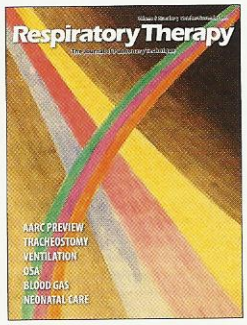

Respiratory Therapy™
The Journal of Pulmonary Technique

Vol. 6 No. 5
October-November 2011

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Editorial

RESISTANCE TO CHANGE – Lack of "Champion-Clinicians" Hold Back Medical Advancements

Vivian Wright

Remember how things were a decade ago… your staff, your duties, shifts, medical procedures, hospital policies, the equipment you used, government regulations… even the corporate culture was different back then. There's been much change and many advancements within your facility and healthcare in general.

Hard to believe 10 years has flown by…or did the past decade drag by? Does it matter? It should matter because you have been practicing in what many consider one of the most exciting decades in modern medicine. It has been a decade that has seen countless medical advances. If it feels as if the past decade dragged by, perhaps you're in the wrong career or maybe you've lost your passion, your motivation. On the other hand, if the decade passed so quickly you wonder where the last ten years went, congratulations, you adapt to and welcome change.

Yet one thing hasn't changed over the past ten years…previous 120 months…last 3,600 days: your patients. They blur one into another. Admissions, discharges, re-hospitalizations, discharges, admissions…and they keep coming – their illnesses, their diseases, their chronic conditions, even their pain blurs. Or does it?

It certainly matters to each patient and to their loved ones. They are acutely aware when a clinician views them as just another a blurred face. You can't hide it, it's in your eyes, in your walk and it's in your touch. However, when "their" nurse, RT or physician sees them as an individual, a clinician's dedication radiates as "quality care." When the patient is the recipient of the clinician's knowledge, experience and compassion, there is no doubt in the patient's mind that their nurse, respiratory therapist or doctor is on his or her game. They know they are getting the very best you have to give and the best modern medicine has to offer.

Life is synonymous with change. Change within the healthcare environment results in advancements which lead to improvements for healthcare professionals, patients, caregivers as well as improvements in our entire healthcare system.

Whether it's adding an orphan product or device which may improve a process, or replacing a protocol step with an enhanced step, why would a clinician stand in the way of "something new" or "a promising change?" Why, when the purpose of "new" and/or "change" is to enhance the patient's quality of care, expand clinician knowledge, enhance clinical expertise, lead to additional innovations, create new jobs, bring value to one's facility as a whole, why do so many clinicians resist "new or change" and the exciting possibilities that may result?

Sadly, many clinicians' mantra is, "It'll increase my work load", "…it's fine the way we've always done it," "I don't have time as it is," "they've been cutting the budget there's no way they'll hire more staff."

Resistant clinicians find excuses why they don't champion a product or idea up the chain of command to a supervisor or product review board, even when the clinician clearly sees the benefits of a new product. "If they don't like it, it'll reflect badly on me!" "It takes too much time." "It's a lot of work," and "What am I going to get out of it?"; "I just do my job and stay under the radar," "That's not my job."

Of course not all clinicians are resistant to change, sometimes change is not at all determined by individual resistance or acceptance. On occasion, union leaders decide whether an Administration request for integration of new procedures or operation of new equipment by member-clinicians meets with union approval. If union approval

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Why should AARC participants visit your display ?
In addition to the enhancements to the MiniSpacer MDI adapter family, Thayer Medical will feature its innovative MDI holding chamber – the LiteAire. The LiteAire is the only dual-valved, holding chamber constructed of paperboard. It is offered in a dispenser box of twenty-five individually packaged devices allowing for easy access and storage. It is re-usable for up to a week for single patients and is ideal for PFT labs, emergency departments and in-patient floors. The LiteAire is a low-cost, alternative to plastic holding chambers in many environments. Generous quantities of LiteAire samples will be provided to qualified clinical sites. Participants should also visit the Thayer Medical booth to learn about the cost-savings available with the originally designed, US manufactured, Valved Tee family of ventilator circuit components.

Vortran Medical Technology 1

Booth 311

What products will you be presenting?
Vortran Medical Technology 1, Inc manufactures and markets a patented line of fully automatic disposable respiratory devices for patients in the hospital and other market segments (EMS, post acute and home care). Our latest advances in product development and applications provided for an addition to the VAR-Plus Models product line. In addition to the VAR-Plus PC Model with an entrainment feature for an FiO_2 delivery option of 50% or 100%, the *new* VAR-Plus PT Model features an FiO_2 delivery of 100% only. Both the VAR-Plus Models PT and PC offer our customers three packaging configurations. Our new VAR-Plus Model to be featured at the AARC convention is of particular importance because the VAR-Plus PT and PC Models are manufactured with a modulator diaphragm eliminating tilting asymmetric friction and spring force effect as with the RT/RC piston modulator, suitable for both pediatric and adult patients (body weight 10 kg and above).

Discuss other recent developments.
Because of this recent development, two of the older VAR Models, and related packaging configurations were discontinued effective, September 1, 2011. After this date, the RT and RC Models are available for purchase until our inventory is depleted, or by January 1, 2012, whichever is sooner. We have made suggestion for the appropriate VAR-Plus Model to replace the two older RT and RC Models to be discontinued. Both of the suggested replacement VAR-Plus Models are less expensive than the RT/RC Models, suitable for both pediatric and adult patients (body weight 10 kg and above), and are manufactured with a modulator diaphragm eliminating the tilting asymmetric friction and spring force effect as with the RT/RC piston. Of course, Vortran will continue to support all VAR Model RT/RC users, but encourages the user to transition to the suggested replacement VAR-Plus Model as soon as possible. To assist customers in this transition, users may be eligible for a sample evaluation of the suggested replacement VAR-Plus Model to evaluate the improved operational characteristics and performance.

Discuss educational/training materials.
Vortran utilizes various avenues for education and training through media, on-site visits, tradeshows, industry publication advertising, and our network of specialty dealer representatives to communicate key education and training messages. Our message promotes and heightens the clinician's awareness of our Educational Module Sponsorship for FREE online continuing education units at no charge to medical professionals, an interactive CDROM which contains a multi-media presentation for PC platform of all Vortran products, and our website at http://www.vortran.com with up-to-date information on clinical research, company policy and statement, and PDF format of product brochure and user guide.

Why should AARC participants visit your booth?
The AARC convention presents a well-seasoned clinician's affair, climaxing three days of hard work with many topics. Vortran being a small manufacturer realizes speaker sponsorship would enhance relationships, but we prefer the lighter side in State Society meeting themes. This permits a more affordable financial arrangement necessary for speakers, and we are included in deciding the select topics for the appropriate occasion. We encourage AARC participants to visit the Vortran display located at booth #311 so they may interact with product demonstrations for all Vortran products, obtain educational materials providing the opportunity to secure free CEUs, creating an experience of touch, sight, and sound, and we believe this will create a lasting impression on participants so that our brand, our products, and our offers are burned into their minds long after the tradeshow ends.

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is received, member-clinicians proceed with the Administration request incorporating the new procedures or new equipment into their daily routines or protocols.

Whether it be resistant clinicians or union disapproval of a "new or changed" procedure or product, loved ones – mothers, sons, spouses, are forced to suffer hour after hour, day in and day out with a problem that could be erased or drastically reduced with a "new or changed" product, device or procedure that is being held back from use on the floor or unit until a clinician-champion or union leadership is ready to embrace change.

For clinicians resistant to change the answer could simply be because making a decision to champion a new product, procedure or device, that may offer benefits to the patient, isn't worth the risk if they don't perceive it to be as industry changing as for example, the discovery of penicillin. If this reasoning is the case, we are denying the patient quality of care and denying ourselves as medical professionals, personal, professional and industry wide advancement.

Another explanation for resistance and the lack of "champion-clinicians" is possibly due to the culture in which some clinicians practice. Until recently, evidence-based medicine (EBM) and evidence-based practice (EBP) were not part of the medical profession's focus, in fact, EBM and EBP are today key concepts to change; however they are not yet status quo either in the halls of higher learning nor universally practiced in our current healthcare system. "EBM/EBP recognizes that many aspects of healthcare depend on individual factors such as quality and value-of life judgments, which are only partially subject to scientific methods. EBP, however, seeks to clarify those parts of medical practice that are in principle subject to scientific methods and to apply these methods to ensure the best prediction of outcomes in medical treatment, even as debate continues about which outcomes are desirable."[1]

EBM and EBP will be further encouraged indirectly through the

FDA Office of Orphan Products Development (OOPD), whose mission is in part to advance the evaluation and development of products that demonstrate promise for the diagnosis and/or treatment of rare diseases or conditions. Through initiatives such as this, the FDA along with CMS are in fact discouraging the "resistance to change" attitude throughout all levels of our healthcare system.

Acceptance of new innovative products and changes in patient care are painfully slow in the healthcare profession. Perhaps because of that fact, CMS is now requiring immediate attention and action from the healthcare profession, encouraging improvement in patient transitions and tracking reduction and ultimate prevention of re-hospitalizations.

A report published in 2001 from the Committee on Quality of Healthcare in America observed that "scientific knowledge about best care is not applied systematically or expeditiously to clinical practice."[2] Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place."[3] A decade after these words were written these statements remain true in 2011.

Innovative products and ideas result out of necessity, frustration and often desperation when first-hand experience produces unsatisfactory results. With the thought, "there has to be a better way" the goal is increased efficiency. Clearly it's about taking a fresh look at an old problem. Whether a new product or idea offers minor improvements or major improvements, improvements bring change and with change advancement is possible.

Consider advancement of the auto industry. Although the auto industry has had more than 35 years, (from the 1970s oil crisis to 2001), to bring alternative fuel vehicles to the market, the hybrid was only introduced in 2001. In other words, it took 25 years for auto makers to *combine* the 125 year old gasoline powered technology with the 169 year old electric golf-cart technology. The reality is an "alternative" type vehicle was invented *first*, with the 1769 steam powered vehicle, sixty-six years later it was followed by the electric vehicle, (in 1832) and finally, fifty-three years later (in 1885) the gasoline fueled vehicle was invented.[4]

The computer industry has been far more productive yet didn't have the luxury of over a century of prototypes to refer to. The first computer was invented around 1936. In seventy-five years the computer has evolved from a speed of 1Hz and 64-word memory to the amazingly powerful portable feather-weight tablets we can't live without today.

From pharmaceutical companies to DME (Disposable Medical Equipment) manufacturers, it is apparent that while it takes 7 to 12 years for a product to gain acceptance in the US, in countries such as Israel, Australia, Canada and many European and Asian countries, clinicians are encouraged to introduce new products and changes to their employers resulting in significantly less time for products to gain acceptance. There seems to be a collective effort in these countries to welcome new improvements in the quality of care they provide and embrace new product development in their healthcare systems.

Meanwhile, for new (trial) knowledge to become policies and procedures and incorporated into practice it takes an average of 17 years.[5] The reality is, your facility's "new" policies and procedures are actually on average 17 years old. With that in mind, current RT students may see today's new trial knowledge become policies and procedures in their 15th year as a respiratory therapist.

How much time is lost during those 7, 12 and 17 years to "making its way through the system?" How long does it take a product, policy or procedure to go from introduction to practice in your facility? How many weeks, months, years does that procedure languish on desk after desk? How many patients have come and gone from your floor in that time, patients who may well have benefited from that one procedure, that one little product or device?

There has been much published in the past few years identifying specific approaches and an abundance of successful strategies for reducing readmissions. What those articles leave out is the most important element that facilitates successful reduction in readmissions... you, the clinician. Everything you do for the patient, goes home with the patient. Anything you don't do, comes back to you as a readmission or results in mortality. It is just a matter of time before respiratory therapists will be encouraged to seek out and ensure the best prediction of outcomes in respiratory treatment even if the debate continues about which outcomes are desirable.

Some experts contend that the will to adopt successful strategies is lacking. Lack of will ultimately harms patients. "This isn't necessarily about implementing a protocol, but about leadership at the organizational level to make transitions of care a priority," said Dr Amy Boutwell, Director of Health Policy and Strategy at the Institute for Healthcare Improvement. "At thousands of hospitals across the United States, transitions are absolutely an afterthought. There is very rarely a systematic approach to handing the care over to the next provider in the community. What we see is that it's not so much about the ideas as it is the intention and the motivation. That's where the results are found."[6]

References

1 Evidence-based Medicine, From Wikipedia, the free encyclopedia, http://en.wikipedia.org/wiki/Evidence-based_medicine

2 Suzanne Beshore Bringing Evidence Based Change to Hospital Policy and Procedure http://ucdrn.blogspot.com/2010/12/bringing-evidence-based-change-to.html 12/5/10

3 Danforth, W. H., & Perrin, E. B. (2001). *Crossing the quality chasm: A new health system for the 21st century: executive summary.* Retrieved from The National Academies Press: http://books.nap.edu/catalog.php?record_id=10027

4 www.loc.gov/rr/scitech/mysteries/auto.html

5 Millenson, M. L. (2008, September 19). Evidence of a need for change. *Miller-McCune.* Retrieved from http://www.miller-mccune.com/health/evidence-of-a-need-for-change-4241/

6 Amy Boutwell, MD, Director of Health Policy Strategy at the Institute for Healthcare Improvement & Principal Investigator, State Action on Avoidable Rehospitalizations (STAAR) Initiative www.ama-assn.org/amednews/2011/02/07/prsa0207.htm

Vivian Wright is President of Wright Solutions LLC. This editorial was provided by Wright Solutions LLC.