This paper provides guidance and considerations in the application of the AARC Position Statement: Best Practices in Respiratory Care Productivity and Staffing adopted by the AARC Board of Directors in July 2012.

Background and purpose

The provision of safe respiratory care is largely dependent on staffing adequate numbers of competent respiratory therapists (RTs). Understaffing puts at risk the welfare and safety of patients and may not allow care consistent with national guidelines and community practice. On the other hand, respiratory services represent a significant expense in the provision of health care and overstaffing respiratory therapists is neither productive nor efficient.

The 2012 AARC Position Paper regarding Respiratory Care Productivity and Staffing was approved and published to address growing concerns that inappropriate measures were being applied to determine the number of RT staff needed at a given institution. This White Paper is intended to provide additional guidance to AARC members and to health care institutions and other providers to ensure that respiratory care productivity and staffing levels are provided within acceptable standards of practice recognized by the profession and that patient safety is protected.

Considerations for rendering respiratory care

Medicare Hospital Conditions of Participation state that there must be adequate numbers of respiratory therapists, and other personnel who meet the qualifications specified by the medical staff, consistent with state law. Medicare Hospital Conditions of Participation further require hospitals that provide respiratory care services to meet the needs of their patients in accordance with acceptable standards of practice. “Acceptable standards of practice” as noted in the Hospital Interpretive Guidelines for State Surveyors include compliance with applicable standards that are “set forth in Federal or State laws, regulations or guidelines, as well as standards and recommendations promoted by nationally recognized professional organizations (e.g., American Association for Respiratory Care, American Medical Association, American Thoracic Society, etc.).”

The documentation of competency in delivering respiratory care services may be assured by applicable state licensing boards and/or the attainment of respiratory therapy credentials awarded by the National Board for Respiratory Care (NBRC). All respiratory therapists employed by the hospital to deliver bedside respiratory care services must be legally recognized by state licensing laws, where applicable, as competent to provide respiratory care services. For states that do not require licensure, a CRT or an RRT credential from the NBRC should be required to assure documented competency and assure patient safety.

The metrics described in this paper apply to the provision of care in which the RT provides direct oversight of care one patient at a time. Having therapists provide therapy to multiple patients simultaneously may be considered as a mechanism to reduce labor expenses. This practice denies patients the direct supervision of a respiratory therapist for the duration of treatment, thus diminishing quality and potentially placing the patient at risk. Medications delivered by aerosol and other interventions provided by respiratory therapists are noted to have serious side effects that require rapid recognition and corrective action, which can only be achieved by direct observation of the patient. The practice of providing therapy to multiple patients simultaneously diminishes the respiratory therapist’s time needed to observe the patient’s tolerance and compliance with the medication and to provide patient education. More to the point of this paper, when multiple patients are treated simultaneously, the time standard for the treatment is no longer valid because it is based on the assumption that the therapist remains at the bedside of each patient throughout the patient’s therapy.
Assessment/Screening of Patients for Invasive and Non-Airway Management Procedures

Examples of other health care professionals who bill for reimbursement therapists have not been assigned a CPT code. CPT codes The majority of clinical procedures conducted by respiratory

References

3. Productivity metrics for which the source is undisclosed (common practice among external consultants) or including an arbitrary number of procedures is inappropriate and unacceptable.

Summary

The AARC urges organizations that offer Respiratory Care Services to work closely with Respiratory Care Department managers and respiratory therapists to develop comprehensive and realistic metrics, staffing models, and benchmarks which are evidence-based and data-driven.

Staffing requires consideration and some level of exclusion of required activities such as mandatory education, and support of the Respiratory Care Department for safe and effective delivery of care that consume therapist

Therefore, performing simultaneous treatments leads to reporting productivity values that are erroneously high. Performance Improvement Activities

Summary

In peer-reviewed, evidence-based research indicates that a daily, RVU-based, flex procedure volume and the associated RVU, should be used to drive staffing decisions in which staff can be added or reduced to match demand (by shift, by day or hour), based on specific workloads are not appropriate for determining staffing levels (see above).

Adjustments, driven by any workload estimation or use of inaccurate metrics of workload, may lead to understaffing by limiting required staffing requirements. For instance: An exclusive focus on Current Procedural Terminology (CPT) codes (or other standards based only on billable activities) based research indicates that a daily, RVU-based, flex

The majority of clinical procedures conducted by respiratory therapists have not been assigned a CPT code. CPT codes describe procedures and services provided by physicians and other health care professionals who bill for reimbursement. However, relatively few have been assigned to procedures and activities provided by respiratory therapists. Examples of activities with time standards for all the services provided by a department. Because of the significant variability in the nature and types of care rendered in treating

Recommendations for using metrics for determining staffing levels

Recommendations for using metrics for benchmarking

Workload metrics used to predict staffing levels must include contribution and support activities that respiratory therapists perform, as stated in the AARC position statement. An organization must account for all activities that are driven by physicians or medical staff approved protocols. If there is an obligation to perform the procedure, it must be included in determining required staff, regardless of eligibility for CMS payment. Clinical support activities should be included, such as labor law mandated breaks, shift report, participation in required activities without the provision of safety test equipment.

AARC urges organizations that offer Respiratory Care Services to work closely with Respiratory Care Department managers and respiratory therapists to develop comprehensive and realistic metrics, staffing models, and benchmarks which are evidence-based and data-driven.

Adequate fixed time should be budgeted for operation and support of the Respiratory Care Department for regulatory and support activities such as mandatory education, department meetings, competency assessment, performance improvement projects, research, and patient safety initiatives. Fixed time should not be included in variable flexed staffing estimates.

Understaffing respiratory care services places patients at risk for substandard care, missed treatments, and delays in medication delivery, as well as increases the liability risk for hospitals. On the other hand, appropriate staffing levels help to ensure consistent, safe, cost-effective, and high quality care. Medicare staffing and reporting productivity among different departments may be based on a restricted range of activities provided that such activities are common to all the departments in the compare group.

Staffing, adjusted by any workload estimation system or benchmarking analyses must include a monetary effect of staffing shortfalls on current outcomes. Monitoring outcomes like length of stay, COPD readmissions, missed therapies, delays in treatment, and delays in medication administration may also minimize risk and improve the ability to provide quality and safe care

Workload metrics used to predict staffing levels should be distinguished from metrics used for benchmarking procedures to identify quality of care and identify gaps in care consistent with the Deficit Reduction Act. CMS reimburses hospitals based on the process of comparing performance among different departments for the purposes of identifying best practices and for benchmarking purposes (i.e., the process of comparing performance among different departments for the purposes of identifying best practices on discharge or readmission is appropriately reimbursed through billing systems. Metrics based on such data reflect only a portion of the total workload. However, if properly

Assessment/Screening of Patients for VAP

Assessment/Screening of Patients for Weaning

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