Management Bulletin

March/April '99

American Association for Respiratory Care

Notes from the Chair

by John Kimble, RRT, RCP

As I write this column, I am sitting here with my cowboy boots on and my ten gallon hat atop my head. No, I'm not getting dressed for a rodeo. It's to honor the Ladies and Gents from Texas who submitted articles for this issue of the *Bulletin*. At our section business meeting in Atlanta I "volunteered" the managers from my home state to fill this edition with submissions, and the issue came together through the hard work, begging, pleading, and badgering of Wadie Williams from St. Luke's Episcopal Hospital in Houston. I hope you find their offerings as interesting, thought provoking, and insightful as I did. ■

Notes from the Guest Editor

by Wadie Williams, RRT, RCP, manager and systems administrator, respiratory care department, St. Luke's Episcopal Hospital, Houston, TX

I would like to thank the following individuals for the opportunity to contribute to our organization and share information with my peers and colleagues around the country by serving as guest editor of this issue. I consider it an honor to have been asked to participate in this manner. First, let me say thank you to the therapists from New Mexico for the articles they contributed to the Sept./Oct. 1998 issue of the *Bulletin*. The format they began with that issue (i.e., having managers from one state "take charge" of a particular edition of the *Bulletin*) provided the impetus for us to produce this issue of the *Bulletin*. Indeed, their efforts have shown us all how we can share our experiences with others and provide hope to those who may feel there is none.

Next, I would like to thank John Kimble, section chair, for "volunteering" me for this opportunity. Seriously though, I have enjoyed the chance to contribute to our profession and our section and to assist my friend and colleague in his efforts to have a successful and fruitful tenure as chair.

Lastly, I would like to sincerely thank everyone who contributed to this "Texas" issue of the *Bulletin*. I appreciate your efforts to "squeeze" one more thing in your already busy and hectic schedules. Your willingness and eagerness to contribute is greatly appreciated and a testament to why we, as a profession, will be around and thriving during the next millennium and beyond.

As you will see, we have enlisted therapists and managers from around the state of Texas to share with you what they are doing to manage their staffs, explore new territories, grow their services, and demonstrate through action the value that the respiratory therapist brings to our various organizations. We hope you will read about what they have done and then use that information to find opportunities within your own facilities to explore, embrace, and take on.

It goes without saying that none of the programs outlined herein were easy to develop. There are great risks involved and many unknowns that have to be dealt with. However, like every journey, it all begins with the first step and making the commitment to seek out new areas of responsibility. The payback is tremendous. The skill level of the staff is increased, our knowledge base grows, our involvement is highly visible, and our value and worth is demonstrated in such a fashion that words fail to do justice.

In the following stories, we share

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with you our successes (we can talk about the missteps at another time), and we hope they will point you in new directions, encouraging you to seek these and other opportunities in your own facilities. From working in the operating room and leading transport services to coordinating facility ACLS classes and case management, these respiratory therapists have proven that we have but to look at and question ourselves as to where we want to go next.

As we rapidly approach 2000, we must continue to ferret out every opportunity to demonstrate that we are ready, willing, and able to be the professionals of choice for our patients and their families, physicians, nurses, other professional coworkers, payers, and each other.

Good fortune to us all in the months and years to come, and let's all succeed together!

For more information, Wadie can be reached via email at wwilliams @sleh.com ■

Case Management in Respiratory Care

by Virginia Arrington, RRT, RCP, computer systems specialist, pulmonary services, Hendrick Medical Center, Abilene, TX

Like all hospitals, Hendrick Medical Center in Abilene, TX, has faced several budget cuts over the years. In the past, when upper management said we must work smarter and wiser, we responded by expanding our scope of services to include EEG/sleep lab, hyperbaric medicine, pulmonary rehabilitation/lab, and subacute respiratory care. We evaluated our procedures, made changes where feasible, and monitored the productivity of our staff. We avoided decentralization by showing that we were already "decentralized," working throughout the health care system wherever and whenever needed and proving our worth with aggregate data.

Now we face the consequences of the Balanced Budget Act of 1997, including the prospective payment system (PPS) for skilled nursing and its effects on subacute respiratory care. As a result of PPS, we have seen a reduction in respiratory care provided by qualified, licensed personnel in the nursing home environment throughout the community. Our on-campus skilled nursing units face similar concerns, with a significant loss of revenue to the hospital. Hence, another budget cut.

But this time, rather than finding new ways to provide more services, we are finding better ways to provide the services we were originally trained for. The six essential activities of case management are similar, if not identical, to the responsibilities of the respiratory care practitioner. The difference lies in our assertiveness when utilizing these skills. Consider the following:

Patient assessment – Heart rate, respiratory rate, breath sounds – but what else? Oxygen saturation, sure. But what about patient history and previous admissions? Is your staff well-informed about their patients? What can be done to get them more information? What information is available on their worklists?

Plan of care – Is your staff involved in the planning of their patients' care? Are care plans filled out and routinely reviewed? Are specific goals and treatments designed to meet the patients' needs based on patient assessment? Are the plans action-oriented and time-specific?

Implement therapy – Is your staff providing the treatments to accomplish the goals determined in the plan of care? Are the treatments appropriate for the patient's physical, medical, psychological, social, and behavioral needs?

Coordinate with other staff – Does your staff organize and integrate the resources necessary to accomplish the goals determined in the plan of care? Does your staff communicate directly and effectively with the patient's physician, nurse, nutritionist, social worker, and/or other health care professionals on a regular basis?

Monitor effectiveness – Is sufficient information about the patient's response to treatment routinely gathered from all relevant sources? Does this information include the quality of the patient's response?

Evaluate outcomes – Is the effectiveness of the patient's treatments routinely evaluated in terms of reaching the desired outcomes and goals? Is treatment modified when required?

Therapist-driven protocols (TDPs) can encompass all of these activities. But even for patients who are not on TDPs, these activities should still be utilized, with consistent interaction between your staff and the physicians and nurses.

From a management standpoint, we also should use these skills in our daily operations. Our "department" is the patient, our "mission" is the plan of care, and our "programs" are the therapy. If we are to maintain our viability in the health care profession, we must let our skills as managers and knowledge as therapists guide us to be proactive rather than reactive in the face of health care reform. Utilizing case management skills to provide results-oriented, cost-effective services can offer a safe path in these changing times.

For more information, Virginia can be reached via email at varringt@hen - drickhealth.org. ■

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Expanding Our Reach . . . Shaping Our Image

by Elizabeth Bearden, RRT, RCP, clinician, respiratory care diagnostics, and Joy Kraus, RRT, RCP, manager, respiratory care patient care services, St. Luke's Episcopal Hospital, Houston, TX

At St. Luke's Episcopal Hospital, located in the Texas Medical Center of Houston, we have the good fortune of working in one of the top ten hospitals in the country for cardiovascular and cardiology services. Our 949-bed facility treats thousands of patients each year for cardiovascular disease and cardiac problems.

Our respiratory care department is an integral part of that care. But in addition to providing the specialized care of ventilatory support, physiologic monitoring, and routine therapeutics, we are involved in many other areas that increase the value and quality of care to our patients. We also assist our staff and others with maintaining good clinical skills and acquiring new skills and responsibilities. Although our department's FTEs have decreased significantly over the past several years (40% over 6 years), we continue to provide high quality service and have expanded our areas of involvement to demonstrate our worth to our patients and our facility. The following are just a few of the areas in which we have extensive input and exposure.

Anesthesia support

Approximately seven months ago, we became intimately involved with the workings of our large operating room service. The perioperative services department is comprised of 42 rooms for which the anesthesia department provides care and support. There are two medical groups that provide anesthesia services to our patients; one for cardiovascular surgery and the other for general surgery. Our support includes direction of the anesthesia technicians, who support both services in an almost seamless operation.

We have also developed systems to ensure that the rooms are ready and that the equipment necessary for the anesthesiologist to provide care has been properly assembled, inspected, and tested prior to patient care delivery. We have implemented a proactive approach to eliminating common problems that affect the readiness of the surgical and anesthesia delivery systems, thus keeping the operating room on schedule. In addition, we have supplemented the resource base for the anesthesia techs and medical anesthesia staff by providing the clinical and organizational expertise of respiratory care within the operating room. We are currently researching other avenues to involve respiratory care in this environment on a routine and regular basis.

ACLS coordination

Since January 1990, the respiratory care department has been responsible for coordinating the ACLS classes within our institution. These courses are a collaborative effort between our medical staff, cardiology fellowship program, nursing, respiratory care, and pharmacy. This came about as a result of a need for in-house training at a time when our department had the resources to accommodate the need. Although our staffing has diminished, we continue to staff and support the program with therapists and supervisors who are ACLS instructors. There are 4-6 courses taught each year, and we also provide courses for several clinics in the area that are affiliated with St. Luke's.

Code validation

Several years ago, our nursing service deployed a new competency program for team response to code situations. Post-code assessments revealed that while most individuals were competent in basic CPR procedures, the actual performance of employees during codes needed improvement. Performance concerns focused on personnel not being involved in code situations for several months and becoming "rusty." A Code Validation Program was developed to enhance and refine skills, including EKG interpretations, airway management, defibrillation, and external pacing; practical matters, such as where things are found in the crash cart, were covered as well. Since we were involved in and coordinate the ACLS program, the respiratory care department was asked to participate as one of the developers.

Respiratory therapists are involved as "trainers," who teach the "validators" who, in turn, "check-off" students on their skills. Respiratory therapists also attend the code validation classes and "check-off" similar to nurses. The program has been expanded to include pharmacists and nonlicensed personnel. What's more, it has been recently determined that this course meets the new Joint Commission requirements for in-house documentation of CPR training.

For additional information, Beth and Joy can be reached via email at ebear - den@sleh.com or Jkraus@sleh.com. ■

Life At Texas Children's Hospital

by Lee W. Evey BS, RRT, RCP, interim director, respiratory care/physical medicine and rehabilitation, and Garry Sitler, RRT, RCP, assistant director, transport services, Texas Children's Hospital, Houston, TX

Texas Children's Hospital is a 456-bed tertiary care pediatric facility located in the Texas Medical Center. We treat patients from countries all over the world and are a regional cystic fibrosis center.

The hospital opened in 1954 and is affiliated with Baylor College of Medicine, which operates one of the largest pediatric residency programs in the country. In 1991 Texas Children's expanded its facilities, making the hospital the largest pediatric hospital in the country. The hospital has a 60-bed level 3 nursery, 60 beds in level 2 nurseries, a 30-bed pediatric intensive care unit that includes an 8-bed cardiovascular recovery room, a 24-bed ICU step-down unit, and several floors of subspecialty care. The emergency center (EC) sees 50,000 patients per year.

The respiratory care department is

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volved in numerous clinical studies nd administers nitric oxide and oscil-tory ventilation. In 1998 the depart-ent performed 1,345,508 procedures nd is on pace to exceed that in 1999. he department employs over 110 erapists who receive a 6-7 week omprehensive orientation.

esource utilization

As new positions became difficult obtain, the department implemented 2-hour shifts in 1993. This has lowed the department to continue to offer new services without significantly increasing FTEs. The ICUs are staffed to allow time for the assessment and treatment of the patients. The EC is staffed with at least one respiratory therapist at all times; during the busy winter months up to three therapists are staffed in the EC. The acute care area of the hospital is generally staffed to allow 30-35 treatments in a 12-hour shift.

Additional areas of involvement

On the day shift, a respiratory therapist is assigned to cover the post-anesthesia care unit. This therapist also covers the cardiac catheterization rooms and assists with bronchoscopies. On each shift there is one respiratory therapist assigned to the PICU transport team and one respiratory therapist assigned to the NICU transport team. Additionally, there is a third therapist on each shift who backs up both transport teams and is available for long distance transport by fixed wing aircraft.

For additional information, Lee and Gary can be contacted via email at Levey@texaschildrenshospital.org or Gsitler@texaschildrenshospital.org ■

"Routine to the Procedure" Medicare Fraud and Billing of Respiratory Care Procedures

y Lynn LeBeouf, RRT, executive vice president, Tomball Regional Hospital, Houston, TX

In my role as executive vice presi-ent at Tomball Regional Hospital, I n responsible for dealing with the Medicare fraud and abuse initiatives. I ave spent many days and hours with Medicare consultants and attorneys in n effort to ensure proper compliance ith the Medicare regulations at my ospital.

As a 29-year veteran of the respira-ry therapy profession, I have also ied to pass my "unique" perspective n these issues on to as many respira-ry care managers in our state as pos-ble so that they can avoid common tfalls in their billing practices. As ou are aware, Medicare billing rates r medical procedures were set by viewing each individual "proce-ure" and all "cost" associated with at procedure in all areas of the coun-y. That data was then used to deter-ine the billing codes and rates for the arious procedures. Everything that is outine to the procedure" is covered nder the allowable billing rate set for that procedure.

According to the Medicare Provider Reimbursement Manual, HCFA Pub. 15, Section 2203.2: The billing of "additional services" that are "ordinarily used for or on most patients" is considered "un-bundling the procedure" and has been deemed Medicare fraud. This creates several distinct land mines for the billing of respiratory care procedures.

One large land mine is pulse oximetry. If there is a protocol for oxygen therapy that utilizes pulse oximetry to "titrate" the oxygen on all patients receiving oxygen therapy, then that use of pulse oximetry has just become "routine to the procedure of oxygen therapy" and is therefore not separately billable. Also, if most or all patients in a specific care area (i.e., critical care, endoscopy suite, recovery room, etc.), are "routinely monitored" with pulse oximetry, then it is "routine to that unit" and is not separately billable. (This is the same rationale that states that you cannot bill for a cardiac monitor in addition to a critical care unit.)

However, it is allowable to bill for continuous pulse oximetry on a med-surg unit because it is not "routine" to that unit. The only other form of pulse oximetry that is billable is "diagnostic oximetry" that is physician ordered and medically necessary for the patient's condition, such as "pulse oximetry for SOB" or "pulse oximetry for chest pain."

To avoid problems when it comes to billing for additional services, all RC managers should review their charge masters with these questions in mind:

1. Is it routinely used on most, if not all, patients who receive that procedure?
2. Is it ordered by a physician?
3. Is it medically necessary for the patient's condition?

If you cannot answer "no" to the first question and "yes" to the other two, you should not be separately billing it! ■

Review of CPGs

The AARC Clinical Practice Guidelines Steering Committee would like your help in revising the Clinical Practice Guidelines (CPGs).We need the respiratory community to identify specific areas of the CPGs for revision. Note that the CPGs are evidence based; therefore, please identify areas for revision, provide suggestions for revision, and cite peer-reviewed literature to support those suggestions.

Please e-mail your specific comments to the chair of the Steering Committee, Dean Hess, PhD, RRT, FAARC, at dhess@partners.org or fax them to 617/724-4495.

You will find copies of all the CPGs published by the AARC at: http://www.rcjournal.com/online resources/cpgs/cpg index.html

Patient Self-Administration of Inhaled Medication

by Joe Horn BS, RRT, director of cardiopulmonary, Huguley Health System, Ft. Worth, TX

In the early '90s it became clear that the environment of health care was changing, and changing drastically. The delivery mechanism, as well as the reimbursement mechanism, was taking on a new face. At Huguley Health System in Fort Worth, TX, we began learning – and even occasionally using – the term "managed care." The more we learned about managed care the more we realized that we had to find new and innovative ways to deliver respiratory care to our patients. We were forced to "think outside the box."

At first, we didn't know where to start. Specifically, we didn't know that other hospitals were quickly deciding that they could not afford to continue to pay respiratory therapists to stand and watch a patient take an updraft or handheld nebulizer treatment that they usually take at home by themselves. But once we realized what the end result needed to be, we simply started putting the pieces of the puzzle together – backward. We realized that we needed to find a way to allow patients who possessed the proper cognitive skills and alertness to do their own therapy. Processes were developed to standardize communication, evaluation, assessment, and procedures.

Under this new mindset our emphasis shifted from the delivery of routine therapy to patient education and assessment – and none too soon. A very wise man once said, "perception is reality." For too many years the perception of the respiratory therapist's skills and knowledge has been tainted by this thing we call "routine therapy." A frequent observation may go like this: housekeeping personnel see us twist the top off, squirt the medication into the "little dilly," put it back together, and hand it back to the patient. One can only imagine what they are thinking about their own ability to begin taking on respiratory therapy respons bility and pay that very day!

This project has also been super fo morale and job satisfaction – one of th most difficult and constant challenge we face as managers. Giving respirato ry therapists the opportunity to shar knowledge with their patients, educat them about their disease, or convers with the physician concerning the findings on his or her patient's assess ment is a tremendous step forward. I fact, since we have shifted our focu from routine therapy to patient educa tion and assessment, it has becom quite common for physicians to writ orders asking for respiratory to asses the patient and recommend a plan c care. In my eyes this is very promising I know we still have much work to d but I do think we are moving in th right direction. ■

FYI . . .

Writing your congressman can pay off

The AARC is always urging its members to write their congressmen and senators about issues that are impacting the profession. But do these letters do any good? Consider the case of AARC member Bill Roberts, who both wrote and called Senator Tom Daschle (D-SD) about the need to assure the competency of caregivers providing respiratory therapy in skilled nursing facilities. Members of Sen. Daschle's health staff not only saw a definite need to address the issue, they called for a meeting with the Health Care Financing Administration (HCFA) to discuss the matter and invited AARC representatives to attend.

In discussing the issue of competency requirements for caregivers providing respiratory therapy, the AARC's primary question to HCFA was, "How can you guarantee quality respiratory therapy will be administered in SNFs when some facilities have a financial incentive under PPS to use inappropriate personnel to deliver that care?"

The AARC urged HCFAto establish requirements for SNFs that would ensure that facilities hire appropriate, qualified personnel to deliver respiratory care to their patients. Noting that it is difficult for HCFA to make any changes in competency requirements without further legislative authority, the federal agency suggested that it may be time to push for the introduction of legislation that would require nursing home staff to meet competency requirements in order to provide respiratory therapy services in SNFs – an idea that the AARC fully supports and has been advocating for some time.

The moral of this story? One letter can make a difference, so please send your own letters to your senators and congressmen expressing your concern about assuring the competency of caregivers providing respiratory therapy in SNFs.

Medicare managed care risk adjustment method on the way

The Health Care Financing Administration (HCFA) is getting ready to implement, on a phased-in basis, a more accurate payment method for Medicare managed care patients. The goal is to assist Medicare managed care plans that enroll th sickest beneficiaries.

Required by the Balanced Budge Act of 1997, the new risk adjustmer payment method will be phased in ove five years, gradually increasing pay ments to plans that care for the sickes beneficiaries who stand to gain th most from managed care's focus o coordinating care. Medicare currentl pays health maintenance organizatior (HMOs) and other managed care plar a fixed monthly amount per beneficia ry, adjusted only by demographic fac tors.

Risk adjustment looks at a person diagnosis in one year and predicts hov much, if any, additional cost there wi be for that person the next year. Fo example, a person who has appendic tis in one year is not expected to hav higher than average costs the followin year. If a person has a stroke, howeve additional costs beyond the average ar predicted and a plan would receive larger payment to cover the additiona expected costs.

Risk-adjusted payments to plar will begin Jan. 1, 2000. However, t ensure that plans have time to adjust t

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the new payment method, in 2000 only 10 percent of a plan's payment for each beneficiary will be calculated based on the new risk adjusters. The payment plan will continue to be phased in between 2000 and 2004.

Only six million of Medicare's 39 million beneficiaries are currently enrolled in managed care, but, on average, 60,000 to 70,000 Medicare beneficiaries enroll in these plans every month. (HHS)

Federal government kicks off International Year of Older Persons

1999 has been officially proclaimed the International Year of Older Persons. The theme of the year, "Towards a Society for All Ages," was designated by the United Nations General Assembly in 1992 to highlight the challenges and opportunities of a rapidly aging global population.

Noting that in 2000 older people will for the first time in history outnumber children, Health and Human Services Secretary Donna Shalala has emphasized that "We've completely changed what it means to 'act your age.'"

Over 30 federal government departments and agencies, coordinated by the Administration on Aging (AoA), will be planning activities throughout 1999 to discuss common issues affecting the aging populations of this country in the next century, and to collect and share best practices among other nations of the world. Key events include a government-wide conference in June focusing on the implications of longevity and active aging on federal programs, services, and policy areas, as well as the development of an aging agenda for the 21st Century.

For more information about the International Year of Older Persons, contact Marla Bush, International Year of Older Persons Coordinator, AoA, (202) 619-3996. (HHS) ■

AARC Releases New CPGs

The January 1999 issue of Respiratory Care contains four new AARC CPGs:

1. Removal of the Endotracheal Tube
2. Single-Breath Carbon Monoxide Diffusing Capacity, 1999 Update
3. Suctioning of the Patient in the Home
4. Selection of Device, Administration of Bronchodilator, and Evaluation of Response to Therapy in Mechanically Ventilated Patients

An AARC Clinical Practice Guideline (CPG) is a systematically developed statement to help the practitioner deliver appropriate respiratory care in specific clinical circumstances. Practice guidelines are common in many disciplines and are developed for a variety of reasons. The AARC CPGs exist for the noblest of reasons-to improve the quality of respiratory care administered to patients.

The variability in clinical practice from one hospital to another is well known, and these variations have come under increasing scrutiny over the years. In response to this, the AARC published its first five CPGs in 1991 and has continued to take a leadership role in the development of clinical practice guidelines to improve the appropriateness of respiratory care practice throughout the country. The Association currently has 49 available CPGs. You can order them from the AARC by calling 972/243-2272 or download them from our website at www.aarc.org. ■

Bulletin Deadlines

Issue	Date I must have copy	Date AARC must have copy
May/June	April 1	April 10
July/August	June 1	June 10
September/October	August 1	August 10
November/December	October 1	October 10