless respiratory services are provided by practitioners with documented competency, misallocation will occur. Misallocation (the provision of services that are not indicated) increases both the cost and risk of providing care. Since cost reduction and control is a primary goal of restructuring, reducing misallocation is consistent with the goals of your organization.

In the September 1998 issue of *Respiratory Care:* "The Rationale for Respiratory Care Protocols: An Update," James K. Stoller, MD, identifies three reasons why misallocation occurs:

1. "Respiratory care conditions are frequently misdiagnosed, leading to the prescription of inappropriate therapies.
2. Respiratory care treatments are prescribed more cavalierly than drugs, with inadequate attention to appropriate dose and frequency.
3. Health care providers who are empowered to order respiratory care services lack appropriate knowledge about underlying principles to make optimal prescribing decisions."

For these reasons, it is critical that those providing respiratory services have documented competency and a thorough understanding of clinical practice guidelines.

Differentiating RC

How can we convince key decision-makers that misallocation occurs in the absence of documented competency? *First and foremost, we must differentiate respiratory care from the other ancillary services in the hospital.* We cannot let organizational decision makers (administrators) and consultants who come into our hospitals work under the assumption that respiratory therapy is simply a collection of motor skills and, as such, easily assumed by others without specific training and competency documentation in respiratory care — or, worse yet, by untrained, non-credentialed assistive personnel.

Administrators and consultants must understand that:

- Orders for respiratory therapy are not static, but dynamic, and thus often need to be changed or adjusted from treatment to treatment or sometimes even during a treatment to appropriately match the needs of the patient. (Conversely, orders for an X-ray or

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other diagnostic tests do not usually require modification after they are written.)

- Because patients are labile, even the most competent physician cannot write an order for respiratory therapy that is guaranteed to remain appropriate over the course of the patient's care.
- In most cases, therapy has to change as the patient's condition changes.
- Physicians rely on the documented competency of respiratory therapists to assess their patients during the delivery of respiratory services and contact them when these changes are necessary.

In short, the message we must send to these consultants — as well as our own administrators — is that respiratory therapy is *a combination of **psychomotor skills** and the **cognitive ability** to assess the patient at each encounter and influence appropriate changes in physicians' orders.*

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A simple solution: *Keep track of what you are already doing*

Fortunately, most respiratory care departments are well-positioned to send this message. Their therapists are already assessing patients at the bedside before, during, and after treatments, and phoning physicians to get updated orders based on the patient's condition.

Unfortunately, what most departments are not doing is documenting that fact.

So what should you, as an RC manager, do to ensure that you have the necessary data in hand when the consultants come knocking on your door? A simple first step is to start keeping track of what you are already doing. Your therapists routinely document the care they deliver. Simply have them document how they influence that care as well by having them *record each and every time they convince a physician to change an order — to decrease or increase the frequency of therapy or to use an alternative form of therapy — based on the RT's assessment of the patient.* Consultants generally come into hospitals with the assumption that all orders are written correctly, and that all a respiratory therapist does is go through the hands-on steps required to deliver the treatment. This documentation will serve as the linchpin of your efforts to change that thinking, because it will show how often your cognitive skills directly influence the care ultimately received by the patient. *Start collecting this information today to ensure that you will have several months worth of data on hand when restructuring again surfaces in your hospital.* **This is an added-value we must document if we are to succeed in differentiating ourselves from other ancillary services.**

Support from the literature

You can support your own numbers documenting misallocation with a range of studies published in the literature over the past decade that clearly demonstrate the large percentage of misallocated treatments in respiratory care and the impact that respiratory therapists have on this misallocation. The following chart (source: September 1998 issue of *Respiratory Care:* "The Rationale for Respiratory Care Protocols: An Update," James K. Stoller, MD) lists these studies and their major findings. RC managers would be well-advised to acquire copies of them all to have ready as evidence that the assessment skills of respiratory therapists make a major impact on utilization. A bibliography of the citations in this chart is found at the end of this article.

Table 1 Frequency of Misallocation of Respiratory Care Services in Selected Series

Types of Service	Author(s)	Date	Patient Types	N	Frequency of Over-ordering	Frequency of Under-ordering
Supplemental oxygen	Zibrak et. al.	1986	Adult	NS	55% reduction in incentive spirometry after therapist supervision begun	NA
	Brougher et. al.	1986	Adult, non-ICU inpatients	77	38% ordered to receive O2 despite adequate oxygenation	NA
	Small et. al	1992	Adult, non-ICU inpatients		72% of those checked had PaO2 > 60 mm Hg or SaO2 > 90% but were prescribed oxygen	NA
	Kester and Stoller	1992	Adult, non-ICU inpatients	230	25.2% overall for 5 respiratory care services; 28% for supplemental oxygen	10.5% overall for 5 respiratory care services, 8% for supplemental oxygen
	Albin et. al	1992	Adult, non-ICU inpatients	274	61% ordered to receive supplemental oxygen despite SaO2 > 92%	21% under-ordered, including 19% prescribed to receive inadequate O2 flow rates.

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Bronchial hygiene techniques	Zibrak et. al	1986	Adult	NS	55% reduction in incentive spirometry after therapist supervision begun	NA
	Shapiro et. al.	1988	Adult, non-ICU inpatients	3400	61% reduction of bronchial hygiene after system implemented	NA
	Kester and Stoller	1992	Adult, non-ICU inpatients	230	32%	8%
	Alexander et. al.	1996	Adult, inpatients	177	59.6% over-ordering	NA
Bronchodilator therapy	Zibrak et. al.	1986	Adult	NS	50% reduction in aerosolized medication after therapist supervision begun	NA
	Kester and Stoller	1992	Adult, non-ICU inpatients	230	12%	12%
Intermittent positive pressure breathing (IPPB)	Zibrak et. al.	1986	Adult	NS	92% reduction in IPPB after therapist supervision begun	NA
	Kester and Stoller	1992	Adult, non-ICU inpatients	230	40%	6.7%
Arterial blood gases	Browning et. al.	1989	SICU patients	724 ABGs	42.7% inappropriately ordered before guidelines implemented	NA
	Pilon et. al.	1997	Adult, inpatients in 5 periods	150	56% inappropriately ordered before guidelines, reduced to 21% inappropriate 13 months after	NA

NS: Not Stated NA: Not Assessed

Surviving the swell

There are several other key strategies that managers can use to position themselves for success when the next wave of restructuring hits their departments, and we will go over these in upcoming issues of the Bulletin. But the two tactics presented here — *keeping track of how your therapists influence the orders of individual patients and becoming knowledgeable about the scientific literature on misallocation of respiratory treatments* — are the first steps in assuring the future of your department in today's data-driven health care environment. The bottom line of any restructuring effort is to contain costs, and the manager who can demonstrate with hard, cold facts that his or her department is capable of doing just that will certainly survive and even thrive, regardless of the size of the swell.

Bibliography

1. Albin RJ, Criner GJ, Thomas S, Abou-Jaoude S. Pattern of non-ICU inpatient supplemental oxygen utilization in a university hospital. Chest 1992; 102(6): 1672-1675.
2. Alexander E, Weingarten S, Mohsenifar Z. Clinical strategies to reduce utilization of chest physiotherapy without compromising patient care. Chest 1996; 110(3): 430-432.
3. Brougher LI, Blackwelder AK, Grossman GD, Straton GW Jr. Effectiveness of medical necessity guidelines in reducing cost of oxygen therapy. Chest 1986; 90(5): 646-648.
4. Browning JA, Kaiser DL, Durbin CG Jr. The effect of guidelines on the appropriate use of ABG analysis in the intensive care unit. Respir Care 1989; 34(4): 269-276.
5. Kester L, Stoller JK. Ordering respiratory care services for hospitalized patients: practices of overuse and underuse. Cleve Clin J Med 1992; 59(6): 581-585.
6. Pilon CS, Leathley M, London R, McLean S, Phang PT, Priestly R, et al. Practice guideline for ABG measurement in the intensive care unit decreases numbers and increases appropriateness if tests. Crit Care Med 1997; 25(8): 1308-1313.
7. Shapiro BA, Cane RD, Peterson J, Weber D. Authoritative medical direction can assure cost-beneficial bronchial hygiene therapy. Chest 1988; 93(5): 1038-1042.
8. Small D, Duha A, Weiskopf B, Dajczman E, Laporta D, Kreisman H, et al. Uses and misuses of oxygen in hospitalized patients. Am J Med 1992; 92(6): 591-595.
9. Zibrak JD, Rossetti P, Wood E. Effect of reductions in respiratory therapy on patient outcome. N Engl J Med 1986; 315(5): 292-295. ■

Notes from the Guest Editor

by Gary J. Hospodar, MAOM, RRT, RCP, director of cardiovascular and respiratory care services, California Pacific Medical Center, San Francisco, CA

Never let the odds keep you from pursuing what you know in your heart you were meant to do.
— Life's Little Instruction Book, Volume III

Greetings from Northern California! Last January I traded the high desert, mountains, and splendor of New Mexico for the Golden Gate, sea otters, the most unique and colorful city in the world, and a new position here in San Francisco. Yes, change can be good, but before we address that issue, first let me take a moment to care of a few other items.

First I'd like to thank John Kimble for his generous offer to again serve as guest editor for the *Management Bulletin* and its auspicious membership. Second, let me commend the other regional contributors (I, too, challenge more regions to provide input to this publication) who have used the format developed by my New Mexico colleagues last fall. It is very gratifying when a formula is embraced by so many highly talented and motivated

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RTs from throughout the country and used to share such outstanding information. (Maybe we could generate interest among our international contingent next — another challenge for John and the group.)

As I mentioned earlier, change can be good. Here in Northern California, we are fortunate to have a network of managers and educators — the Bay Area Managers Group — which epitomizes the flexibility and rapid-pace stamina necessary to deal with the complexities of health care and its ever-shifting business environment. Our meetings are collaborative in nature and take place quarterly. Ideas are discussed, experiences shared, (JCAHO and Y2K have been very prevalent this year), and plans for the future are bounced off some of the many experts in our profession. This network has proven to be very beneficial in paving the way for the information found in this Bulletin and a variety of other publications. I acknowledge their accomplishments, appreciate their contributions to this issue, and look forward to working with them in the future.

In this issue, *change* will be the primary theme. Al Barcena, BS, CRT, RCP, director of respiratory care at Kaiser-Permanante Santa Teresa Hospital in San Jose, provides an overview of operational changes in an HMO environment. Chris Comstock, MPA, RRT, RCP, director of respiratory care services at Mills-Peninsula Health Services in San Mateo, offers a dispatch from the front lines of change. Paul Roggero, MBA, RRT, RCP, assistant manager of respiratory care at Kaiser-Permanante's San Francisco facility, discusses the operational impacts that can occur when a respiratory care department undergoes facility mergers, acquisitions, and consolidations. Finally, I provide a brief overview of one facet of health care dynamics in a heavily saturated managed-care marketplace that seems to shift and shake more frequently than a California earthquake faultline. ■

Experiences from an HMO

by Al Barcena, RCP, CRT, BS, manager of respiratory care services, Kaiser-Permanente-Santa Teresa Hospital, San Jose, CA

Managed care has been a permanent fixture in our organization since it was founded in the 1940s. However, intense pressure surfaced about eight years ago when President Clinton and his wife, Hillary Rodham Clinton, brought managed care to the attention of the public. Since then, our organization has experimented with many different structured models, following the recommendations of consultants and due to increased pressure from health care market competition. (Up to the early 1990s, Kaiser Permanente was pretty much the sole player in the managed care field.) The increase in scrutiny was also dictated by escalating health care costs.

As a result of these increased operational pressures, my experiences as an RC manager have been profound. I have seen the "wheel" re-invented several times, with the final outcome coming full circle. Different models were implemented at Kaiser-Permanente facilities in Northern California. At our facility, Santa Teresa Kaiser-Permanente, we started with "member-focused care." This particular model had RTs performing a variety of tasks, such as phlebotomy, EKGs, and vital signs. In other words, the department's operational base was decentralized. This model was also employed by other Kaiser facilities in Northern California.

The final outcome of this model was unsuccessful, primarily because of the inordinate expense incurred by having an RT perform tasks that could be more cost-effectively performed by aides and medical assistants. Subsequently, and for approximately the next 15 years, Kaiser utilized the "primary care model" (staffing all nursing floors strictly with RNs). This, too, was not cost-effective. As a result, consultants were brought back in and nursing has now gone back to a nursing skill mix; i.e., RNs, LVNs, and aides. Of course, I realize that this is what suits our system and gives us the most quality and service for the money. But it may not suit other facilities or the way their systems are organized.

Under the centralized model within Kaiser, most respiratory care areas report to the critical care area nursing manager. At Kaiser Santa Teresa, however, our department reports directly to the nursing leader at the facility, since most traditional administrator positions were eliminated. At first I was reluctant to be "under" nursing. But I found that once we demonstrated the value of our department and worked hand-in-hand with nursing to accomplish mutual goals, the relationship could be rewarding.

My best advise to all RC managers is to be receptive to change, be proactive with your department, become a valued member of the managing team, and always have data to support your point of view. Fortunately, the impact of restructuring on our department has been minimal. Originally, 4.6 FTEs were eliminated from the department. These included supervisory, educational, and clerical staff. The basic core of practitioners was not impacted.

While different models of staffing have been tried in our Northern California service area, after everything has been said and done, each facility has gone back to its traditional staffing patterns. When changes are suggested in your facility, ask yourself the following questions: Who does oxygen rounds, who does blood draws, who does routine respiratory care, who does EKGs, who manages the ventilators, how do you determine your staffing needs, do you use a multi-task staffing approach? These and many other questions should be answered with another question: What is the best, most cost-effective way of providing high quality care to your patients? The answer to that question holds the key.

At our facility, our department is very proactive within patient care. Practitioners are expected to suggest reasonable alternative modalities and/or medications to physician orders. Sure, we have care paths and algorithms — but nothing takes the place of a one-on-one conversation with the physician. Over time, physicians will gain respect and trust for the staff and the department. We have also been fortunate to have an information management system (Clinivision) in place for several years. I have utilized this management tool to provide my administrator with the necessary data to support operations. As a result, we have regained all the staff we originally lost and added 2.3 FTEs to support the emergency department 24 hours a day, seven days a week.

So, when faced with change, remember the three golden rules:

1. Be receptive to the proposed changes.
2. Be proactive with your department.
3. Create a value for your department. ■

Mergers, Acquisitions, and Consolidation

by Paul Roggero, MBA, RRT, RCP, assistant manager of respiratory care, Kaiser-Permanante San Francisco

The past decade has seen a tremendous change in the health care environment. We have seen changes in patient care technology, the methods in which payment is provided for health care delivery, the expectations of consumers regarding health care, and the organizational structure of respiratory care departments, to name just a few.

However, one change that is becoming increasingly frequent is consolidation with another health care organization. Forces such as managed care, reduced hospitalizations, and reduced reimbursement from federal and state payors have driven health care organizations to seek out alliances or partners to effectively provide care in the new environment. It has been predicted that these forces will result in the survival of only three or four health care networks per region. For example, during the last 15 years in San Francisco, the number of fully independent hospitals has fallen from 12 to three. During 12 of the last 15 years, I was employed by only two medical centers. But during those 12 years, I was a manager at an organization that acquired two other organizations, a manager at an organization that merged with another organization, and a manager at an organization that was acquired by another organization.

Being part of an organization that is undergoing a consolidation usually creates anxiety and uncertainty. The anxiety will affect both staff and managers. Uncertainty comes from not being sure how your job and your organization will change as a result of the organizational change. Will I still have the same responsibilities that I previously had? Will I still be able to work with the same staff? Will I have to change the location where I work? Will I report to the same supervisor? Will I still have a position after the consolidation?

During this time of uncertainty there are some steps that staff members and managers may take to reduce their anxiety. One of the most effective is to try to stay as informed as possible regarding the changes that may come about due to the coming consolidation. Seek out opportunities to become informed about changes that may occur to your organization as well as your department. Managers should openly communicate this information to staff on a routine basis, i.e., hold staff meetings in an effort to provide whatever factual information is known. If your organization is not providing regular updates of the progress of the consolidation and expected changes from the process, ask that the information be provided.

We also need to clarify rumors as they arise. Rumors will always develop when there are times of uncertainty. Rumors tend to focus on the negative, which may make a trying situation even more difficult. Try to clarify rumors with a person who you trust who is in a position to be informed. If that person is not sure if the rumor is false, ask him or her to find out from his or her superior. Managers should routinely seek out staff to find out what rumors may be circulating and attempt to clarify inaccurate information.

Seek to maintain a positive balance between your professional and your personal life, as well. It is important not to allow the events in your workplace to overwhelm the other essential parts of your life. Be sure to follow your usual routine for stress reduction or management, or develop a strategy to deal with stress that works for you.

You can also review the marketplace for other professional opportunities. Some individuals are affected by the feeling of being out of control as organizations go through the consolidation process. One way to regain some degree of control is to realize that the current workplace situation is not the only option available.

Attempt to recognize the potential benefits from a consolidation. Many health care organizations are seeking alliances because they are not surviving in the current environment or fear that they will not survive in the future. One option for the organization to carry out its mission of providing health care is to become part of a larger entity. Other possible benefits may be opportunities for increased professional growth in the new organization and networking with other health care professionals.

During the period of uncertainty produced by organizational upheavals, we must not lose sight of our primary mission: to provide high quality, compassionate, and cost-effective care to our patients. Being prepared to deal effectively with this change can help us retain our focus. ■

Change in the Community Hospital Setting

by Chris Comstock, MPA, RRT, RCP, director, respiratory care services, Mills-Peninsula Health Services, San Mateo, CA

"Everyone talks about change in the workplace — the constancy of it, the speed of it, the importance of adapting to it — but few people can give you a simple set of instructions not only to cope with it but also to take advantage of it." (1) This is a quote from **The Artist's Way at Work: Riding the Dragon**, by Mark Bryan and Julia Cameron with Catherine Allen. I highly recommend this book for every respiratory care manager, for in today's fast paced environment what we do is a blend of science and art. We struggle to keep up with technology, transition through change, and maintain our creativity. All of these points are illustrated in the following summary of the changes that have taken place at our community hospital in Northern California in the 1990s.

Today, Mills-Peninsula Health Services (MPHS) is a member of Sutter Health Systems, which comprises approximately 36 health care facilities in Northern California and Hawaii. Ten years ago, MPHS consisted of a 375-bed acute care hospital in downtown San Mateo and a 402-bed acute care hospital located just four miles north in Burlingame. Since that time, the respiratory care staffs have gone through many of the same operational and organizational changes that others in the San Francisco bay area have weathered.

First, there was the merger of the two distinctly different departments. Both staffs were well educated and highly functional, but they had different ways of doing just about everything. Equipment and supply choices had varied over the years. Even the simple disposable supplies were different. The RT's scope of responsibility varied between facilities. One staff performed arterial blood gas punctures. The other did not. One staff managed infants on ventilators. The other did not. Both staffs maintained different working hours (standard eight, alternative 12). Both staffs actually had different job descriptions and levels of

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compensation. Both staffs had extremely strong work cultures that still exist to this day. This dragon is known as the "we versus them" phenomena, or the "Mills staff and the Peninsula staff."

One of the first major changes (other than the obvious standardization that addressed the previously stated issues) was the movement of the very active labor and delivery service, including the Level II nursery, from one site to the other. Training and competency validation became ongoing issues. Significant changes occurred in all departments and, as in any facility, morale issues ebbed and flowed among all staff. Some staff transferred between sites early in the merger. Others crossed lines only when threatened with corrective action. Several chose to work elsewhere.

Three years ago, all acute services were consolidated at a single site identified as the Medical Center. The Health Center remains open for all outpatient services, including a same-day surgery center, recovery care inn, and stand-by emergency department (SBED). For those not familiar with the latter phenomena, this is a 24-hour ED that accepts walk-in and Code 2 ambulance traffic. There is 24-hour coverage by an emergency room physician, registered nurse, and a radiology technologist . The RN provides respiratory services and point of care laboratory analysis. The radiology technologist is cross-trained to provide ECGs and phlebotomy. Code 3 ambulance traffic is diverted to the Medical Center and there is an ambulance stand-by at the Health Center to provide immediate transfer of any unstable walk-in patient.

Prior to the actual physical consolidation of all RTs at the Medical Center, the patient care redesign model was identified. Upon consolidation, the model was implemented, with RTs unit based on a medical surgical ward. Less than one year later, the respiratory care component of the project was identified as too costly, and respiratory care services were re-centralized. This resulted in two staffs being consolidated in one department at a facility that had been remodeled and expanded. There's no place like home, and no one on staff felt like it was home. Many long-term employees (the person with the lowest seniority was me, at 13 years) felt lost. They still worked for the same employer, but the facility had changed.

Storage space was reassigned. Locker space was reassigned. Work hours were standardized. Capital equipment was combined and re-allocated to support patient wards. Simultaneously, the information systems department changed the laboratory and supply management systems. Staff could no longer count on even minor things being the same. Even the patient room numbers were changed to meet the Americans with Disabilities Act regulations. Now all rooms (including broom closets, offices, etc.) have a number, and numbers flip across hallways (for example, 2402 is opposite 2401). RTs were in a very unusual situation. They were senior staff, and they were lost.

Two years ago we thought we had successfully navigated through our most significant changes. We were wrong. Since then the amount of change in our immediate environment has increased in both intensity and frequency. Technology has allowed for faster communications and management information overload.

Technology has allowed us to obtain accurate data rapidly. We monitor supply purchases and usage across multiple sites. We benchmark services and productivity locally and nationally. We monitor patient care outcomes and patient satisfaction. The Sutter Health respiratory care service (RCS) directors videoconference monthly to share information regarding clinical issues, operational issues, and of late, Y2K issues. (San Francisco is expecting 1.5 million revelers on New Year's Eve, but that's for another article.)

Change. Random House dictionary states that change is to "make different." It seems we "make different" on almost a daily basis. But several things have helped me to manage these changes.

First, I use the following model for controlling change. I separate the change into three segments: that which I cannot control, that which I can influence, and that which I can control. For example, I cannot control the fact that we must replace our facilities prior to 2008 to meet new state seismic requirements. I can negotiate how much funding of the new facilities will be taken from the RCS operating budget. I can control what funding there is to provide the essential services that support quality of care and positive patient outcomes.

Second, I remind myself of the phases of change and that not all individuals are at the same phase at any given time. William Bridges wrote a wonderful book in 1980, **Transitions: Making Sense of Life's Changes.** (2) In it he describes the transition cycle as having five stages that move us through three zones. The stages of change are denial, resistance, detachment, exploration, and commitment. In the denial stage you may observe avoidance, disbelief, and shock. During the resistance phase you may observe a decrease in productivity, anger, carelessness, and/or pessimism. Both of these phases are integral parts of the *ending zone*; i.e., for there to be change, something must end.

The *ending zone* is followed by the *neutral zone*. While in the *neutral zone* you may observe withdrawal, attentive inactivity, and disorientation. Coming out of the *neutral zone* one enters the *beginning zone.* Here the stages are exploration and commitment. Exploration is demonstrated by energetic participation, creativity, training, chaos, and risk-taking. During commitment one observes high performance, collaboration, continual improvement, and a focus on the bigger picture.

People transition through all five phases of this change model. Organizations transition through three of their own: *contact*, *chaos*, and *integration*. People transition relatively quickly, although each at a very individualized pace. Organizations transition slowly. It may take up to 15 years to reach integration following an organizational merger. Therefore, as my staff and I start to reach a point of equilibrium, the organization remains in chaos.

To prepare for the changes that are certain to come in the next ten years, we must attempt to identify our endings so that we can move more quickly to our new beginnings. We must embrace technology to help us provide services in the most efficient way, and we must take time to celebrate our accomplishments — specifically, that we have successfully weathered the 90s and look forward to the new millennium.

References

1. Bryan, M., Cameron J. and Allen, C. The Artist's Way at Work: Riding the Dragon. New York: William Morrow and Company, Inc.,1998.
2. Bridges, W. Transitions: Making Sense of Life's Changes. Massachusetts: Perseus Books, 1980. ■

Healthcare Dynamics: Oxymoron of the New Millennium?

by Gary J. Hospodar, MAOM, RRT, RCP, director of cardiovascular and respiratory care services, California Pacific Medical Center, San Francisco, CA

Ask yourself if what you're doing today is getting you closer to where you want to be tomorrow.
— Life's Little Instruction Book, Volume III

Health care dynamics — is it really an oxymoron? Fee schedules, contracts, volume reimbursement strategies, Medicare, Medicaid, MediCal, third party payers, self-payers, IPOs, IPAs, PPOs, HMOs . . . how do we, as managers, have time to balance the hours of one day and keep track of the constant state of flux regarding product line delivery and its cost effectiveness and net revenue justification from the variety of payer-mixes and sources that continually confront us? In most organizations, it's next to impossible, as it is much too overwhelming for the manager to be responsible for net revenue adjustment and justification. However, it is not unrealistic for managers to request reimbursement information that will continue to assist in their operations strategy of demonstrating the value of their staffs while maintaining the longevity of their current position. As you would probably agree, both are important factors in the business environment we practice in today.

One key to success is *proactively* requesting net revenue reimbursement information and not relying on the operations strategy of gross revenue statements. I do not have to tell this group of supervisors, managers, and directors that long-gone are the days when certain aspects of health care were automatically considered profit or revenue centers. I'm not suggesting that health care cannot be profitable — many organizations have proven that it can be — but today's manager must be much more savvy to the business environment to remain successful. One cannot rely on cost-accounting information or revenue projections that are performed only when a new service is initiated and new charge structure put in place. Financial analysis must occur on a continual basis.

Since most organizations support dozens upon dozens of contracts and agreements, and since they change frequently without the manager being advised, a periodic snapshot of net revenue information by procedure code should be acquired and scrutinized. This should be done quarterly, biannually, annually, or whatever will work for you to support your operation in concert with your organization's mission.

In the future, contracts and agreements will only become more intricate and complicated, requiring more thorough analysis than ever before. As payers continue to react to cost pressures by evaluating the most cost-effective use of health care resources, patient care providers who incessantly document their impact by providing outstanding patient outcomes stand to have the competitive edge over other types of providers in negotiating new or existing contracts or agreements. Productivity and purchasing benchmarks will assist the process, but only to a certain point. Actual expenses taken from gross revenues are misleading at best in the management of your operation. Therefore, request to see the "real" bottom line — not just what a customer is billed. What may be a minor inconvenience to your accounting department today may be the information you need to remain successful and dynamic in the health care arena tomorrow. Oxymoron? You be the judge. ■

One Last Thought from California . . .

- In the 1800s there were blacksmiths. As technology reduced the use of the horse as the primary means of transportation, blacksmiths learned new skills and became the first mechanics.
- In the 1900s there were typewriter repairmen and typists. As technology reduced the use of the typewriter, these persons learned new skills and became copy machine repairmen and computer technicians. Typists became word processors.
- In the 2000s there were managers of respiratory care services. As technology reduced the time it took to collect information, aggregate data, and prepare, plan, control, and orchestrate the provision of respiratory services, these managers made time to rekindle their creativity. It is a fantastic time! ■

Nursing Shortages May Impact Respiratory Care

by William H. Dubbs, MHA, RRT, AARC associate executive director

In a recent issue of Russ Coile's *Health Trends*, Coile discusses the national nursing shortage. According to the article, today's 2.6 million RNs are increasingly seeking professional opportunities outside of acute hospitals. Coile cites Chicago, IL, as an example. Only 56% of nurses are employed in Chicago hospitals today, down from 66% a decade ago.

Nursing school enrollments, he continues, are down as well. According to the American Association of Colleges of Nursing, they dropped 5.5% to 113,000 last year, continuing a four year slide.

The US Bureau of Health Professions says the average nursing salary was $40,097 in 1996. Coile observes, "Wage wars are back." According to reports, wages are being hiked 3-5% in 1999, and multi-thousand dollar signing bonuses are becoming commonplace. The shortage is not likely to be over soon. Projections indicate that the number of nurses needed in 2005 will have increased 25% over the number needed in 1994.

The AARC is currently conducting a nationwide respiratory therapist human resource survey. Results will be reported in late 1999 and should assist managers in understanding national trends in the utilization of RTs. However, in light of this information about the nursing shortage (especially in hospitals), it is already clear that strategies to utilize nurses to deliver respiratory care services make little economic sense.

For the complete story, refer to the June 1999 issue of Russ Coile's *Health Trends* (Vol. 11, No. 8). ■

Request for Assistance: New Technology

Susan Blonshine is writing a "clinical perspectives" article for *AARC Times* on new technologies in 1999 and would like to know what new technology this year has had the greatest impact on your specialty area and why.

Please respond by October 10 to Susan by email (sblonshine@aol.com) or fax (517-676-7018). ■

Just for Laughs . . .

Employee Review: One day, a project leader was asked to submit a review of one of his employees. He wrote the following:

1. Bob Jones, my assistant programmer, can always be found
2. hard at work in his cubicle. Bob works independently, without
3. wasting company time talking to colleagues. Bob never
4. thinks twice about assisting fellow employees, and he always
5. finishes given assignments on time. Often, Bob takes extended
6. measures to complete his work, sometimes skipping coffee
7. breaks. Bob is a dedicated individual who has absolutely no
8. vanity in spite of his high accomplishments and profound
9. knowledge in his field. I firmly believe that Bob can be
10. classed as a high-caliber employee, the type who cannot be
11. dispensed with. Consequently, I duly recommend that Bob be
12. promoted to executive management, and a proposal will be
13. executed as soon as possible.

Regards, Project Leader

Shortly thereafter, the HR department received the following memo from the project leader:

"Sorry, but that idiot was reading over my shoulder while I wrote the report sent to you earlier today. Kindly read only the odd numbered lines for my true assessment of him."

Regards, Project Leader ■

Come Celebrate AARC's Cultural Diversity

by Janyth Bolden, AARC Cultural Diversity Committee Chair

The AARC would like to hear your ideas on how "cultural diversity" should be addressed within the organization. In keeping with this goal, the Cultural Diversity Committee would like to invite you to attend a forum on cultural diversity. This first forum is being held at the Las Vegas Hilton Monday, Dec. 13, 1999 in conjunction with the 45th International Respiratory Congress. We are eager to listen to your ideas and suggestions, so please come share them with us.

We would like to make this a festive occasion — so why not dress the part? We invite and encourage you to wear something that identifies your ethnic, religious, or other cultural group. And keep in mind, "cultural diversity" does not refer only to Black, White, Brown and Yellow. It also includes Jewish, Hindu, German, Assyrian, Italian, American Indian, Greek, etc. Come prepared to show off!

The AARC Cultural Diversity Committee is made up of managers, educators, staff, and entrepreneurs who represent regions from around the globe. Please join us Dec. 13 for insightful, constructive conversation about our varied backgrounds. Let us not just point out our differences; let us also learn about and appreciate our similarities. It is by recognizing and utilizing our diversity that the AARC can become a "Fortune 500" association.

By the way, have you utilized the information found in the AARC Online cultural calendar? If not, why not? Check out this new feature on AARC Online at http://www.aarc.org/times_plus/calendar.html. This special feature is just the beginning of things to come. If you have any comments or suggestions, feel free to contact me at jbolden@chw.edu. ■

Bulletin Deadlines

Issue	Date editor must have copy	Date AARC must have copy
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
November/December	October 1	October 10