NOTES FROM THE CHAIR: MOTIVATION
by Karen Stewart, BS, RRT

With malice toward none; with charity for all; with firmness in the right, as God gives us to see the right—let us strive on to finish the work we are in.
—Abraham Lincoln

There is currently a tremendous effort underway to motivate employees, both within the health care field and in other sectors of our economy. Many of us in respiratory care work for people who tell us to motivate our employees, and we, as managers, face the pressure to do so in order to facilitate redesign, reengineering, and cost reduction initiatives.

The first lesson to learn when it comes to motivation, however, is that “you, the individual, can’t motivate.” Motivation is an individual’s desire for change. As a manager, you can only attempt to direct your employees’ motivation. This is best done through a series of attitudinal steps. As the manager, you can—

Create awareness. Make employees aware of the problem and apprise them of the direction in which the organization is moving or the goals you are expected to accomplish.

Increase the employee’s understanding with good explanations. This is particularly important when facing reengineering and cost reduction initiatives, because many times your employees can assist with solutions.

When all goes according to plan, steps number one and two should foster concern in the employee. Typically, when an employee is concerned, he or she will make an effort to act on that concern.

When the concern fostered by steps one and two turns into dissatisfaction, that dissatisfaction becomes the motivation which will create the change, or movement toward new goals.

Another way to create motivation is to influence a person’s individual goals by investing your time in making sure that the employee’s goals are aligned with your goals and those of the organization. Once goals are changed, employees become motivated to meet the new goals and expectations.

Most importantly, we, as managers, need to make sure that our own motivation not only remains intact throughout all the changes taking place in health care today, but is carefully aligned with the goals and objectives of our organizations as well. As managers in the era of managed care, we no longer POAC (plan, organize, actuate, and control) but rather POEM (plan, organize, empower and mentor).

BENCHMARKING PROJECT ON THE DRAWING BOARD

Have you ever wanted to know how your cost for service compares to that of others? Would you like to have details on costs per treatment? Are you caught up in redesign and wondering where the statistics you are being compared to come from?

These problems are common to many of us in respiratory care management. Now the Management Section is poised to help. The section is in the process of submitting a proposal to the Board of Directors to request funding for a benchmarking project that could help provide the answers we all seek. If approved by the Board, the project would be conducted on an ongoing basis, beginning with an organizational phase that is expected to last 18 to 24 months. If you are interested finding out more about this effort, please e-mail me at karen.stewart@camcare.com.

AARC COMMENTS ON SALARY EQUIVALENCY GUIDELINES

The AARC recently provided comments on the proposed Salary Equivalency Guidelines issued by the Health Care Financing Administration (HCFA). The proposed guidelines, which would cover physical therapy, speech language pathology, occupational therapy, and respiratory therapy, were published in the March 28, 1997 Federal Register.

The AARC expressed concerns about three aspects of the proposed rules—

1. The compression of the registered respiratory therapist (RRT) and the certified respiratory therapy technician (CRTT) professionals with non-credentialed workers into one generic category of “respiratory therapy.”
2. The methodology and data sources used to determine the proposed respiratory therapy salary equivalencies.
3. The disregard of added costs imposed by respiratory therapy’s unique Medicare transfer relationship between a hospital and a skilled nursing facility (SNF).

In a letter to Bruce Vladeck, HCFA administrator, from AARC President Kerry George, the AARC went on record as opposing the adoption of the salary equivalency guidelines.

In commenting on the single level respiratory therapy category, George said, “The single category does not account for the higher level of compensation an RRT receives,
nor the propensity for SNFs to utilize the advanced RRT practitioner with experience."

In addition, the methodology used to determine salary equivalency rates for all of the therapy professions does not represent an equitable calculation. “The Medicare transfer agreement requirement limits the efficiency of providers in contracting for respiratory therapy services; a unique set of circumstances not faced by other therapy professions,” said George. “This must be addressed in the regulation.”

**ARCF “SILENT AUCTION” OFFERS RC MANAGERS THE CHANCE TO ACQUIRE EQUIPMENT AND SUPPLIES AT A DISCOUNT**

In an effort to increase the amount of funds available for important research projects and other programs aimed at positioning the RCP for success in the managed care environment, the American Respiratory Care Foundation is planning to conduct its first-ever “Silent Auction” during the AARC’s 43rd International Respiratory Congress, scheduled for December 6-9 in New Orleans, LA. All AARC members and officially registered attendees at the Congress will be eligible to bid onsite or they may participate in the pre-meeting bidding that will take place November 1-30.

While many of the items at the auction will be geared toward individual bidders, much of the inventory will consist of respiratory equipment and supplies designed to appeal to respiratory care managers working under increasingly restrictive budget constraints. Since opening bids for all donated items will be set at approximately 25% of retail value, the Silent Auction offers an outstanding opportunity for managers in all care settings to acquire much needed equipment at discounted prices.

RC managers or others with purchasing authority are encouraged to take advantage of this opportunity by working with their purchasing departments now to acquire the necessary purchase requisitions. In most cases, auction items will be shipped directly by the donor to the individual or institution with the winning bid.

A preliminary catalog of items will be included in the October issue of AARC Times to assist bidders in planning for the bidding process and to allow those unable to attend the Congress the opportunity to participate in pre-meeting bidding. A final catalog of items will be distributed at the meeting in December.

All funds raised by the auction will go directly into the ARCF’s unrestricted fund supporting educational grants, research projects, practice surveys, consensus conferences, and other philanthropic programs.

The Foundation is currently soliciting items for the auction from a variety of sources and plans to have a wide selection of products in all price ranges available for bidding. The solicitation of items for the auction will continue through September 30. Anyone wishing to donate an item (minimum estimated value of $100) may do so by contacting Brenda DeMayo at the ARCF Executive Office at 11030 Ables Lane, Dallas, TX 75229, (972) 243-2272.

**J CAHO PRESIDENT ADDRESSES THE ISSUE OF PERFORMANCE MEASURES**

Like the rest of health care, the accreditation process seems to be in a steady state of evolution. What’s the next big step for the Joint Commission on the Accreditation of Healthcare Organizations? According to a recent article in Joint Commission Perspectives, the integration of performance measures will be the greatest area of concern for organizations in the coming years. How will this integration impact organizations? JCAHO President Dennis S. O’Leary, MD, offered some insight into what organizations can expect. Here are the highlights—

- The use of performance measure data will shift the focus of attention from compliance with standards to actual results, leading to more frequent interactions between the Joint Commission and accredited organizations. In the long term, this may evolve into what some are calling a “continuous accreditation process.” In the short term (by the end of the century) outlier data may trigger communications, and site visits will become increasingly data-driven.
- Since outcomes and performance measures are backward-looking tools, however, they will not replace the Joint Commission’s current standards-based process, which consists of essential forward-looking tools that look at what organizations should be doing to effectively service their communities.
- Organizations should start now to gather outcomes and performance measures, beginning with their high volume, high risk, and problem prone services, as well as those that are of particular interest in their communities.
- The current paucity of data on the reliability and validity of performance measures will make the task of collecting such data difficult, but that should not stand in an organization’s way. While prior testing of the measures may be one factor in the selection of measures for the initial program, the lack of such testing need not eliminate the measure from the group.
- Starting this year, the Joint Commission will try to alleviate the problem by initiating a systematic review of the performance measures in the measurement systems that contract with the JCAHO. Measurement systems that contract with the Joint Commission will be expected to use and report data on selected measures for at least one year.
- A hospital with a low inpatient census and large ambulatory care population may select ambulatory care measures to report.
- Given the number of measurement systems currently available to organizations for the collection of performance data (150-200), it is likely
that some of these systems will either cease to exist or fail to meet current or future criteria established by the Council on Performance Measurement. Organizations should exercise caution in selecting a system, looking for stability, a good track record, adaptability, and ability to service the needs of the organization. However, if the system fails, the Joint Commission will assist the participating organization in its transition to a new measurement system.

• Don’t expect to save money by measuring performance—at least not in the short term. Initially, it will add cost. Over the long haul, however, performance measures will have to live up to the same value barometer applied to all other factions of health care. If they don’t lead to cost saving improvements in patient care, then they may go the way of other innovative, but quickly passing, trends in health care.

(Source: Joint Commission Perspectives, Sept./Oct. 1996)

HOSPITAL-BASED HOME CARE AGENCY WINS FAVORABLE RULING

Chalk one up for hospital-based home care agencies. A senior U.S. District Court Judge in Wilmington, DE, dismissed a lawsuit earlier this year claiming that the Medical Center of Delaware had unfairly leveraged its strong presence to monopolize the area’s home care market. Delaware Health Care, the home care and infusion company that brought the suit, had also charged the hospital with denying its patients access to home care providers other than the hospital-based agency. The court disagreed on both counts, ruling that other referrals were available to the home care company and that the patient discharge process at the medical center was not critical to Delaware Health Care’s survival. (Source: Modern Healthcare, 3/10/97)

DISEASE MANAGEMENT FACES UPHILL BATTLE

Disease management (DM) programs aimed at improving the health status of chronically ill individuals are a great idea because they can keep patients out of the hospital and save money for the system at the same time, right?

In a perfect world, yes, but today’s decidedly imperfect health care system has yet to embrace the idea. Why isn’t disease management getting the attention it deserves? According to a recent survey of those involved in the disease management market, numerous barriers to the effective implementation of this concept are standing in the way. Researchers from Pinney Associates, Inc., a health care consulting firm in Bethesda, MD, attribute the foot-dragging to—

• A lack of standards for DM interventions based on scientific evidence or expert consensus.
• Lack of outcomes data to support the efficacy of DM programs.
• Lack of patient and physician compliance with DM programs.
• The belief among MCOs that DM programs are too expensive
• Lack of adequate data systems to identify high-risk populations and collect and analyze outcomes data.
• Biases against drug company DM programs.

(Source: Drug Benefits Trends)

SURVEY GAUGES MANAGED CARE’S IMPACT ON SALARIES

Managed care is suppose to lower costs, and one of the key ways we have all assumed that it accomplishes that goal is by lowering payments to providers. Now the 1996 Physician Compensation and Production Survey conducted by the Medical Group Management Association, offers some insight into what really happens to salaries as managed care takes hold. The following chart outlines the findings—

Median salary by level of managed care

<table>
<thead>
<tr>
<th></th>
<th>No managed care</th>
<th>11%-50%</th>
<th>51%-100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cert. Reg. Nurse Anesthetist</td>
<td>$88,418</td>
<td>*</td>
<td>$76,802</td>
</tr>
<tr>
<td>Midwife</td>
<td>$61,929</td>
<td>*</td>
<td>$55,000</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>$50,000</td>
<td>$46,095</td>
<td>$48,229</td>
</tr>
<tr>
<td>Physician Assistant</td>
<td>$60,000</td>
<td>$58,398</td>
<td>$57,342</td>
</tr>
<tr>
<td>(surgical)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Assistant</td>
<td>$53,925</td>
<td>$56,096</td>
<td>$53,185</td>
</tr>
<tr>
<td>(primary care)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Assistant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(other)</td>
<td></td>
<td>$52,473</td>
<td>$51,489</td>
</tr>
<tr>
<td>Physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(primary care)</td>
<td>$137,374</td>
<td>$127,913</td>
<td>$126,285</td>
</tr>
<tr>
<td>Physician (specialist)</td>
<td>$258,987</td>
<td>$255,000</td>
<td>$220,000</td>
</tr>
</tbody>
</table>

A report on the survey was published in a recent issue of Clinician Reviews. (Source: Medscape’s Journal Club Forum)

THE FIVE DEGREES OF INTEGRATION

Everybody’s talking about it and almost everybody
claims to be doing it, but according to a recent article in Hospitals & Health Networks, that’s where the similarity in system integration ends. In an effort to help health professionals better understand the complexities involved, the magazine offers the following classification of integrated systems. The five degrees of integration include—

Category 1: Horizontal integration—Systems in this stage coordinate care among similar providers in an attempt to cut costs and increase productivity, but they don’t have many centralized administrative functions.

Category 2: Vertical integration, inpatient/outpatient—These systems provide at least two coordinated levels of services, such as inpatient and outpatient, to their primary markets. Some administrative functions may be performed by staff from the largest segment of the system, such as a large medical center.

Category 3: Vertical integration, partly centralized—These systems offer a full range of care via several types of providers either owned or under contract, and many of the administrative functions are handled at a central location.

Category 4: Vertical integration, mostly centralized—These systems provide a full range of care via different types of providers and have headquarters that are separate from their flagship hospitals or HMOs. Many administrative functions, including purchasing, are centralized.

Category 5: Full integration—These systems provide a full range of care and most administrative functions are performed for the entire system, usually by an even larger parent or membership organization.

(Source: Hospitals & Health Networks)

**MANAGED CARE ISN’T THE ANSWER, SAY RESEARCHERS**

Is managed care the answer to the health care system’s financial problems, or are we just fooling ourselves? According to two leading researchers from Columbia University, the latter is more likely the case.

In a recent “Sounding Board” section of the New England Journal of Medicine, Dr. Eli Ginzberg and Miriam Ostow write that the 10-15% savings in national health expenditures that have resulted from managed care in the last few years are nothing but a one time savings attributable to the shifting of beneficiaries from more expensive fee-for-service plans into MCOs. The federal government’s current drive to shift those savings and cause a rise in premiums.

Other factors that they believe may affect managed care’s ability to control costs include—

- The affiliation of physician groups that would improve their ability to bargain with MCOs.
  (Source: Reuters Medical News, 4/3/97)

**HOME CARE ACCREDITATION RESOURCE AVAILABLE**

If your organization is getting ready for a Joint Commission survey in the area of home care, here’s a publication that can help you prepare for the visit—

The Joint Commission Home Care Survey and Accreditation Process Primer is an excellent resource for organizations considering or preparing for home care accreditation. It is available free of charge by calling the Joint Commission at (630) 792-5754.

**REUSING DISPOSABLES MAY BE RISKY BUSINESS, SAYS FDA**

Sterilizing and reusing medical devices manufactured as disposables has become a cost-cutting measure at many hospitals, but the Food and Drug Administration may soon put a damper on the practice. A preliminary study by the FDA has turned up numerous incidents where reusing disposable devices such as cardiac catheters has resulted in infections, chemical injuries, and mechanical failures. Since there aren’t any government regulations controlling the practice of reusing disposable devices, the FDA plans to meet with the Health Care Financing Administration and the CDC to see if such intervention is warranted. The FDA also plans to continue its research into the area to see if stricter controls on sterilization of such devices might solve the problem. (Source: Hospitals & Health Networks, 3/20/97)

**INTERSTUDY RELEASES FINANCIAL BENCHMARKS FOR HMOs**

As more and more elderly and other high cost individuals are shifted from fee-for-service plans to managed care organizations, many wonder if the stellar financial performance enjoyed by MCOs in the first half of the 1990s will hold. (See previous article.) In anticipation of greater interest in data comparing the ongoing achievements of these companies, InterStudy Publications has released financial benchmarks for HMOs developed from year-end 1995 records that will serve as comparison to soon-to-be released information from 1996 and 1997. The benchmarks, which were obtained from 47 state regulatory agency filings, provide the quartile range for the financial ratios most com-
CONSENSUS CONFERENCE
PROCEEDINGS AVAILABLE

RC educators who have yet to obtain a copy of the pro-
cedings from the AARC’s groundbreaking Consensus Con-
ferences on respiratory care education may acquire a
copy(s) by calling or writing the AARC Executive Office at
the number/address that appears on the back page of this
issue of the Bulletin. These important documents include—

- YEAR 2001: Delineating the Educational Direction
  for the Future Respiratory Care Practitioner;
  Proceedings of a National Consensus Conference
  on Respiratory Care Education, October 1992
- YEAR 2001: An Action Agenda; Proceedings of the
  Second National Consensus Conference on
  Respiratory Care Education, October 1993

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 e-mail or will respond to telephone in-
terviews. 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 top-
ics—

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 ex-
ception? How did you go about the implementation process
and what hurdles did you overcome?

Age Specific Education Material: Has anyone at your fa-
cility developed age specific education material? What ma-
terial would you find helpful in developing age specific edu-
cation material? Would you be willing to share how the de-
velopment 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?

Visit AARC on the Internet—
http://www.aarc.org

InterStudy is a health care research company focused on
the market-driven dynamics of health care delivery.
(Source: InterStudy Publications)
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.

AARC DEVELOPS RESOURCE DIRECTORY FOR POST-ACUTE CARE CONTRACTING
by William H. Dubbs, MHA, RRT

To facilitate communication about post-acute contracting within the profession, the AARC has established a Resource Directory for Post-Acute Care Contracting. The directory, which is included in this issue of the Bulletin, contains a list of individuals who have set up contracts with, and/or are responsible for, managing services to SNFs, subacute, or rehabilitation facilities, and are willing to act as a resource for others seeking to do the same.

We would like to add to our list of names in the coming year and are soliciting your help. Please assist us in identifying individuals with substantial experience in this area. If you will provide me with a name and address, I will forward information about this new Resource Directory on to your nominees and encourage them to participate. If you are personally interested in serving, please don’t hesitate to nominate yourself!

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

RESOURCE DIRECTORY FOR POST ACUTE CARE CONTRACTING FORM

Name ______________________________________________
Hospital ____________________________________________
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:

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Please check the appropriate blank:
I am nominating: ___myself ___a colleague
Please mail or fax to:
William H. Dubbs, MHA, RRT
Director of Management Services
AARC Executive Office
11030 Ables Lane
Dallas, TX 75229-4593
(214) 243-2272
FAX: (972) 484-2720

Attention: Sheri Lynn Phillips
Thank you for your assistance!

Visit AARC on the Internet—
http://www.aarc.org
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

__________________________________________________________________________________________________________________

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__________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________

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.
Section Chair and Bulletin Editor
Karen J. Stewart, BS, RRT
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FAX (410) 682-8044

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