Management Bulletin

Issue No. 2

Notes from the Chair

by Karen Stewart, BS, RRT, LRT

As most of you already know, we, as respiratory care providers, recently suffered some really bad publicity when one of our ranks was accused of creating harm against a patient or patients. A respiratory therapist in Glendale, CA, first confessed to, and then recanted, killing more than 50 patients whom he felt were terminally ill and would be better off "put out of their misery." The most egregious incident in this ongoing saga, however, is the fact that shortly after the story broke, the entire respiratory care department in this hospital was put on temporary leave, and four were subsequently fired.

In my 26 years as an RCP this is the first time I can recall such negative publicity for our profession. Indeed, we have come a long way during my tenure. A number of states now have licensure, which has helped to elevate our status. And many RCPs I know are some of the most caring individuals in the health care system. In fact, I recently attended a meeting where a physician stated that he sometimes orders respiratory care services just so the therapist can take the time to evaluate the patient.

I would like to encourage all of you to take the time to think about our success as a profession, pat yourself on the back, and then tell your staff "thank you" for taking such good care of America's mothers, fathers, sons, daughters, and others family members. Remember, we are an important part of the health care delivery system. We should be proud of who we are! ■

The Respiratory Therapist As Disease Manager: Extending the Role in Home Health Care

by Gwendolyn Valentine, MS, RRT, president, MVPRespiratory Management, LLC

Traditionally, the respiratory therapist's role in home health care has been one of setting up equipment and explaining to patients and their families how to take medications that are respiratory-related. However, there are a few companies and physician office practices that take RCPs beyond that traditional role, and MVP Respiratory Management is one of those companies.

At MVP Respiratory Management, we specialize in respiratory disease management. But we also offer disease management for diabetes, HIV, stroke, and hypertension. When Cathy Palmer and I started this company 31/2 years ago, our goal was to fill a void in East Tennessee that was not being covered by home health care agencies.

In October of 1993, there were no disease management companies of any type in our area. The state of Tennessee did not know how to classify our company and eventually put us in the home health care category. Getting started and convincing physicians, HMOs, PPOs, and managed care providers to utilize our services was difficult at first. We began by offering asthma, COPD, and cystic fibrosis education programs, weekly and monthly follow-

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ups, 24-hour service, physical and environmental assessments, and a consultation service. We also worked with a closed-door pharmacy to provide home-delivered respiratory medication.

We have since secured a contract with the University of Tennessee Health Network. Their plan includes 28 insurance companies that qualify to utilize our services. We have also secured a contract with a major home health care agency to provide disease management and patient education to their patients. More importantly, our patients are referring MVP Respira-tory Management to their friends and to physicians who are not familiar with us.

Providing good, sound advice, constant follow-up, and educational materials that are understandable has contributed to our success. Involving the primary physician in the treatment plan has played a major role as well. Not only do we provide our physicians with verbal and written reports, we also recommend treatment and medication changes, and perform drug profiles on all of our patients.

We consider ourselves case managers as well as disease managers. We look at the patient holistically rather than simply as a person with a respiratory disease. For example, if a patient is in need of social services, Meals on Wheels, or transportation, we try to contact individuals or agencies to meet those needs. It is our belief that we must meet the need that the patient considers his or her primary concern before we can focus on the reason we were asked to see the patient in the first place.

As managed care and other changes continue to impact our profession, we, as respiratory therapists, must be willing to step outside of our traditional role as therapist and take on some new and added responsibilities. Don't be afraid to explore options typically considered "outside of the box." There are disease management packages already developed that are easy to follow and can be adapted to meet your needs.

Disease management is the way of the future and we, as respiratory therapists, must be prepared to assume the role of case and disease managers. I would like to encourage all RCPs who are eligible to take the case manager's examination. Third party payers are already using case managers to provide patient education, and this trend is likely to continue as managed care looks for better ways to control costs. ■

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Teamwork: Request For Information

Today, the focus in health care facilities is squarely on teamwork and creating work teams. Everything, it seems, could be better handled by the team approach. Of course, in reality one must first determine if the work really fits in with the team process. Here are a few questions to ask yourself before assigning people to teams:

- Does the work require more than one person?
- Would more than one person improve the outcome of the work?
- Would there be an improvement if more than one person was involved?
- How involved with customers is the essence of the work?

If the answer to the first three questions is "no," then designing a work team may not be the best choice for your organization.

In respiratory care, we can certainly identify some areas, such as customer satisfaction, where a team approach would result in improvements. And clearly, we must be a part of a team when it comes to the overall delivery of patient care and coordinating care with other disciplines.

But do we need a team to deliver direct patient care, such as a nebulizer treatment? What do you think? What is your department doing in regards to teams?

We would like to share your experiences in future issues of the *Bulletin*, so if you have been involved with team building in your institution, please consider submitting a short (500-1000 word) article for publication. Send your contributions to Karen Stewart at the addresses/number listed on page 2. ■

Catch the Wave: What's Happening with Work Redesign

The Management Section has been alerted to a new thread of information winding its way through hospitals throughout the country. Specifically, many of our members are reporting that a new wave of work redesign is taking hold in hospitals in their areas. In some cases these efforts are leading decentralized departments to return to somewhat of a centralized function. Others, however, are continuing to struggle with the whole process. If you have any information regarding this latest wave in work redesign, please contact Karen Stewart at the addresses/numbers listed on page 2. ■

FYI...

HMOs suffer decline in profitability

InterStudy Publications' second annual HMO Financial Benchmarks is showing a decline in profitability for the nation's health maintenance organizations. According to the report, the average margin dropped from 2.4% in 1994 to -1.2% in 1997. While 90% of all HMOs were profitable in '94, just 49% could say the same last year.

Part of the reason for the decline in profitability lies in the increasingly low premium increases being negotiated by public and private purchasers of health care plans. In 1994 the typical premium rose about five percent; by 1996 increases had been cut to an average of 0.5%.

Medical expense inflation tells the rest of the story, says the report. In 1994, medical costs rose five percent. Although they dropped to three percent in 1996, that wasn't enough to offset the greater decline in average premium increases.

Providers go on the offensive

As long as health care consumers value the relationship they have with their physicians more than the relationship they have with their health plans, managed care will be playing a game of catch-up when it goes head to head with recalcitrant providers, writes J. Daniel Beckham in a recent article in Healthcare Forum Journal. He recounts the experiences of Nalle Clinic in Charlotte, NC, as an example.

When the 120-physician group was faced with an HMO that was threatening to bring in its own physicians if the clinic didn't accept what it considered a bad deal, it went on a marketing offensive, calling all of its patients and urging them to switch to a plan that would allow them to retain the clinic's physicians.

Says Beckham, "Hospitals and doctors own the most powerful brands in health care. After an initial foray into advertising during the '80s, hospitals and health systems are beginning to invest in fortifying and extending their brands. Ultimately, this investment will enhance their ability to sell their services directly to employers and consumers."

New IRS rule to impact joint ventures

A new Internal Revenue Service (IRS) rule that defines for the first time what kinds of joint ventures can quality for tax-exempt status is likely to put the brakes on joint ventures between for-profit and not-for-profit hospitals. According to a recent article in the Wall Street Journal, the IRS is warning hospitals that alliances between for-profits and not-for-profits must "give charitable purpose priority over maximizing profits." In other words, the not-for-profit hospital must maintain control in these joint ventures in order to maintain its not-for-profit status.

Columbia/HCA Healthcare Corp. is expected to be among the hardest hit by the ruling. While the company has pulled back from the joint venture strategy in recent months, it still has seven or eight such partnerships in the works. ■

Management Section Resource Directory: Sign Up Today

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, will be updated soon and we are 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 form on page 4. 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. ■

Management 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:
Kelli Hagen
AARC Communications Coordinator
11030 Ables Lane
Dallas, TX 75229
Fax (972) 484-2720

Specialty Practitioner of the Year: Request for Nominations

Don't forget to make your nominations for the Management Specialty Practitioner of the Year. The winner of this important award will be determined by the Section Chair or a selection committee appointed by the chair, and will be honored during the Awards Ceremony at the AARC Convention. Each nominee must be a member of the AARC and a member of the Section. Mail or FAX a short (500 words or less) essay outlining your nominee's qualifications to the Section Chair at the address/number listed page 2 of this issue. Be sure to include both your name, address, and phone number, along with that of your nominee. ■