



AMERICAN ASSOCIATION FOR RESPIRATORY CARE  
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June 8, 2022

Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, Maryland 21244

**Re: CMS-1765-P: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2023; Request for Information on Revising the Requirements for Long-Term Care Facilities to Establish Mandatory Minimum Staffing Levels**

Dear Administrator Brooks-LaSure:

The American Association for Respiratory Care (AARC) is pleased to submit comments on the subject regulation. The AARC is a national professional organization with a membership of 40,000 respiratory therapists who specialize in ventilator management and providing pulmonary diagnostics and treatment for patients who suffer from respiratory conditions like Chronic Obstructive Pulmonary Disease (COPD), asthma, pneumonia, lung trauma and other respiratory-related diagnoses.

We believe the extensive work by the AARC in developing a guide to determine safe and effective staffing can be used to assist CMS in making informed decisions moving forward. Our comments address the request for information on revising the requirements for long-term care (LTC) facilities that include skilled nursing facilities and nursing homes to establish mandatory minimum staffing levels. Although CMS' primary concern is aimed at addressing nursing shortages, it also seeks information that can impact other direct care workers. In that context, we believe it is important to address the value of respiratory therapists in LTC facilities in addressing the needs of those individuals who present with chronic respiratory conditions, including situations that require extensive services like ventilator management.

**The AARC recommends respiratory therapists be assigned all care and treatments associated with chronic respiratory conditions in LTC facilities to relieve concerns regarding minimum nurse staffing levels.**

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Utilizing the expertise of respiratory therapists will ensure this patient population receives appropriate therapeutic regimens from experts in pulmonary medicine defined by competency, training, and an interdisciplinary approach necessary for patient safety and improved outcomes.

When CMS changed the payment methodology for Skilled Nursing Facilities to a Patient-Driven Payment Model (PDPM) in 2019, it removed respiratory therapy services that were previously included in the nursing component and created a Non-Therapy Ancillary (NTA) component that more accurately recognized the resources associated with certain conditions and extensive services that include ventilator management, chronic obstructive pulmonary disease (COPD), cystic fibrosis, tracheostomy care, suctioning, respiratory arrest, pulmonary fibrosis, and other chronic lung disorders.

Ventilator management, for example, is one of the top four categories on the NTA Comorbidity Score Calculation Worksheet for SNFs. Ventilator care is very technology driven and it is not appropriate to provide this level of care without personnel who are specifically trained in the current technologies, such as respiratory therapists. Their expertise is essential for ongoing assessment and in determining the ability to wean the patient off the device which is more common in the SNF setting. Most SNFs primarily utilize Licensed Practical Nurses (LPNs) in which ventilator care is not within their scope of practice.

We also recommend the facility have a licensed respiratory therapist onsite 24 hours a day, seven days a week in addition to utilizing their expertise in the care and treatment of individuals with chronic respiratory conditions that require ventilator care, administration of medical gases, administration of aerosol medications, diagnostic testing, and monitoring of life support systems. ,

**The AARC recommends any metric, model, or system used to define respiratory therapy staffing levels within LTC facilities recognize and account for all activities required to address chronic respiratory conditions.**

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In the AARC Position Statement titled [Best Practices in Respiratory Care Productivity and Staffing](#),<sup>1</sup> we recognize that activities among institutions vary considerably in the nature and types of care rendered in treating patients requiring respiratory care services. The same can be said for care rendered by the LTC facilities' nursing staff. Unweighted metrics such as patient days, should not be used to determine respiratory therapist or nurse staffing levels, which can lead to inaccurate staffing requirements and the potential for error and harm.

As discussed in the position statement, health care reforms and programs may provide new opportunities in which value metrics can be applied. In such cases, respiratory and nurse staffing resources can be justified by assessing productivity through "value outcomes, inclusive of indicators of quality, cost reductions, customer satisfaction, penalty reduction, decreased readmissions, and other metrics."

**To develop appropriate respiratory care resources as well as nursing care, the AARC recommends use of a new metric called "value-efficiency" to capture and report both time and value standards. A value-driven methodology ensures that resources are only consumed based on cost, efficiency, quality of service, and safety.**

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Measuring productivity alone is no longer relevant if the procedures provided are not clinically indicated or driven by evidence-based practice. In the AARC issue paper titled [Determining the](#)

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<sup>1</sup> [https://www.aarc.org/wp-content/uploads/2017/03/statement-of-best-practices\\_productivity-and-staffing.pdf](https://www.aarc.org/wp-content/uploads/2017/03/statement-of-best-practices_productivity-and-staffing.pdf) July 2015.

[Value-Efficiency of Respiratory Care](#),<sup>2</sup> “value-efficiency” is defined as “the product of activity value and activity efficiency”. As highlighted in the *Abstract* below, it is important to capture and report both time and value standards in justifying staff resource use.

Activity efficiency is defined, conventionally, as activity hours (product of activity volume and standard time) divided by worked hours. Activity value is a new concept. It is assigned according to the degree to which any given respiratory care activity contributes to the general patient care goals of safety, comfort, or liberation. The rubric is to score each activity on a scale of 0 to 2 for five categories of value: evidence, utility, indications for use, and goals served. The value ratings for all activities of a given respiratory care department can be established using expert opinion, discussion, and literature review. Significant challenges are facing the respiratory care profession and a focus on “Value-Efficiency” is a direction the profession must pursue. This approach is a practical response to the increasing demands of payers, administrators, consultants, and patients.

To incorporate value-efficiency as a mechanism to define the number and type of caregivers required, the paper addresses three key considerations:

1. What value does respiratory care (nursing) add to the health care organization?
2. Are the interventions provided necessary and of clinical value?
3. What is the value of the respiratory therapist (nurse) in the delivery of these services?

To answer these questions, the issue paper offers an overview of how to calculate value efficiency, provides a model that includes a general selection of categories to function as a rubric for defining value, and establishes a simple spreadsheet analysis to determine the total value hours summed across all activities. Although the focus is on respiratory care, we believe this valuable tool can also assist CMS in determining appropriate levels of nursing resources, and we encourage you to read it carefully as it may answer many of the questions outlined in the proposed rule.

The AARC appreciates the opportunity to provide comments and recommendations we believe can assist CMS in achieving its goal in addressing the unprecedented impact on staff and residents of LTC facilities, including the evolving effects on staffing due to the COVID-19 pandemic.

Sincerely,



Sheri Tooley BSRT, RRT, RRT-NPS, AE-C, CPFT, FAARC  
President and CEO 2021-2022

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<sup>2</sup> Robert L. Chatburn, MHHS, RRT-NPS, FAARC; Richard M. Ford, BS, RRT, FAARC; Garry W. Kaufman, MPA, RRT, FAAC, FACHE. Determining the Value-Efficiency of Respiratory Care, 2021. <https://www.aarc.org/wp-content/uploads/2021/06/issue-paper-value-efficiency.pdf>