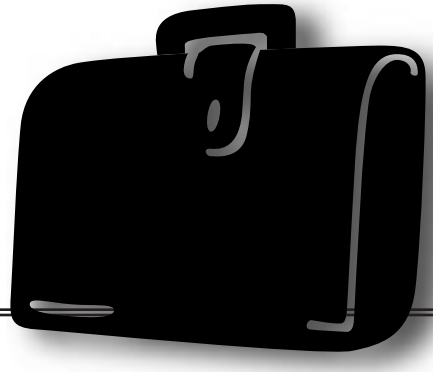
Management Section Bulletin



THE AMERICAN ASSOCIATION FOR RESPIRATORY CARE

NUMBER 5 SPRING 1997

NOTES FROM THE CHAIR

by Karen Stewart, BS, RRT

Attendees at the AHA conference in Washington came back with the following opinion of activity in the nation's capitol: "The bottom line is every one is waiting for the bottom line." As of this writing in early February, the administration's idea of the bottom line is a $138 billion cut over six years. Suffice it to say, hospitals will take a hit, though not as debilitating as would have been the case last year.

Here are a few other observations from the conference—

- **Key people to watch:** It is obvious that in the Senate the new middle of the road players are Sen. Jay Rockefeller (D-WV) and Sen. Bill Frist (R-TN), who is also a physician. Both spoke at the AHA conference and both are articulate and reasonable. New majority leader Trent Lott is also respected and has the ability to bring disagreeing parties together. In the House, experts believe that Mr. Gingrich will not have the "lock step loyalty" he had before his recent difficulties, and a few votes here and there can change things greatly.
- **White House watch:** The president wants his legacy to be preserving Medicare and balancing the budget. He is optimistic about bipartisanship.
- **Attitude watch:** To quote *Washington Post* columnist David Broder, who spoke at an afternoon session, we're dealing with a "chastened Congress and a more modest president." Most are hoping the present homage to "bipartisanship"—a word as popular this year as "paradigm" was five years ago—will continue.

HR CORNER

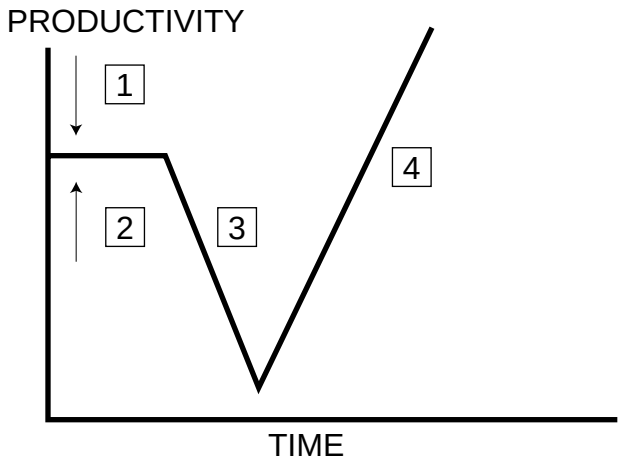
One of the realities of working in today's health care environment that we need to accept is the fact that everything is subject to change. Although as managers, we know that change is inevitable, we seldom take the time to discuss the dynamics of change with the very people we are trying to encourage to change and to accept change. There is little we can do to motivate our employees if we do not give them the tools to understand what is happening. One of the strongest tools we can share with our employees is the dynamics of change. If employees have a better understanding, they can become change advocates. Our role as managers is to be the change manager.

The following quotes illustrate the fact that change has never been easy to master and change causes disruption in the lives of many—

- *Change is not made without inconvenience, even from worse to better*. —**Richard Hooker** (1554–1600), English theologian. Quoted in: Samuel Johnson, *Dictionary of the English Langauge*, Preface (1755).
- *Much is the state of life, that none are happy but by the anticipation of change: the change itself is nothing; when we have made it, the next wish is to change again. The world is not yet exhausted; let me see something tomorrow which I never saw before.* —**Samuel Johnson** (1709–84), English author, lexicographer. Nekayah, in *The History of Rasselas*, ch. 47 (1759).

THE CHANGE CURVE

by Karen Stewart, BS, RRT



Steps:

1. Initial equilibrium with both positive forces.
2. Initial equilibrium with negative forces.
3. Expect movement into the valley of despair.
4. Things improve and you reach a higher level than the original equilibrium.

The change curve is a graphic illustration of the impact of change. It represents the impact on productivity or morale which is usually associated with any change. The first level plane is equilibrium and represents the time prior to change. The arrows are forces that keep all things equal. In the change process there are forces which push the curve downward, causing a decrease in morale or productivity. It happens no matter how hard you try to prevent it.

What is important is to help staff understand that in any change, things go sour before they get better. The bad feelings are frequently associated with the item that is being changed rather than the dynamics of change itself. It is our role as change managers to help our staff understand the dynamics of change so as not to blame the bad feelings on the item being changed and to help eliminate forces which extend the time it takes for the change to occur.

Reducing the time it takes to achieve change allows productivity to resume at a normal or accelerated level sooner. But to manage change, first we must orient the staff to the change model. The graphic illustration is used to show that things do, indeed, get tough before they get better, but that once they are better, performance is greater than before the change. In other words, they should expect that, "No pain is no gain."

The next tactic is to become more visible. Your staff knows that your time is very important and your visibility supports the premise that you understand their concerns and are available if they should need you. Most importantly, however, you must orient the group to the task at hand. Make sure they understand why the change is needed and what goal is being attempted. Keep the staff informed. And remember, "Only man is not content to leave things as they are but must always be changing them, and when he has done so, is seldom satisfied with the result." —**Elspeth Huxley** (b. 1907), British author. *The Mottled Lizard*, ch. 4 (1962). Thus today's health care environment . . .

AARC ONLINE: *A READILY AVAILABLE RESOURCE FOR BUSY MANAGERS*

by William Dubbs, MHA, RRT
AARC Director of Management Services

The content of the AARC World Wide Web site (http://www.aarc.org) is expanding weekly and may have the information you need readily available for instant downloading. When you reach the site, click on "AARC Online Services and Information." There you will find the following areas, many of which are of particular interest to managers—

Physician Letter of Support: In October of 1996, the American Society of Anesthesiologists issued this statement in support of respiratory care practitioners versus substitute caregivers. The content of this letter is reproduced here along with instructions on how to obtain a signed copy of the letter on ASA stationery.

Conventions, Meetings, and Seminars: Learn about the AARC International Convention and Exhibition, Affiliate Meeting information, and Special Seminars.

Products and Services: Products and services related to respiratory care, and the *1996 Buyer's Guide of Cardiorespiratory Care Equipment & Supplies*, are available here.

AARC Clinical Practice Guidelines: All 46 of the AARC's Clinical Practice Guidelines are available online.

$1,000,000 Fund Grant Application: The AARC has established a fund of $1,000,000 to promote research into the clinical and economic value of respiratory care practitioners. Details on how to apply can be found here.

Links to Other Respiratory Care Related Sites: Links to other sites of interest—

More information for managers can be found in the "Member's Only Section." In this section (members get their unique password through e-mail) you will find—

The AARC Help Line: In this area members can pose their questions or respond to the questions of others. You can review the responses others have made to the questions posted. Some of the questions under discussion this month related to management issues are—

- Extended/advanced practice
- Institutions using TDPs without a respiratory care information system
- Patient assessment skills
- Inpatient pulmonary rehab
- Criteria for discontinuing RC services
- Outsourcing respiratory care in acute care settings
- Charting by exception
- Cardiac rehabilitation
- RCPs as case managers
- Differences in duties (CRTT and RRT)
- Joint Commission experiences
- Therapist-driven protocols
- Respiratory therapists starting IVs

Position Statements: The AARC has advanced a number of position statements and guidelines regarding the provision of services or the practice of respiratory care. These statements are presented here.

CRCE: The AARC approves respiratory care educational programs for CRCE credit, which many states use as the basis of continuing education. A month-by-month listing of the courses approved by the AARC is posted here.

Resources: This is a particularly rich area for managers. Information here includes the following—

- **Post-Acute Care Contracting Resource List:** A list of AARC members who are engaged in contracting post-acute care services.
- **Restructuring Resource List:** This is peer counseling network of AARC members who have been involved in hospital restructuring initiatives.
- **Model Transfer Agreement:** This is a sample of a transfer agreement between a hospital and skilled nursing facility.
- **Model Management Agreement:** This is a sample of a respiratory therapy program management agreement between a hospital and a SNF.
- **Overview of the Medicare Program:** A white paper providing a general description of Medicare.
- **Utilization in Respiratory Care:** A white paper describing utilization review in acute and post acute settings.
- **Recentralized Respiratory Care:** A list of organizations that have recently recentralized respiratory care services.

There is much more to come, so I encourage you to check the site frequently. For example, in the near future we will be posting the AARC's JCAHO Cross Walk document. This identifies the 1997 Standards that managers of respiratory care services in acute care facilities should be familiar with when preparing for an accreditation site visit. Also, those who visit our site in the future will be able to quickly determine the current adjusted hourly salary equivalency amounts and standard travel allowances for respiratory care practitioners providing services to residents in skilled nursing facilities covered by Medicare Part A.

JCAHO ACCREDITATION VISIT REPORTS

In an effort to keep you informed regarding JCAHO site visits, the AARC has been requesting information from organizations

that have recently gone through the review process. (See JCAHO Accreditation Visit Form in this issue to provide input on your visit.) Here are six recent responses—

Homecare Medical Associates, Inc. (Home care)
6600 NW 12th Avenue
Ft. Lauderdale, FL 33309
Contact: Jay J. Gutierrez, RRT, (954) 772-5052
Inspection Date: 1994

1. What was the surveyors' focus during your last site visit?
   QA / Infection control/documentation/pt care plans.
2. What areas were cited as being exemplary?
   QA
3. What suggestions were made by the surveyors?
   Further documentation on corrective actions taken/measure impact.
4. What changes have you made to improve compliance with the guidelines?
   More follow-up and documentation on any actions taken to correct a deficiency.

Additional comments: *More emphasis is being given to performance improvement. Patient care.*

Virginia Mason Home Care (Home care)
925 Seneca St., Mailstop H4HHE
Seattle, WA 98111
Contact: Kathy Baillie, (206) 340-2011
Inspection Date: August 1995

1. What was the surveyors' focus during your last site visit?
   DME/clinical respiratory services.
2. What areas were cited as being exemplary?
   Clinical respiratory.
3. What suggestions were made by the surveyors?
   Needed improvement in infection control monitoring.
4. What changes have you made to improve compliance with the guidelines?
   Changed policy & procedure.

Additional comments: *None*

The Jewish Hospital (Hospital)
3300 Burnet Avenue
Cincinnati, OH 45229
Contacts: Debbie Nesbit, Manager; Jackie Caccia, Supervisor
(513) 569-2125
Inspection Date: November 18-21, 1996

1. What was the surveyors' focus during your last site visit?
   Life safety issues, policies on patient restraints, multidisciplinary approach to patient care.
2. What areas were cited as being exemplary?
   Performance improvement, multidisciplinary focus.
3. What suggestions were made by the surveyors?
   Change some paperwork to reduce redundancy.
4. What changes have you made to improve compliance with the guidelines?
   Definitive changes not yet decided. Final report not yet in - preliminary report indicates our final grade will be 97-98 with possible commendation (which we've earned in the last 2 reviews).

Additional comments: *Unlike reports we had previously received, respiratory was not a "focus" issue. We were included on all clinical visits (and questioned) and a part of multiple administrative reviews.*

Sacred Heart Hospital (Hospital)
5151 N. 9th Avenue
Pensacola, FL 32504
Contact: Cindy Carter, RRT, (904) 416-7760
Inspection Date: October 28, 1996

1. What was the surveyors' focus during your last site visit?
   Bronchoscopy service, H & P, conscious sedation, bronch reports.
2. What areas were cited as being exemplary?
   Protocols that showed ↓LOS/↑(improved) pt outcomes, TQM problem solving process.
3. What suggestions were made by the surveyors?
   Improve process for positive bronch reports on in & out patients and forwarding to physicians. Could simplify H & P if info was sent w/pt from physician's office.
4. What changes have you made to improve compliance with the guidelines?
   Worked w/medical records and transcription to utilize reporting options available to reduce turnaround time and issue multiple reports to appropriate physicians and to pts chart for inpts.

Additional comments: *In cases where needle re-capping is done, state that a needle re-capping device is used, or the syringe cap is not held when the needle is inserted into the cap. They did ask about where bronchoscopes were cidexed and monitoring employee exposure to sources of radiation in the bronchoscopy suite.*

Ambassador-Lincoln (Long term care)
4405 Normal Blvd.
Lincoln, NE 68506
Contact: Tad Hunt, RRT, (402) 488-2355
Inspection Date: July '96

1. What was the surveyors' focus during your last site visit?
   LTC/Subacute care rehab.
2. What areas were cited as being exemplary?
   Rehab/respiratory.
3. What suggestions were made by the surveyors?
   Performance improvement/environment services.
4. What changes have you made to improve compliance with the guidelines?
   Formulated teams to implement changes.

Additional comments: *JCAHO accreditation in long term care and subacute care.*

Medical Center of SW Louisiana (Pathology & Clinical Laboratory Services)
2810 Ambassador Caffery
Lafayette, LA 70506
Contact: Sharon Real, (318) 989-6713
Inspection Date: January 17, 1997

1. What was the surveyors' focus during your last site visit?
   Licensure of employees, documentation, verification of proficiency testing.
2. What areas were cited as being exemplary?
   Documentation of sample review on complement (CIBA CORNING/CHIRON).
3. What suggestions were made by the surveyors?
   Use of orientation checklist for annual competency testing.
4. What changes have you made to improve compliance with the guidelines?
   Change wording on annual review form to include the word "competent."

Additional comments: *Surveyor checked every employee folder for valid state licensure verification.*

PRIVATE SECTOR OUTPACES PUBLIC SECTOR IN CONTAINING HEALTH COSTS

Private sector health care spending is still growing at a slower clip than health spending in the public sector. Data released in late February by the Health Care Financing Administration (HCFA) showed that while private sector spending increased by 2.9% in 1995, public programs, including Medicare, experienced an 8.7% spending hike. The nation's overall health care bill increased by just 5.5%—the slowest rate of growth in 30 years.

This trend toward greater spending in the public sector began in 1990 and has health officials concerned. Public health programs need to work towards restoring their fiscal health and better serving the public by embracing the innovative delivery approach used by the private sector. HCFA attributes the private sector's lower rate of growth to its use of health plans that coordinate care. Coordinating care, says HCFA, saves money by emphasizing prevention and focusing on quality. (Source: *Health Care News and Information*, Vol. 4 No. 3 January 31, 1997)

HOSPITALS BENEFIT FROM HMO OWNERSHIP, DRIVE INTEGRATION

When it comes to the development of a more independent health care system, hospitals are leading the way, say two new studies. Researchers from the international pharmaceutical company, Hoeschst Marion Roussel, found that hospitals that own HMOs are generally more efficient than those that do not. According to the *Integrated Health System Digest*, part of Hoeschst's *1996 Managed Care Digest Series*, hospitals, rather than physicians or others, have been the force driving the elimination of fragmented care in the nation's most highly integrated markets. The digest highlights 159 health care systems that the authors believe have made the greatest progress towards integration.

The report characterizes the transformation from a fragmented, highly independent system to an integrated one as a process that (1) raises the quality, effectiveness, and efficiency of health care services; (2) allows for the negotiation and delivery of care under broad managed care contracts; and (3) aligns the incentives of hospitals, physicians and other providers. The successful integrated health system features—

- A shared mission among all participants calling for the elimination of unnecessary redundancy, improvements in quality and efficiency, and better control of costs.
- A shared goal of meeting all medical, self-care, and information needs of patients.
- Joint-equity ownership in (or contracts among) all components of the health care delivery system—including acute care, physicians, long term care, home care, and a managed care component—leading to the seamless delivery of care.
- Properly aligned incentives for providers and patients fostering optimal use of the system by all.
- Systemwide contracts with payers under which the system accepts significant financial risk.
- Systemwide electronic sharing of medical, clinical, financial, and operational records.
- Formal sharing of capital among providers.
- Ability to document improvements in the population's health status.
- Unified governance.
- A focus on a clearly defined, enrolled population for which the system is responsible.

(Source: *AHA News*, January 13, 1997)

DON'T RELEASE COMMUNITY ACQUIRED PNEUMONIA PATIENTS TOO SOON, SAYS STUDY

It takes an average of four days for patients hospitalized with community acquired pneumonia to have their vital signs stabilized, says a study involving 700 patients at four medical centers, and they should remain in the hospital for the entire time. Researchers from Massachusetts General Hospital in Boston who conducted the study found that patients who were discharged prior to achieving stability "had a two-to-threefold increased risk of (mortality) during the 30 days following discharge."

According to the study, vital sign stability is defined as a temperature of 100 degrees F, respiratory rate of 22 breaths per minute, and oxygen saturation of 92%. The authors believe their findings are troublesome because a median stay of four days conflicts with the current trend in hospitals, which is to release patients with community acquired pneumonia earlier than that. The study appeared in the November 15 issue of *Internal Medicine News*. (Source: Reuters Medical News, 12/6/96)

STATES READY TO MOVE ON MANAGED CARE ISSUES

As more and more people come up against the arbitrary rules imposed by managed care organizations, cries of foul are resounding throughout state legislatures. This may be the year they do something about it. According to several reports released earlier this year, a number of states are poised to take aggressive action regulating MCOs during 1997. Here's a brief look at what's happening where—

- A model HMO bill developed by a group called Women in Government is slated to be introduced into nine state legislatures. The Managed Care Consumer Protection Act would ban "gag" clauses, require coverage of emergency care for problems that the average person would consider potentially severe, and allow patients to see out-of-network providers for an extra cost. In addition, the bill would guarantee patients access to all government-approved drugs, require plans to disclose their policies regarding the coverage of experimental treatments, and increase state monitoring of MCO quality. States slated to sign on to the legislation are Texas, New Jersey, Colorado, Delaware, Georgia, Kansas, Ohio, Oregon, and Tennessee.
- Legislation calling for the creation of an independent commission to oversee all aspects of health care policy and a bill designed to expand health coverage to more than 5,000 children and 1,000 pregnant women is scheduled to be introduced in Maryland.
- Massachusetts legislators will consider bills addressing the uncompensated care pool, utilization review processes, health care services for the mentally ill, consumer protections, fair contracting, and emergency

access to health care.
- Pending legislation in Michigan includes bills that would prohibit insurance companies from rating or refusing coverage to victims of domestic violence and require providers to allow women to name OB/GYNs as their primary care physicians. (Michigan is also slated to consider HB 6097, which would license and regulate respiratory therapists, along with legislation aimed at promoting fairness in drug pricing and giving advanced nurse practitioners the authority to write prescriptions independent of physicians.)
- In Minnesota legislators will consider legislation to strengthen protections for consumers, improve affordability for small employers and individuals in rural areas, and expand coverage for unemployed residents. Bills to ban "gag" clauses and establish a statewide health care consumer assistance office will also go on the docket.
- Mississippi legislators may introduce legislation to create committees to study managed care regulations and are expected to debate changes/expansion of the state's fully capitated Medicaid managed care demonstration project.
- A Joint Interim Committee on Managed Care formed last summer will introduce legislation on managed care regulation in Missouri. In addition, legislators are expected to consider bills prohibiting insurance companies from denying coverage to women with a pre-existing diagnosis of breast cancer and requiring insurance companies to provide (1) prosthetics and/or reconstructive surgery to mastectomy patients and (2) 24 hours of coverage following any surgery lasting more than three hours.
- Patient protections for managed care enrollees will be on the docket in Montana. Legislators will consider bills to ban "gag" clauses, regulate the gatekeeper function, and force insurers to pay beneficiaries in cases where liability is uncertain and allow liability to be determined at a later date.
- Lawmakers in Nebraska will consider consumer protections for managed care enrollees and examine the effect of the recently passed Kassebaum-Kennedy health insurance reform law.
- New Hampshire legislators will introduce bills requiring insurers to cover reconstructive surgery after mastectomies, creating a council to guarantee efficient delivery of health care to children, and establishing standard Medicaid rate-setting procedures.

(Source: Reuters Medical News, 1/9/97, 1/17/97)

FLORIDA DOCS SLAM MCOS

Managed care organizations rated by Florida internists in a survey conducted by the American Society of Internal Medicine (ASIM) received low marks across the board. When doctors were asked to evaluate the MCOs they had contracts with, the vast majority said the MCOs weren't living up to their marketing claims of providing higher quality, cost-effective preventive services and had policies and procedures that actually increase costs. Specifically, the physicians said that—
- Precertification requirements fail to reduce unnecessary care
- Profiling systems don't provide useful information that improves quality
- Physicians aren't adequately involved in profiling
- Requirements for credentialing, referral, and encounter data collection are overly redundant, and
- Plans don't provide patients with adequate information about capitation and medical services provided under financial risk arrangements, particularly for those suffering from complex diseases.

None of the physicians surveyed said they would recommend any of the MCOs they have contracts with to a family member.

(Source: Reuters Medical News, 1/20/97)

SMALL BUSINESSES JUMP ON THE MANAGED CARE BANDWAGON

Doctors may not be crazy about managed care (see previous article), but small businesses appear to be all for it. According to a study published in *Health Affairs*, managed care enrollment among employees of companies comprised of 50 workers or less has grown from just 22% in 1993 to 69% in 1995. HMOs, preferred provider organizations, and point of service plans are more attractive to small businesses, says the study, because they offer lower premiums and deductibles than traditional fee-for-service plans. (Source: Reuters Medical News, 1/21/97)

HMO REPORT HIGHLIGHTS GROWTH

As the only truly capitated version of managed care, HMOs represent the greatest challenge—indeed, some would even say threat—to the traditional health care system. When HMOs reach a certain level of penetration in a given area, major change is virtually inevitable.

Which parts of the country are being hardest hit and where are HMOs headed next? According to the latest report from InterStudy Publications, large metropolitan markets (population of a million or more) represented more than 90% of the nation's total HMO enrollment in 1996. While the average penetration in these markets was down slightly from a year earlier (25.8% compared to 26.3% in 1995), the number of metropolitan markets served by HMOs was up by six percent.

Here's a look at penetration rates for specific markets and geographic regions, along with some information on growth trends—

Top five markets—
Rochester, NY: 53.5%
Sacramento, CA: 52.8%
Miami, FL: 46.4%
Buffalo, NY: 45.1%
San Jose, CA: 44.6%
Regional penetration—
Pacific: 27.1%
Mid-Atlantic: 19.9%
Mountain: 19%
Northeast: 18.2%
East North Central: 18.1%
East South Central: 13.9%
South Atlantic: 12%
West North Central: 12%

West South Central: 10.6%
Markets that experienced high growth in 1996—
Fort Lauderdale, FL
Hartford, CT
Phoenix-Mesa, AZ
Portland-Vancouver, OR-WA
Providence-Warwick, RI-MA
Riverside-San Bernardino, CA
San Francisco, CA
San Jose, CA
Seattle-Bellevue-Everett, WA
West Palm Beach-Boca Raton, FL
Markets with high growth potential—
Fort Worth-Arlington, TX
Columbus, OH
New Orleans, LA
Bergen-Passaic, NJ
Fort Lauderdale, FL
Indianapolis, IN
Hartford, CT
Middlesex-Somerset-Hunterdon, NJ
Jacksonville, FL
Richmond-Petersburg, VA
Albany-Schenectady-Troy, NY
Raleigh-Durham-Chapel Hill, NC
Austin-San Marcos, TX
(Source: The Competitive Edge Regional Market Analysis 6.2)

ANA Survey Points To Consumer Concerns About Unlicensed Personnel

Seventy-five percent of consumers polled in an American Nursing Association survey said that reducing the number of RNs who provide bedside care in acute care hospitals leads to lower quality care. Over 65% believe increased utilization of unlicensed personnel to deliver services traditionally handled by an RN also has a negative impact on care quality. More than 80% say unlicensed personnel should not be allowed to draw blood or insert catheters or other tubes.

In addition, the survey found that 45% of consumers say that choosing their own providers is the most important factor in selecting a health plan. Just 17% report that cost is the most important factor. Choice of hospital was selected as most important by only ten percent of the group surveyed, but 70% said that hospital choice was "very important" in selecting a plan. (Source: *Case Management Advisor*, 1/97)

Readmission Rate For Congestive Heart Failure Patients Is Too High

Current practice patterns aren't preventing hospital readmissions among congestive heart failure patients, says a study of readmission rates for all Connecticut Medicare patients admitted to 33 acute care hospitals between 1991 and 1994. Forty-four percent of the 17,448 patients studied landed back in the hospital within six months of discharge. Says study author Dr. Harlan M. Krumholz, "This striking rate of readmission in a common diagnosis demands efforts to further clarify the determinants of readmission and develop strategies to prevent this adverse outcome." The study was conducted at Yale University and published in the *Archives of Internal Medicine*. (Source: Reuters, 1/23/97)

Americans Give Health Care System A Thumbs Down

Have Americans lost confidence in their health care system? Yes, says a new National Coalition on Heath Care survey designed to gauge the public's mood on the subject. Here's a brief rundown of the results—

- 80% of respondents believe something is "seriously wrong" with the system.
- 87% believe quality of care needs improving.
- Eight out of ten think the profit motive is to blame for quality problems.
- Just 15% express "complete confidence" in hospital care.
- Less than half (44%) think the system "will take care of me."
- 72% want the government to take an active role in fixing the health care crises.

The NCHC is comprised of nearly 100 groups which together employ or represent 100 million Americans. Says President Dr. Henry E. Simmons, "There's a serious problem with today's health care system—it's not just about Medicare or Medicaid—it's about the entire delivery system." (Source: *The Dallas Morning News*, 1/24/97)

Ruling Revives Anesthesiologists' Suit Against Aetna

An appeals court in New York has decided that a group of New York anesthesiologists can pursue a lawsuit against Aetna for requiring them to sign managed care agreements that allowed Aetna to drop physicians from the health plan at any time and without cause, and blocked doctors from acting as advocates for patients who were being denied care by Aetna. The January 24 ruling states that the physicians "can file an amended lawsuit charging that Aetna coerced them into signing contracts with it that they felt were unfair." The suit, which was brought by the doctors in 1995, was dismissed in district court last year. Aetna has denied any wrongdoing in the case. (Source: Reuters Medical News, 1/31/97)

"Medicare Choices" Takes Aim At Risk Adjustment

Government officials charged with ensuring the solvency of the Medicare program are in a quandary. Controlling Medicare costs hinges on greater enrollment of beneficiaries in managed care, but many plans are reluctant to accept Medicare patients because of their typically higher costs. Now a demonstration project being

conducted by the Health Care Financing Administration hopes to solve the problem. Six plans have volunteered so far to participate in the Medicare Choices project, which will use "Diagnostic Cost Groups" (DCGs) and "Hierarchical Coexisting Conditions" (HCC) to adjust premiums paid to the plans to account for the varying costs of caring for high- and low-risk enrollees.

The method classifies enrollees into diagnostic groups that are weighted based on their relative care costs. An overall weight for the health plan is then calculated based on that data, and premiums are adjusted accordingly. Built-in mechanisms that take multiple conditions into account prevent plans from assigning additional diagnoses to an enrollee simply to increase capitation premiums.

Five of the six plans will be paid the way Medicare HMOs are paid now during the first year of the demonstration project while tracking costs for Medicare enrollees. Payments in the second year will be prospectively adjusted based on the health status calculated from first-year costs. The sixth plan has chosen to receive adjusted payments the first-year through a concurrent adjuster. That means that the first five plans could end up being paid less because they won't receive a first year adjustment, but they preferred the certainty of knowing their first-year premium revenues in advance.

While the HCFA project is using the DCG-HCC method of risk adjustment for Medicare managed care plans, officials say other methods may also be considered, including the Ambulatory Diagnostic Groups (ADGs) method developed at Johns Hopkins University and various survey-based methods. Data from the six plans in the demonstration project will, in fact, be used to simulate use of the ADG approach, and if it shows promise, it may be used to adjust payments as HCFA expands the testing program. (Source: *Medicine & Health*, 1/6/97)

HOSPITALS, HMOS, SQUARE OFF IN FIGHT FOR MEDICARE BUSINESS

While HCFA tries to come up with a way to encourage MCOs to enroll greater numbers of Medicare beneficiaries by adjusting the risk incurred by the plans (see previous article), hospitals are looking for a way to break into the Medicare managed care market that has traditional MCOs hopping mad.

Provider sponsored organizations (PSOs) set up to contract directly with health care purchasers on a capitated basis enable hospitals and physicians to band together to provide services without the insurer middle man, and since they aren't insurers per se, they say they should be exempt from state licensure laws governing HMOs. Hospital groups, including the American Hospital Association, the Federation of American Health Systems, VHA, Inc., and the Catholic Health Association are currently lobbying Congress for federal exemption from licensure and other laws (including those involving financial matters) that would make it easier for PSOs to compete with traditional HMOs for Medicare beneficiaries.

The Blue Cross & Blue Shield Association has countered that holding PSOs to different financial and quality standards would seriously compromise the care delivered to Medicare beneficiaries. They note that the states have generally been more aggressive in passing regulations aimed at protecting consumers and that lack of such standards for PSOs would diminish the impact of those regulations.

The hospital industry, however, says that the insurance industry's protestations are just sour grapes. Says AHA Vice President Richard Pollack, "We want to be held to high standards but different standards." (Source: Reuters Medical News, 1/30/97)

DOWNSIZING HITS HIGHER PAID PERSONNEL

The first round of downsizing in hospitals may have targeted the lower end of the wage scale but recent cutbacks have focused on the higher paid, older doctors and nurses who hold management positions, says a recent report in the *New York Times*. The newspaper quotes industry experts who say that older doctors and nurses with "high salaries and roots in old-style medicine . . . are natural targets for hospitals trying desperately to economize."

The Center for the Health Professions at the University of California at San Francisco agrees, saying that the current trend in hospitals to weed out upper level personnel parallels what has happened in other industries. Says Janet Coffman, a researcher at the center, "In the '80s, lower-level folks got squeezed; in the '90s, it's upper-level folks and management." (Source: Reuters Medical News)

ARCF FELLOWSHIPS PROMOTE RESPIRATORY CARE RESEARCH

Every year, the ARCF joins with sponsors from industry to award more than $10,000 to RCPs and others engaged in clinical research projects designed to further the scientific basis of respiratory care. Fellowships available through this alliance include—

Respironics Fellowship in Non-Invasive Respiratory Care: This fellowship is designed to foster projects dealing with non-invasive techniques to provide ventilatory support. Projects can focus on device development, device evaluation, cost-effectiveness analysis, and education programs. Current fellowship funding includes a cash award of $1,000, plus airfare and one night's lodging to attend the Awards Ceremony at the AARC Convention.

Monaghan/Trudell Fellowship for Aerosol Technique Development: The fellowship is designed to support projects dealing with aerosol delivery issues. Projects may include modeling studies, in-vitro studies, or clinical studies. The focus should be on developing cost-effective approaches to aerosol delivery. Current fellowship funding includes a cash award of $1,000, plus airfare and one night's lodging to attend the Awards Ceremony at the AARC Convention.

Lifecare Fellowship in Mechanical Ventilation: This fellowship is designed to foster projects dealing with mechanical ventilation, especially outside of the intensive care unit. Projects may include device development, device evaluation, protocol development, cost-effectiveness analysis, or education programs.

Current fellowship funding includes a cash award of $1,000, plus airfare and one night's lodging to attend the Awards Ceremony at the AARC Annual Convention.

Glaxo-Wellcome Fellowship for Asthma Education: This fellowship provides supplementary support for a one-year period to permit fellows to complete a project in asthma education. The purpose of the fellowship is to foster projects that address issues of asthma education, asthma self-management, and asthma awareness. Current fellowship funding includes $3,500 per year, plus airfare and one night's lodging to attend the Awards Ceremony at the AARC Convention.

Application Procedure

Applications must be received by June 30 to qualify for awards beginning January 1 of the following year. They will be judged on merit by the ARCF Board of Trustees in consultation with appropriate reviewers and the fellowship sponsors.

- The application must consist of no more than 20 pages, including references, tables, and figures.
- The application must have the following components:
- Background of the projects. This should include a scientific review of the problem and previous work in the field.
- A description of the planned project. This should include the hypothesis (if applicable), the methods to be used, the analytical plan, the expected outcome, and the clinical relevance.
- The facilities and resources that are available, including consultants and supervisors (appropriate CVs are requested).
- Other financial support that is anticipated.
- The significance of the project and how it meets with the intent of the fellowship
- A letter of support from the program director or department director stating that adequate time will be made available to carry out this project. If other resources are going to be required, this also needs to be stated in the letter.
- A curriculum vitae of the applicant

Applications for the Respironics, Monaghan/Trudell, Lifecare, and Allen & Hanburys Fellowships will be accepted from January 1-June 30.

Recipients will be selected by September 1 and the fellowships presented by the ARCF during the Awards Ceremony at the AARC Convention.

Additional information about these four fellowships is available from the ARCF Executive Office, 11030 Ables Lane, Dallas, TX 75229, (972) 243-2272.

CALL FOR CONTRIBUTORS

The Management Section is looking for people to share their experiences in several areas. We would like to publish your feedback in future issues of the Bulletin. You don't have to submit a formal manuscript to participate—we will accept responses by email or will respond to telephone interviews. You give us the ideas and information and we will do all the work. Call, write, fax, or e-mail Karen Stewart with your contributions at the addresses/numbers listed on the back page of this and every issue.

We are looking for information about the following topics—

Integrated Delivery Systems: Has your hospital become part of an integrated delivery system? If so has there been any increase in the array of services your respiratory care department offers? Have you contracted services to an HMO?

Documentation: Are you doing patient charting by exception? How did you go about the implementation process and what hurdles did you overcome?

- **Age Specific Education Material:** Has anyone at your facility developed age specific education material? What material would you find helpful in developing age specific education material? Would you be willing to share how the development was done?
- **Cooperative Agreements:** Are you in the process, or have you completed a cooperative purchasing agreement for capital purchases or disposable products where both the hospital and the vendor share risk?

MANAGEMENT SECTION RESOURCE DIRECTORY: SIGN UP TODAY!

We are all of us richer than we think we are.
—Montaigne

The Management Section Resource Directory, a new tool designed to help members get in touch with each other to receive advice or share information on topics of concern, is being updated in this issue. However, we are still looking for names to add to the list. If you would be willing to serve as a resource for your colleagues around the country, please take a few minutes to fill out the following form. Your name and area of expertise will be included in an updated version of the Resource Directory and used to provide information to members seeking help in your area(s) of expertise.

RESOURCE DIRECTORY SIGN-UP FORM

Name _____

Title _____

Organization _____

Address _____

City, State, Zip _____

Phone _____ Fax _____

e-mail _____

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

____Competency Documentation
____Performance Appraisals
____Respiratory Care Information Systems
____Benchmarking
____Case Management
____Other _____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

Return to this form to:

William H. Dubbs, MHA, RRT
AARC Director of Management Services
11030 Ables Lane
Dallas, TX 75229
Fax (214)484-2720

MANAGEMENT SECTION RESOURCE DIRECTORY

Topics

Competency Documentation
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Marta Tingdale
Quinton Gregg Beckham
Tad Hunt, RRT
Sharon Real

Performance Appraisals
Marta Tingdate
Quinton Gregg Beckham
Tad Hunt, RRT

Respiratory Care Information Systems
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Trish Blakely, RRT, RCP
Karen Stewart, BS, RRT

Benchmarking
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Quinton Gregg Beckham
Natalie J. Golden, BS, RRT
Sharon Real

Case Management
Michael Burchman, RRT, RRCP
Richard L. Pharr
Trish Blakely, RRT, RCP
Marta Tingdale
Quinton Gregg Beckham
Natalie J. Golden, BS, RRT
Tad Hunt, RRT

Other
Richard L. Pharr
Madeleine MacCallum (Conversions of policies and procedures to clinical practice guideline format)
Marta Tingdale (Care paths, protocols)
Quinton Gregg Beckham (Long-term pediatric subacute services)
Natalie J. Golden, BS, RRT (Protocols for long-term patients without regard to DRG amounts, provider contracts)
Tad Hunt, RRT (Managed care, post acute care, Clinivision, clinical pathways, teamwork, sharing duties RT/nursing.)
Sharon Real (Sample subacute contracts, transfer agreements, performance evaluations)
Carrie Breneiser (Long term acute care policies and procedures)

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JCAHO Accreditation Visit Report Form

The following survey form is provided to enable the reporting of recent JCAHO accreditation site visits. Compiled results will be published regularly through select section newsletters and the *AARC Times*. Please return your completed survey to:

William H. Dubbs, MHA, RRT
AARC Director of Management Services
11030 Ables Lane
Dallas, TX 75229-4593
Phone # (972) 243-2272 Fax # (972) 484-2720

Inspection Date: _____

Name: _____

Facility: _____

Address: _____

_____

_____

Phone: _____

If you are willing to discuss your accreditation visit with others check this box ☐ and this information will be added to a list that is available to AARC members. If you do not check the box your response will remain anonymous.

Please check the type of accreditation visit you are reporting:

Pathology & Clinical Laboratory Services ☐

Hospitals ☐

Home Care ☐

Long Term Care ☐

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

What areas were cited as being exemplary?

What suggestions were made by the surveyors?

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

Please offer any additional comments about the site visit that will be helpful to others. (use additional sheet if necessary)

_____

_____

_____

SPECIALTY PRACTITIONER OF THE YEAR

Don't forget to make your nominations for the Management *Specialty Practitioner of the Year*. This honor is given to an outstanding practitioner from this Section each year at the AARC's Annual Meeting.

The recipient of this award will be determined by the Section Chair or a selection committee appointed by the chair. Each nominee must be a member of the AARC and a member of the Section.

Use the following form to send in your nominations for this important award—

I would like to nominate _____ for Management *Specialty Practitioner of the Year* because

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____	_____
Nominee	Your Name
_____	_____
Hospital/School	Hospital/School
_____	_____
Address	Address
_____	_____
City, State, Zip	City, State, Zip
_____	_____
Phone	Phone

Mail or FAX your nomination to the Section Chair at the address/number listed on the last page of this issue.

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Management Section
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Deadlines for submitting copy for publication in the *Bulletin*—

Spring Issue: February 1
Summer Issue: May 1
Fall Issue: August 1
Winter Issue: October 1

American Association for Respiratory Care
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