MANAGEMENT SECTION BULLETIN

NO. 4 THE AMERICAN ASSOCIATION FOR RESPIRATORY CARE WINTER 1996

MANAGEMENT SECTION PRACTITIONER OF THE YEAR: *L. LYNN LEBOUEF, RRT*

One machine can do the work of 50 ordinary men. No machine can do the work of one extraordinary man.
—Elbert Hubbard

If success is defined as where you end up, then our 1996 Specialty Practitioner of the Year has gone beyond all expectations from a managerial standpoint. While most managers in respiratory care are happy these days to hang on to anything even resembling a supervisory position, L. Lynn LeBouef, RRT, has defied the odds to reach the position of senior vice president at Tomball Regional Hospital in Tomball, TX.

How did he do it? LeBouef says the promotion was a direct result of "utilizing a multidisciplinary teamwork approach to managing cardiopulmonary services." The success he had in incorporating diverse disciplines into the framework there led administrators to put him in charge of the departments of nursing, surgery, CCU, SICU, ER, IMCU, PACU/Endoscopy, med-surg, RehabCare, medical records, medical staff services, cardiopulmonary, utilization management, administrative services, volunteers, cardiac rehab, home health, quality management, New Day Psychiatric Services, social services, and the skilled nursing center.

A 23-year member of the AARC, LeBouef remains a strong supporter of his professional organization. "The AARC provides every member with the necessary tools needed not only to perform and improve the daily functions of a respiratory therapist but to prepare for the future of our profession."

He believes membership in the section augments that preparation by providing a forum in which issues pertinent to management can be discussed. "Being a member of the Management Specialty Section allows you to exchange ideas, concepts, and problems with your peers. It keeps you informed on how to meet the latest regulations and, through the newsletter and specialty seminars, better prepares managers to meet the challenges and opportunities of tomorrow."

JCAHO RELEASES DATA ON TOP TEN PROBLEMATIC GRID AREAS

Experience is not what happens to a man. It's what a man does with what happens to him.
—Aldous Huxley

Where do hospitals fall down on the job and why? The Joint Commission on the Accreditation of Healthcare Organizations has released the following information on the top ten grid elements that gave hospitals trouble in 1995, the most common causes of the problem, and the percentage of hospitals receiving low scores. The items in bold-face type may be of particular concern to respiratory care departments:

Grid Element	Root Cause	Percent Scoring Low
Special Treatment Procedures	Restraint and seclusion	53.4%
Patient-Specific Data & Information	Patient records not completed within 30 days, verbal orders not authenticated, medical record entries not authenticated	49.6%
Medical Staff Credentialing	Challenges to licensure not considered in credentialing and privileging, primary source verification not done, loss of medical staff membership not considered for reappointment	37.7%
Medication Use	Poor emergency medication system and poor security and control of meds	34.6%
Management of Environment of Care — Design	Non-compliance with the Life Safety Code and no evaluation of effectiveness of the life safety plan	33.9%
Competence Assessment	**Age-specific competency not assessed in staff**	**33.7%**
Management of Environment of Care — Implement	Fire drills not done and poor equipment preventive maintenance	32.2%
Assessment of Patients — Initial Assessment	Incomplete initial screening, no pre-anesthesia assessment, H&P not done within 24 hours	30.8%
Patient and Family Education	No education on food/drug interactions and patient learning needs not assessed	23.7%
Additional Requirements for Specific Patient Populations	**No age-specific assessment and no immunization status taken**	**19%**

LEGISLATIVE ACTIVITIES MAKE MCOS NERVOUS

Experience is what enables you to recognize a mistake when you make it again.
—Earl Wilson

There's an old saying that goes, "Be careful what you wish for—you just might get it." Managed care organizations (MCOs) that wanted tighter control over the care their patients received might be wondering why they didn't pay closer attention. As Congress and the states crack down on practices designed to limit care and prevent doctors from advising their patients on treatment options, the industry is getting nervous.

Legislation on the state level to ban "gag" orders placed on physicians and crack down on other MCO practices designed to cut benefits and services are problematic, but it's the willingness that Congress has shown to directly influence health plan benefits that really has them worried. The passage of legislation there last summer to require 48-hour stays for new mothers and parity in spending for the treatment of mental illnesses,

they say, could open the flood gates of legislation aimed at protecting the health care interests of special groups. Says an analysis by the National Association of Health Underwriters, "Virtually every other disease group is likely to seek similar protection."

How these legislative efforts to protect patients against too much cost-cutting by their insurers will play out is still up in the air—MCOs say they must retain the freedom to determine health plan benefits without interference from Washington—but hardly anyone believes they won't have some effect. Says Russ Newman, director of professional practice for the American Psychological Association, "If everything worked the way it should, why would we need the government stepping in to be sure patients are getting care they need?" (Source: *The Dallas Morning News*, 10/4/96)

COULD TREND TOWARDS TRAINING ALL DOCS AS GENERALISTS HAVE IMPLICATIONS FOR RCPS?

Life is what happens to you while you're busy making other plans.
—John Lennon

When it comes to trends in health care training, physicians generally lead the way. The movement towards greater and greater specialization that occurred in the '60s and '70s created not only more narrowly trained doctors but more narrowly trained allied health professionals like RCPs as well.

Now the pendulum is swinging back the other way, and once again, physicians are on the cutting edge. Alarmed by the decreasing need for specialists in the managed-care environment, more and more medical school students are choosing to major in family medicine, general internal medicine, and general pediatrics. Jordan J. Cohen, MD, president of the Association of American Medical Colleges believes it's time to take that trend one step further. In a recent presentation delivered at Harvard Medical School in celebration of "National Primary Care Day," he called for all U.S. medical schools to train all of their students as generalists first, regardless of their ultimate choice of practice areas. He believes a consensus is building for that philosophy among American medical schools and will soon become the norm. The question for RCPs is, can allied health be far behind? (Source: Association of American Medical Colleges)

ELDERLY AND POOR SUFFER UNDER MANAGED CARE

It is impossible to support both the government and family on one salary.

Okay, so patients with rheumatoid arthritis do just as well under managed care as they do under fee-for-service. (See previous article.) But what about the elderly and poor with chronic conditions like diabetes, high blood pressure, and heart disease?

They aren't so lucky, says a 4-year study involving 1,574 patients in Chicago, Los Angeles, and Boston. Researchers from the New England Medical Center who compared the results from surveys filled out by the participants in 1986 and 1990 found that 54% of the elderly and 68% of the poor and elderly patients in managed care felt that their health had declined over the 4-year period. Among the elderly covered by traditional plans, only 28% reported a decline in health. Twenty-seven percent of the poor and elderly

covered by traditional plans said their health had gotten worse. Among the elderly and poor, 22% in managed-care plans reported better health after 4 years. For those in fee-for-service, that figure stood at 57%.

What's interesting is the fact that these dismal statistics didn't pertain to the younger and better-off participants in the study. The average patient in the group, who was neither old nor poor, did about as well under managed care as he/she did under fee-for-service. (Source: *JAMA*, 10/2/96)

UCSF STUDY FINDS NO DIFFERENCE IN OUTCOMES FOR MANAGED CARE, FEE-FOR-SERVICE PATIENTS WITH RHEUMATOID ARTHRITIS

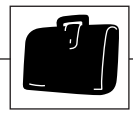
Anyone can win—unless there happens to be a second entry.
—George Ade

Sure, patients and physicians aren't crazy about managed care. (See previous article.) It's just not human nature to enjoy being told that you can't have something you think you need or want. But is managed care really having a negative impact on health care outcomes? That question is a long way from being answered (see following article), but here's one study that says no:

Researchers from the University of California at San Francisco who looked at the short- and long-term experiences of rheumatoid arthritis patients who received care under both managed-care and fee-for-service systems found no difference in either quantity of care or outcomes. The study, which is one of the first to compare the effects of prepaid group practice and fee-for-service settings on health care use and outcomes among patients with chronic conditions, involved 1,025 patients, 227 of whom were enrolled in a prepaid program.

The group followed the patients for 11 years, conducting yearly telephone surveys to determine demographic information, signs and symptoms of the condition, overall health status, functional status, health care use for the year, a description of health insurance for physician visits, and hospital admissions. After analyzing the results for a 1-year period and then for the entire 11 years, they noted little significant difference between the two groups when it came to any measure of health care use over either time frame.

Patients in both settings used about the same amount of ambulatory services, underwent about the same number of outpatient surgical procedures, and had around the same number of hospital admissions. What's more, those in the managed-care setting experienced the same number of in-patient surgical procedures for rheumatoid arthritis as those in the fee-for-service setting, including the most expensive, total joint replacement. Outcomes—as represented by various functional measurements—were identical for the two groups. (Source: *JAMA*, 10/2/96)



ADVISORY BOARD REPORT DISCUSSES "THE FAILED PROMISE OF PATIENT-FOCUSED CARE"

It's called Pandora's Rule: Never open a box you didn't close.

A new report from the Advisory Board's Governance Committee titled *Built to Last* makes several observations about

"The Failed Promise of Patient-Focused Care" and other cost reduction strategies that have been implemented in hospitals over the past few years. Specifically, the report states that

- **"Slash and burn" strategies provide only temporary respite:** A study of 281 hospitals found that 77%-88% of costs saved from initial across-the-board cuts crept back into the system within 18-24 months.
- **Savings generated often compromise quality:** The same study noted a 100% increase in mortality and morbidity in hospitals making 4% cuts; those making 7% cuts experienced a 300% increase in mortality and morbidity.
- **"Reengineering" is often an empty exercise:** Seventy-one percent of hospitals surveyed noted minor or no FTE reductions, despite the lengthy and involved reengineering process they went through to achieve this goal.
- **Patient-focused care (PFC) fails to reduce costs for most:** A survey of ten hospitals employing the PFC method found that 70% reported no cost savings as a result. Forty percent of these institutions are rapidly dismantling their programs.
- **Patient-focused care fails to produce low-cost advantage:** A survey of 129 hospitals with and without PFC found a slightly higher median cost per CMI-weighted adjusted discharge in PFC institutions. Although the higher 5.7% median cost for PFC hospitals is not considered statistically significant, certainly it indicates that these institutions are not advantaged by cost.

The Advisory Board is a nationally recognized health care consulting company based in Washington, DC. Its Governance Committee report *Built to Last* is available to institutional members of the Governance Committee. Respiratory care practitioners may want to find out if their hospitals are institutional members because members are entitled to receive special reports on changes in the health care market nationwide.

The Advisory Board Governance Committee office is located at 600 New Hampshire Ave. NW, Washington, DC 20037, (202) 672-5600, Fax: (202) 672-5700. (Source: Advisory Board)

WHEN IT COMES TO ICUS, IT'S A WASH

A billion dollars isn't what it used to be.
—Nelson Bunker Hunt

If you read the previous two articles, you know that managed care is currently in the "win some, lose some" category when it comes to comparisons with fee-for-service on outcomes of care. Here's one on costs that that may help break the tie:

ICU services eat up some $55 billion, or 30%, of total acute care hospital costs each year. As such, they represent a huge potential for cost savings to traditional and managed-care insurers alike. On the surface, managed-care organizations (MCOs) appear to be doing the best job of realizing a savings in this area. Their patients currently consume fewer ICU resources than those under fee-for-service plans.

But appearances can be deceiving, say researchers from the University of Pittsburgh Medical Center who compared the lengths of stay for 90,000 managed-care and non-managed-care patients admitted to ICUs in Massachusetts in 1992. When factors like age, severity of illness, comorbidity, reason for admission, and whether the patients lived or died were figured in, they found no difference in ICU length of stay between the two groups.

They conclude that most of the ICU savings being experienced by MCOs right now are coming from the fact that they enroll mostly younger

and healthier people. Says lead investigator Derek Angus, MD, MPH, "One must wonder whether managed-care organizations will be able to continue offering health care coverage at lower cost than traditional insurance programs as the managed-care case mix changes to include sicker and older patients." (Source: *JAMA*, 10/2/96)

NEW WEAPONS BEING DEVELOPED AGAINST DRUG RESISTANT BACTERIA

He who never walks except where he sees other men's tracks will make no discoveries.

The increasing drug resistance of bacterial infections like *Streptococcus pneumoniae*, *Staphylococcus aureus*, and enterococci has been a growing concern in hospitals for quite some time. As resistant strains of these bacteria gain ground, however, many are now leaving the hospital for other areas of the community. Particularly vulnerable are those in high-risk populations, such as the elderly, young children, and those with underlying medical conditions that leave them with compromised immune systems. Health officials estimate, for example, that resistance to penicillin—the first defense against *S. pneumoniae* — currently stands near 40% and other drugs, such as cephalosporins and non-beta-lactam agents, are catching up fast. Says Robert C. Moellering, MD, chair of the department of medicine at New England Deaconess Hospital in Boston, "While resistance was once found primarily in the hospital setting, we're beginning to see more and more evidence of resistant pathogens in the community."

Clearly, new drugs are needed to curtail the spread of these deadly bacteria. Rhone-Poulenc Rorer believes it has a couple of possible replacements. The company is currently awaiting approval from the FDA for an injectable streptogramin antibiotic called Synercid® (quinupristin/dalfopristin), and an oral antibiotic called Zagam® (sparfloxacin) that appears to provide comprehensive coverage of community acquired infections, particularly those involving the respiratory tract. "Based on extensive clinical trials, Synercid and sparfloxacin show promise in treating several important antibiotic resistant strains," says Moellering. "New agents, combined with infection control measures and judicious antibiotic use, will help us win the war against microbes."

Moellering's comments were made during a satellite symposium aired prior to the 36th Interscience Conference on Antimicrobial Agents and Chemotherapy held last fall. (Source: PRNewswire, 9/16/96)

NEW JOINT COMMISSION *CUSTOMER SERVICE DIRECTORY* CONTAINS ENHANCEMENTS

Quality is not an act. It is a habit.
—Aristotle

The JCAHO's 1996-1997 *Customer Service Directory* has been redesigned to include new features aimed at making it easier for health care organizations to get in touch with folks at the Joint Commission. After soliciting ideas during a series of focus groups around the country, the JCAHO has added a quick reference page and a series of Rolodex cards to the new edition, which went out to CEOs and executive directors in August. Also included in the '96-'97 issue are the new Joint Commission phone numbers reflecting changes that were made in area codes earlier this year. The new numbers are

- Main telephone number: (630) 792-5000
- Main fax number: (630) 792-5005
- Joint Commission Customer Service Center: (630) 792-5800

- Department of Standards Interpretation Unit: (630) 792-5900
- Department of Indicator Measurement: (630) 792-5220

ARE YOU AN RC MANAGER WHO HAS ADDED VALUE TO YOUR ORGANIZATION? IF SO, READ ON . . .

No matter what happens, there's always somebody who knew it would.
—Lonny Starr

There's no doubt that respiratory care managers all over the country are successfully dealing with the challenges created by health care reform and managed care. Equally certain, however, is the fact that many others are still struggling. In better days, their loss might not affect your gain, but not today. For respiratory care to survive as a profession, *successful outcomes must occur across the board*.

How can we make that happen? The winners *must* stand ready to "coach" those who have yet to cross the finish line. One way you—as the successful manager of RC services today—can help is by sharing your personal triumphs with your colleagues across the nation through an article in this publication.

In future issues of the *Bulletin*, we would like to publish short success stories from managers who have added value to their organizations. This may have been accomplished by consolidating other services within your organization, establishing contractual arrangements for respiratory care services outside of the hospital walls, or establishing other innovative service delivery programs. Basically, we are looking for 1- to 3-page, typed, double-spaced articles that answer the following six questions:

1. What was done?
2. What organizational issues were addressed?
3. Who was involved?
4. What were the major obstacles and how were they addressed?
5. What principal benefit(s) did the organization realize from the effort?
6. What would you have done differently based on what you have learned?

These short vignettes can provide much needed ideas and inspiration for managers who are trying to make things better in their organizations. After all, if it worked for you and your hospital, chances are it can work for other RC managers and their institutions as well! Please submit your articles to Bill Dubbs, AARC Director of Management, AARC Executive Office, 11030 Ables Lane, Dallas, TX 75229, or call Bill at (972) 243-2272 for more information.

MANAGEMENT SECTION RESOURCE DIRECTORY: SIGN UP TODAY!

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

The last issue of the *Bulletin* featured the first edition of a 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. 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 _____

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 this form to
William H. Dubbs, MHA, RRT
AARC Director of Management Services
11030 Ables Lane
Dallas, TX 75229
Fax (972) 484-2720
Thank you for your assistance!

NEW MANAGEMENT TOOLS AVAILABLE

JCAHO STANDARDS INFORMATION

For many years the JCAHO's Accreditation Manual for Hospitals contained a separate chapter for respiratory care services. When the format of the accreditation process changed in 1996, the standards from the respiratory care chapter were absorbed into chapters in the manual. Although the JCAHO published an appendix which provided a crosswalk between the 1994 and later standards, many of our members requested more specific information. In response to those requests the 1997 standards with implications for respiratory care services were identified. Where applicable, these standards were referenced to 1994 standards. Additionally, comments on examples of implementation and examples of evidence of performance are provided.

This project was completed by Karen J. Stewart, BS, RRT, and Cheryl Clark, RRT. Karen is the Director, Respiratory Care and Sleep Disorders, and Cheryl works in the Pulmonary Function Department at Charleston Area Medical Center in Charlestown, West Virginia. Karen is currently the AARC Management Section Chair.

EXAMPLE OF CONTRACT FOR CONTRACTING WITH SNFS FOR RESPIRATORY CARE SERVICES

A sample contract covering the details of contracting with SNFs for Respiratory Care Services has been developed and is available from the AARC. This was developed in response to many requests from respiratory care managers in acute care facilities. They were seeking tools to help them develop contracts for providing respiratory care services to SNFs with whom their hospital has a transfer agreement. This example contract will be added to the AARC's existing SNF information packet.

Members can (1) download these materials free from AARC OnLine (http://www.aarc.org) (2) request a free hard copy from the executive office, or (3) request these materials as attached files by email if you provide an email address and have Microsoft Word for Windows 6.0 Address email requests to phillips@aarc.org.

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! The resource list is also available on AARC's web site at www.aarc.org.

RESOURCE DIRECTORY FOR POST-ACUTE CARE CONTRACTING FORM

Name _____

Hospital _____

Address _____

City _____

State _____

Zip _____

Phone _____

Fax _____

E-mail _____

Please check the appropriate box:

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
(972) 243-2272
FAX: (972) 484-2720

Thank you for your assistance!

INTEGRATED CLINICAL SYSTEMS MANAGEMENT CONGRESS HELD IN DALLAS

The inaugural Congress on Integrated Clinical Systems management will be held March 13-16, 1997 in Dallas, Texas. The primary focus of the congress is to provide a collaborative forum for learning for all allied health care managers. The Congress is designed to provide multiple opportunities to improve management skill and understanding of other allied health care professionals. The target audience is mid-to-high level managers who are faced today or in the future with managing multiple departments that are often outside our areas of clinical expertise. The final program will be available in January. Attendance is limited to approximately 50 attendees from each profession. Any questions can be directed to Susan Blonshine at (517) 334-2646.

MARK YOUR CALENDAR!

Plan to join us for this important meeting!

Congress on Integrated Clinical Systems Management

Doing More Together!

March 13-16, 1997 • Dallas, Texas

This groundbreaking event unites major organizations representing a wide variety of health-care disciplines

Health care is not only changing—it's converging! Every day, hospitals are creating multidepartmental systems, thus uniting disciplines such as nursing, pharmacy, laboratory, material management, radiology, information management, cardiac testing, and respiratory therapy. In general 15-20% of managers in these disciplines are now reporting multidepartmental responsibilities. This percentage will undoubtedly grow in the very near future. In response to this trend, a group of organizations serving professionals from many of these disciplines is coming together to discuss issues surrounding this movement.

CONGRESS ON INTEGRATED CLINICAL SYSTEMS MANAGEMENT

March 13-16, 1997
Dallas, Texas

At this event, you will:

- ➤ learn the essentials of managing new disciplines
- ➤ understand the integration of clinical services, including emerging technologies related to the trend (a case study will highlight what works and what doesn't)
- ➤ network with other participants to relate stories from the frontlines of this trend.

The sessions will also lay the groundwork for continuing collaboration and alliance among attendees, cosponsoring organizations, and industry sponsors.

Attendance from each group will be limited. To ensure that you receive information and a brochure, please complete this form and fax to CICSM, 202/232-0016.

Name _____

Co. _____

Address _____

City/State/Zip _____

Phone _____

Fax _____

Participating professional organizations include (please check the one to which you belong):

- ❑ American Association for Respiratory Care
- ❑ American Health Information Management Association
- ❑ American Healthcare Radiology Administrators
- ❑ American Organization of Nurse Executives
- ❑ American Society of Health-System Pharmacists
- ❑ Clinical Laboratory Management Association
- ❑ Health Information Management Systems Society
- ❑ Medical Marketing Association

SPECIALTY PRACTITIONER OF THE YEAR

Don't forget to make your nominations for the 1997 Management *Specialty Practitioner of the Year.* This honor is given to an outstanding practitioner from this Section each year at the AARC's Annual Convention.

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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_____

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_____

_____

Nominee ***Your Name***

Hospital Hospital

Address Address

City State, Zip City State, Zip

Phone Phone

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

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