AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting

New Orleans, LA • November 9, 2012

Minutes

Attendance

Karen Stewart, MSc, RRT, FAARC, President
George Gaebler, MSEd, RRT, FAARC, President-Elect
Toni Rodriguez, EdD, RRT, FAARC, Past President
Susan Rinaldo-Gallo, MEd, RRT, FAARC, VP Internal Affairs
Colleen Schabacker, BA, RRT, FAARC, VP External Affairs
Linda Van Scoder, EdD, RRT, FAARC, Secretary/Treasurer
Bill Cohagen, BA, RRT, RCP, FAARC
Lynda Goodfellow, EdD, RRT, FAARC
Fred Hill, Jr., MA, RRT-NPS
Denise Johnson, MA, RRT
Keith Lamb, RRT
Doug McIntyre, MS, RRT, FAARC
Camden McLaughlin, BS, RRT, FAARC
Mike Runge, BS, RRT, FAARC
Frank Salvatore, MBA, RRT, FAARC
Joe Sorbello, MSEd, RRT
Greg Spratt, BS, RRT, CPFT
Cynthia White, BA, RRT-NPS, AE-C

Excused

Lori Conklin MD, BOMA Chair

Consultants

Bill Lamb, BS, RRT, CPFT, FAARC, Past Speaker
Dianne Lewis, MS, RRT, FAARC, Parliamentarian
Margaret Traband, MEd, RRT, FAARC, President's Council President

Guests

John Hiser, MEd, RRT, FAARC

Staff

Tom Kallstrom, MBA, RRT, FAARC, Executive Director
Sam Giordano, MBA, RRT, FAARC, Consultant
Tim Myers, MBA, RRT-NPS, Associate Exec Director/Brands Management
Miriam O'Day, Legislative Affairs Director
Anne Marie Hummel, Regulatory Affairs Director
Steve Nelson, MS, RRT, FAARC, Associate Executive Director/IT
Bill Dubbs, MHA, MEd, RRT, Director of Education & Management
Kris Kuykendall, Executive Assistant

CALL TO ORDER

President Karen Stewart called the meeting of the AARC Board of Directors to order at 8:30am CST, Friday, November 9, 2012. Secretary-Treasurer Linda Van Scoder called the roll and declared a quorum.

Ad Hoc Committee on 2015 & Beyond

Denise Johnson moved to accept Recommendation 12-3-32.1 "The 2015 ad hoc committee recommends increased access to baccalaureate degrees (either Bachelors Science Respiratory Therapy {BSRT} or Bachelors Science Health Sciences {BSHS}), for both respiratory therapy students enrolled in associate degree granting programs and for associate-prepared respiratory therapists who are already in the workforce, be readily available to access by established articulation or transfer agreements by 2015."

Lynda Goodfellow made a friendly amendment to replace "BSRT" with "Bachelor's degree from an accredited school of higher education in a health science field."

Fred Hill moved to refer amended motion to President-elect for further work and implementation.

Amended motion carried

Colleen Schabacker moved to accept Recommendation 12-3-32.2 "The 2015 ad hoc committee recommends the acquisition of the competencies approved at the July 2012 BOD meeting by segregating those required at entry level and those that can be acquired after entering practice by 2015."

Fred Hill moved to refer to President-elect for implementation.

Motion carried

Denise Johnson moved to accept Recommendation 12-3-32.3 "The 2015 ad hoc committee recommends that the AARC BOD recruit stakeholders who understand the issues, recognize the barriers, and are motivated to make the 2015 and Beyond efforts successful."

Linda Van Scoder moved to refer to President-elect.

Motion carried

President Stewart led a discussion regarding the document entitled "Suggested BOD Actions to Address Conference Recommendations from Transitioning the Respiratory Therapy Workforce for 2015 and Beyond". (See Attachment "A")

FM 12-3-32.1 Frank Salvatore moved to accept the suggested action on recommendation #1 from the 3rd conference "That this conference recommendation not be considered by the AARC Board of Directors for implementation until CoARC data indicates an adequate number of future baccalaureate graduates are available to satisfy future workforce demand as required by the following transition plan attributes:

- Maintain an adequate respiratory therapist workforce throughout the transition.
- Address unintended consequences such as respiratory therapist shortages."

Motion carried

FM 12-3-32.2 Bill Cohagen moved "That the AARC have a goal of 75% of respiratory therapists with a baccalaureate degree or higher by 2020."

Linda Van Scoder moved to amend the goal to 80%.
Motion defeated

Bill Cohagen amended the original motion to "That the AARC have an aspirational goal of a 25% increase of respiratory therapists with a baccalaureate degree or higher by 2020."
Motion carried

RECESS
President Stewart recessed the meeting of the AARC Board of Directors at 10:22am CST Friday, November 9, 2012.

RECONVENE
President Stewart reconvened the meeting of the AARC Board of Directors at 10:40am CST Friday, November 9, 2012.

FM 12-3-32.3 Frank Salvatore moved to accept the suggested action on recommendation #2 from the 3rd conference. "That action on this conference recommendation be postponed by the AARC Board of Directors until the impact of the NBRC's new consolidated written examination to be implemented in 2015 is evaluated."
Motion carried

FM 12-3-32.4 Linda Van Scoder moved to accept the suggested action on recommendation #3 from the 3rd conference. "That action on this conference recommendation be postponed by the AARC Board of Directors until there is objective evidence the CRT credential no longer adequately documents minimal entry level competency required to prevent patient harm as required by the following transition plan attributes:

- Require competency documentation options for new graduates.
- Support a process of competency documentation for the existing workforce.
- Assure that credentialing and licensure recommendations evolve with changes in practice.
- Address implications of changes in licensing, credentialing and accreditation."

Motion carried

FM 12-3-32.5 Frank Salvatore moved to accept the suggested action on recommendation #4 from the 3rd conference "Refer this conference recommendation to the AARC 2013 president for execution as a component of a comprehensive strategy to identify additional competencies to be acquired by the current workforce by a date to be established by the president."
Motion carried

FM 12-3-32.6 Bill Cohagen moved to accept the suggested action on recommendation #5 from the 3rd conference "Refer this conference recommendation to the AARC 2013 president for execution as a component of a comprehensive strategy to identify additional competencies to be acquired by the current workforce by a date to be established by the president."
Motion carried

FM 12-3-32.7 Mike Runge moved to accept the suggested action on recommendation #6 from the 3rd conference "Refer this conference recommendation to the AARC 2013 president to appoint an ad hoc committee of experts to work with the CoARC to develop models of consortia and cooperative agreements for associate degree programs that wish to align with bachelor degree granting institutions by a date to be established by the president**.**"
Motion carried

FM 12-3-32.8 Linda Van Scoder moved to accept the suggested action on recommendation #7 from the 3rd conference "That the AARC Executive Office conduct a survey of CoARC accredited associate degree granting programs to identify those without existing bridges to baccalaureate programs ascertain their future plans about establishing these bridges and identify any perceived barriers. The results of the survey are to be reported in July 2013."
Motion carried

FM 12-3-32.9 Joe Sorbello moved to accept the suggested action on recommendation #8 from the 3rd conference "Refer this conference recommendation to the AARC 2013 president for execution as a component of a comprehensive strategy to identify additional competencies to be acquired by the current workforce by a date to be established by the president."
Motion carried

FM 12-3-80.1 Joe Sorbello moved to ask CoARC to put a 5 year moratorium on all new associate degree respiratory therapy programs.
Motion carried (11 yes and 6 no)

Joe Sorbello moved to reconsider the motion.
Motion carried with two-thirds majority

Original motion defeated

RECESS
President-elect George Gaebler recessed the meeting of the AARC Board of Directors at 11:55am CST Friday, November 9, 2012.

RECONVENE
President Stewart reconvened the meeting of the AARC Board of Directors at 1:40pm CST Friday, November 9, 2012.

Linda Van Scoder moved to accept the Ad Hoc Committee reports as presented.
Motion carried

HOD Resolutions

HOD Resolution 06-12-03 "Be it resolved that the AARC investigate starting a public membership for patients and other interested parties."

Frank Salvatore moved to refer to Executive Office to look at the feasibility and report back in April 2013.
Motion carried

HOD Resolution 13-12-04 "That the AARC investigate the formation of an apprenticeship Program in partnership with the ARCF, for Respiratory Therapists who would like to learn from established researchers."

Frank Salvatore moved to refer to Executive Office to investigate and report back in April 2013.
Motion carried

Linda Van Scoder moved to accept the General Reports as presented.
Motion carried

FM 12-3-26.1 Bill Cohagen moved to accept, with edits and revisions, the White Paper on "Best Practices in Respiratory Care Productivity and Staffing". (See Attachment "B")
Motion carried

Denise Johnson moved to accept Special Committee Reports as presented.
Motion carried

OTHER REPORTS

ARCF and NBRC reports were reviewed.

Linda Van Scoder moved to accept the agency updates as submitted.
Motion carried

Unfinished Business
There was no unfinished business.

New Business
White Paper Review

FM 12-3-26.3 Frank Salvatore moved to refer the white paper entitled, "Development of Baccalaureate and Graduate Education Degrees" to the Position Statement Committee.
Motion carried

FM 12-3-26.4 Frank Salvatore moved to retire the white paper entitled, "Guidance Document on SARS" and place in the archives.
Motion carried

POLICY REVIEW

Policy No. BOD.015 – Board of Directors – AARC Stationery, Business Cards
Frank Salvatore moved to accept with new reviewed date.
Motion carried

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Policy No. BOD.016 – Board of Directors Votes on HOD Recommendations
Frank Salvatore moved to accept with new reviewed date.
Motion carried

Policy CT.004 – Special Committees, Task Forces, Focus Groups, Panels, and Special Representatives to External Organizations
Colleen Schabacker moved to accept with new reviewed date.
Motion carried

See Attachment "C" for all revised polices listed above.

Treasurers Motion
Linda Van Scoder moved that expenses incurred at this meeting be reimbursed according to AARC policy.
Motion Carried

MOTION TO ADJOURN
Linda Van Scoder moved to adjourn the meeting of the AARC Board of Directors.
Motion Carried

ADJOURNMENT
President Karen Stewart adjourned the meeting of the AARC Board of Directors at 2:25pm CST, Friday November 9, 2012.

Meeting minutes approved by AARC Board of Directors as attested to by:

_____ _____
Frank Salvatore, MBA, RRT, FAARC Date
AARC Secretary/Treasurer

Attachment “A”

Suggested BOD Actions to Address Conference Recommendations from transitioning the Respiratory Therapy Workforce for 2015 & Beyond

Suggested BOD Actions to Address Conference Recommendations from Transitioning the Respiratory Therapy Workforce for 2015 and Beyond

Transition Plan Attributes

The transition plan must:

1. Maintain an adequate respiratory therapist workforce throughout the transition.
2. Address unintended consequences such as respiratory therapist shortages.
3. Require multiple options and flexibility in educating both students and the existing workforce. (e.g. affiliation agreements, internships, special skills workshops, continuing education, etc.)
4. Require competency documentation options for new graduates.
5. Support a process of competency documentation for the existing workforce.
6. Assure that credentialing and licensure recommendations evolve with changes in practice.
7. Address implications of changes in licensing, credentialing and accreditation.
8. Establish practical timelines for recommended actions.
9. Reflect the outcomes of the previous two 2015 and Beyond conferences
10. Identify the agencies most appropriate to implement identified elements.

Recommendations of the third conference publication:

1. That the AARC request CoARC to change by 7/1/12 accreditation standard 1.01 to read as follows:
    - 1.01 the sponsoring institution must be a post-secondary academic institution accredited by a regional or national accrediting agency that is recognized by the U.S. Department of Education (USDE) and must be authorized under applicable law or other acceptable authority to award graduates of the program a baccalaureate or graduate degree at the completion of the program.

      Programs accredited prior to 2013 that do not currently offer a baccalaureate or graduate degree must transition to conferring a baccalaureate or graduate degree, which should be awarded by the sponsoring institution, upon all RT students who matriculate into the program after 2020.

Suggested Action: That this conference recommendation not be considered by the AARC Board of Directors for implementation until CoARC data indicates an adequate number of future baccalaureate graduates are available to satisfy future workforce demand as required by the following transition plan attributes:

- **Maintain an adequate respiratory therapist workforce throughout the transition.**
- **Address unintended consequences such as respiratory therapist shortages.**

2. That the AARC recommends to the NBRC on July 1, 2011, that the CRT examination be retired after 2014; And, that the AARC recommends to the NBRC on July 1, 2011 that the multiple choice examination components (CRT and RRT written) for the RRT should be combined after 2014.

Suggested Action: That action on this conference recommendation be postponed until the impact of the NBRC's new consolidated written examination to be implemented in 2015 is evaluated.

3. That the AARC establish on July 1, 2011, a commission to assist state regulatory boards transition to a RRT requirement for licensure as a respiratory therapist.

Suggested Action: That action on this conference recommendation be postponed until there is objective evidence the CRT credential no longer adequately documents minimal entry level competency required to prevent patient harm as required by the following transition plan attributes:.

- **Require competency documentation options for new graduates.**
- **Support a process of competency documentation for the existing workforce.**
- **Assure that credentialing and licensure recommendations evolve with changes in practice.**
- **Address implications of changes in licensing, credentialing and accreditation.**

4. That the AARC Executive Office request that the AARC Board of Directors ask the appropriate existing sections to develop standards to assess competency of RTs in the workforce relative to job assignments of the RT.
    a. Standards should address the variety of work sites that employ RTs.
    b. Standards should address RT knowledge, skills and attributes relative to the tasks being evaluated.

Suggested Action: Refer this conference recommendation to the AARC 2013 president for execution as a component of a comprehensive strategy to identify additional competencies to be acquired by the current workforce by a date to be established by the president.

5. That AARC encourage clinical department's educators, and state affiliates continuing education venues to use clinical simulation as a major tactic for increasing competency levels for the current workforce.

Suggested Action: Refer this conference recommendation to the AARC 2013 president for execution as a component of a comprehensive strategy to identify additional competencies to be acquired by the current workforce by a date to be established by the president.

6. That the AARC, in cooperation with the CoARC, consider development of consortia and cooperative models for associate degree programs that wish to align with bachelor degree granting institutions for the award of the Bachelor's degree.

Suggested Action: Refer this conference recommendation to the AARC 2013 president to appoint an ad hoc committee of experts to work with the CoARC to develop models of consortia and cooperative agreements for associate degree programs that wish to align with bachelor degree granting institutions by a date to be established by the president.

7. That the AARC provide budgetary resources to assist associate degree programs with the transition to baccalaureate level respiratory therapist education.

Suggested Action: Conduct a survey of CoARC accredited associate degree granting programs to identify those without existing bridges to baccalaureate programs ascertain their future plans about establishing these bridges and identify any perceived barriers. The results of the survey are to be reported in July 2013.

8. That the AARC BOD explores development and promotion of career ladder education options for the member of the existing workforce to obtain advances competencies and the baccalaureate degree.

Suggested Action: Refer this conference recommendation to the AARC 2013 president for execution as a component of a comprehensive strategy to identify additional competencies to be acquired by the current workforce by a date to be established by the president.

Recommendations of the 2015 & Beyond Ad Hoc Committee

Recommendation 1

Education by Degree Focus - The 2015 ad hoc committee recommends increased access to baccalaureate degrees (either Bachelors Science Respiratory Therapy {BSRT} or Bachelors Science Health Sciences {BSHS}), for both respiratory therapy students enrolled in associate degree granting programs and for associate-prepared respiratory therapists who are already in the workforce, be readily available to access by established articulation or transfer agreements by 2015.

Justification: The AARC clearly supports all associate-degree programs that are accredited by the CoARC. However, in order to maintain an adequate therapist workforce and avoid unintended consequences of a shortage of respiratory therapists, multiple options and flexibility are required. Working with CoARC, model affiliation agreements between AS programs and BS programs are needed with mentoring assistance provided in the articulation process. Lastly, distance learning opportunities that provide flexibility for working therapists and the acceptance of experiential work experience should be thoroughly explored. This recommendation addresses recommendations 6 & 8 of the third conference.

Recommendation 2

Competency Level Focus –The 2015 ad hoc committee recommends the acquisition of the competencies approved at the July 2012 BOD meeting by segregating those required at entry level and those that can be acquired after entering practice by 2015.

Justification: If the competencies required at entry- level are identified, then the CoARC can incorporate them into their future standards which will assure that they are included into the curriculum of accredited programs. As these skills find their way into the workplace, the NBRC will eventually detect this through their job analysis and incorporate them into their credentialing examinations. This can be accomplished by the development of standardized curricula that incorporates the teaching of knowledge, skills and attributes (KSA's) necessary to acquire the competencies that can be acquired after entering practice. The content can be delivered through continuing education programs developed by the AARC; CoARC accredited respiratory therapy education programs, and other institutions that deliver education. In traditional courses, participants can gain the needed KSAs and competency documentation. Nontraditional programs can be used to deliver the educational content while the skill development and competency documentation can be conducted in laboratories of accredited respiratory programs or skills labs located in the facilities, or systems (high-fidelity), where therapists are employed. This recommendation addresses recommendations 4, 5 & 8 of the third conference.

Recommendation 3

Project Leadership Focus - The 2015 ad hoc committee recommends that the AARC BOD recruit stakeholders who understand the issues, recognize the barriers, and are motivated to make the 2015 and Beyond efforts successful.

Justification: Representation from CoARC accredited associate degree programs that have and don't have an articulation agreements as well as representatives from baccalaureate and masters (BSRT and MSRT) degree programs are urged to participate in order to successfully overcome barriers to higher education. Other professionals needed to guide the process are a distance learning specialist, representatives from CoARC and the NBRC, respiratory therapy employers from both the hospital and home care settings. As specific tasks are defined, additional volunteers will likely be required. This recommendation addresses recommendations 4,5,6 & 8 of the third conference.

Conclusion: It is essential that the AARC plan for the future and take steps to assure that we are prepared to assume the duties and responsibilities that may be required of the respiratory therapist in the years to come. By accepting these recommendations, the BOD is sending the message that you agree with the findings of the third conference supporting the need for more bachelor degree level therapists and the requirement that the transition plan conforms to the transition plan attributes.

Attachment “B”

White Paper – Best Practices in Respiratory Care Productivity and Staffing

AARC White Paper

November 8, 2012

BEST PRACTICES IN RESPIRATORY CARE PRODUCTIVITY AND STAFFING

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.[1]

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[2], 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.).”[2]

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

Situation analysis and considerations

From a financial perspective, the over-estimation of staffing requirements leads to unnecessary and avoidable labor expenses. In contrast, understaffing may reduce salary cost in the short term, while producing more expense and lost revenue in the long run. Fiscally, there is much to be gained by staffing appropriately. Threats to revenue can result if prescribed treatments are not delivered and billed. Healthcare reforms associated with value based purchasing will affect reimbursement payments from Medicare based on both clinical outcomes and patient satisfaction. Thus, each institution should be financially motivated to assure adequate staffing for patients to receive appropriate care and avoid lengthy hospital stays or unnecessary readmissions. Further, missed and delayed treatments increase institutional liability.

Understaffing negatively affects respiratory therapists' morale because of inadequate time to provide needed assessments and care.[3] Low morale may result in increased staff turnover. These are compelling reasons to ensure adequate staffing in the provision of respiratory care.

Any metric, model, or system that is used to define respiratory staffing levels within institutions should recognize and account for all the activities required of a Respiratory Care Department in that institution. These activities vary greatly among institutions, and therefore must be determined on a case-by-case basis and approved by the medical staff and administration in individual hospitals.

Failure to account for all medically necessary interventions, or use of inaccurate metrics of workload, may lead to underestimation of staffing requirements. For instance: An exclusive focus on Current Procedural Terminology (CPT) codes (or other standards

based only on billable activities) can lead to the omission of a large number of non-billed activities from the estimated respiratory care workload. Similarly, relying on internal measures, such as Total Patient Days, Average Daily Census, Adjusted Discharges per Patient Day, and Nursing hours per patient day (which do not accurately reflect respiratory therapist workload intensity), can lead to the omission of important and necessary tasks that contribute to workload and thus provide erroneous estimates of required staffing.

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 without CPT codes include but are not limited to:

- Airway Management Procedures
- Assessment/Screening Patients for Obstructive Sleep Apnea
- Assessment/Screening of Patients for Treatment
- Assessment/Screening of Patients for Invasive and Non-Invasive Ventilation
- Assessment/Screening of Patients for VAP
- Assessment/Screening of Patients for Weaning
- Cardio Version Monitoring of the Patient
- Continuous Oximeter
- Disease Management
- End Tidal CO2 Monitoring
- Endotracheal Tube Extubation
- Endotracheal Tube Repositioning and Securing
- Heliox Administration and Monitoring
- Incentive Spirometry
- Inpatient Sleep Apnea Monitoring
- Lung Recruitment Maneuvers
- Management of Patient Monitoring Devices
- Moderate Sedation Monitoring
- Nitric Oxide Administration
- Oxygen Administration and Monitoring
- Patient and Family Education, most instances
- Patient Transports Requiring Mechanical Ventilation or Airway Maintenance
- Rapid Response Calls
- Respiratory Care Consultations
- Spontaneous Breathing Trials
- Tracheotomy Management

In addition, there are additional activities required to support the safe and effective delivery of care that consume therapist time. Many of these support activities are required by regulatory agencies. These activities must also be accounted for and include but not limited to:

- Calibration of Equipment
- Cleaning and Stocking of Equipment
- Clinical Instruction of Students

- Cylinder Inventory Management
- Department and Medical Center Meetings
- In-service Attendance
- Maintenance of Equipment
- Patient Care Report/Handoff
- Patient Care Rounds
- Performance Improvement Activities
- Quality Control of Devices and Procedures
- Staff Education and Training

Recommendations for using metrics to determine staffing levels

1. Workload metrics used to predict staffing levels must include all clinical 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 physician orders or medical staff approved protocols. If there is an obligation to perform the procedure, it must be used in determining required staff, regardless of eligibility for CMS payment. Clinical support activities should be included, such as labor law mandated paid breaks, shift report, participation in required training, or the need to safety test equipment.

2. Because of varying time requirements for different respiratory care procedures, systems to determine staffing should be based upon statistically valid activity 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 patients in need of respiratory services, unweighted metrics such as patient days, billable procedures with CPT codes, total procedures, etc., should not be used to determine respiratory therapist staffing levels.[4]

3. Relative value units (RVUs) have been adopted by CMS for physician reimbursement, and provide another mechanism to weight specific procedures.[5] An RVU-based staffing program must be used with a department staffing plan that provides the ability to flex direct patient care staff based upon service needs. The assessment of work demand (by shift, by day or by hour), based on specific procedure volume and the associated RVU, should be used to drive staffing decisions in which staff can be added or reduced to match demand. Peer-reviewed, evidence-based research indicates that a daily, RVU-based, flex staffing system can meet staffing requirements for patient needs and reduce costs by approximately $250,000 per year (5 full-time equivalents, FTEs) in a 400-bed hospital.[6]

4. When constructing a staffing system, the need for “core staffing” or “minimal staffing” should be determined. This means that some staff is always available to immediately respond to emergency situations such as cardiopulmonary arrest or attendance at high-risk neonatal deliveries. Core-staffing requires consideration and some level of exclusion from being managed through a flex staffing model.

5. The literature documents that unscheduled respiratory care activities, such as emergency department procedures, patient transports, rapid response calls, etc., may account for up to 40% of the workload. Staffing should be provided for unscheduled procedures based upon historical data and work rate. Failure to include unscheduled procedures in staffing projections, or failure to recognize peak work

6. rates during the day, result in drastic mismatching between work demand and labor supply.[7]

7. Adequate fixed time should be budgeted for operation and support of the Respiratory Care Department for required 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.[8]

8. Staffing adjustments, driven by any workload estimation system or benchmarking analyses must include a mechanism to assess the effects of staffing on patient outcomes. Monitoring outcomes like length of stay, COPD readmissions, missed therapy, delays in treatment, and other complications provide data to validate adjustments in staffing. Such monitoring may also minimize risk and improve the ability to provide quality and safe care.

Recommendations for using metrics for benchmarking

1. Workload metrics used to predict staffing levels should be distinguished from *metrics used for benchmarking productivity*. Workload metrics used for benchmarking (i.e., the process of comparing performance among different departments for the purposes of identifying best practices) are often based on data that are easily captured through billing systems. Metrics based on such data reflect only a portion of the total workload. However, if properly selected to represent the majority of the workload common to different departments, they are appropriate for the purpose of ranking productivity levels.

2. Metrics are useful for benchmarking productivity only if they can be demonstrated to reflect the same activities in the departments being compared. Benchmarking metrics based on data representing partial departmental workloads are not appropriate for determining staffing levels (see above).

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. This type of data degrades the utility of the measures in proportion to the degree of mismatched activities among benchmarking group members.

Summary

The AARC urges organizations that offer Respiratory Care Services to work closely with Respiratory Care Department directors/managers and respiratory therapists to develop comprehensive and realistic metrics, staffing models, and benchmarks which are evidence-based and data-driven. Metrics used for staffing must capture the full range of activities required of respiratory therapists in order to ensure consistent, safe, cost-

effective, and high quality care. Metrics used for comparing 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.

Understaffing respiratory care services places patients at risk for unsafe incidents, missed treatments, and delays in medication delivery, as well as increases the liability risk for hospitals. On the other hand, appropriate staffing levels help assure that a consistent standard of respiratory care is provided throughout the hospital. Adequate staffing levels decrease the potential for error and harm by providing respiratory therapists adequate time to perform required functions and can contribute to greater levels of patient satisfaction.

Patient harm directly related to inadequate staffing must be reported to the appropriate state and federal regulatory agencies.

References

1. American Association for Respiratory Care Position Statement: Best Practices in Respiratory Care Productivity and Staffing 2012.

   (http://www.aarc.org/resources/position_statements/productivity_and_staffing.html)

1. 42 C.F.R. § 482.57 Condition of Participation: Respiratory Care Services.
2. Schwnezer K and Wang L. Assessing Moral Distress in Respiratory Care practitioners. Crit Care Med. 2006, Dec; 34 (12) : 2967-73.

3. Grady D, Smith T, and Collar L. A Comparison of Metrics for a Respiratory Care Department in an 800-Bed Medical Center. Respiratory Care, 2011 Oct; 56(10): 1703.

4. Dummit L. Relative Value Units. National Health Policy Forum. The George Washington University. www.nhpf.org, February 12, 2009, 1-5.

5. Grady D. and Smith T. Healthcare Cost Reductions Using a Daily, RVU-Based, Flex-Staffing System for a Respiratory Care Department. Respiratory Care, 2011 Oct; 56(10): 1703.

6. Chatburn RL, Gole S, Schenk, P, Hoisington E, and Stoller. Respiratory Care Work Assignment Based on Work Rate Instead of Work Load. Resp Care. 2011, Nov; 56(11): 1785-1790.

7. American Association for Respiratory Care. Uniform Reporting Manual. 5th Ed. Dallas, Tx, Daedalus publishers, 2012.

Attachment “C”

Policy No.BOD.015 – AARC Stationery, Business Cards
Policy No.BOD.016 – Board of Directors Votes on House of Delegates Recommendations
Policy No.CT.004 – Special Committees, Task Forces, Focus Groups, Panels, and Special Representatives to External Organizations

American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: **AARC Stationery, Business Cards**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: November 2012

DATE REVISED:

REFERENCES: AARC Bylaws

Policy Statement:
Only authorized personnel shall use Association stationery and receive Association business cards.

Policy Amplification:

1. Officers and directors may be supplied with business cards indicating their position with the AARC, and their business title and contact information subject to approval of the President.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: **Board of Directors Votes on House of Delegates Recommendations**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: November 2012

DATE REVISED: July 2008

REFERENCES:

Policy Statement:
Resolutions brought by the House of Delegates to the Board of Directors shall be submitted, considered, and voted upon in an appropriate and timely manner.

Policy Amplification:

1. All resolutions from the House of Delegates shall be presented to the Board of Directors by the Immediate Past Speaker and/or a designee identified by the Speaker of the House of Delegates and approved by the President.

2. For a HOD resolution to be acted upon by the Board during the same meeting at which it is considered by the House, it shall be submitted in written form including the House-assigned resolution number by 12:00 noon on the final day of the Board of Directors' Meeting.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

SECTION: Committees

SUBJECT: **Special Committees, Task Forces, Focus Groups, Panels, and Special Representatives to External Organizations**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: November 2012

DATE REVISED: July 2005

REFERENCES: AARC Bylaws, CT.001, CT.002, CT.003 and CT.004

Policy Statement:
Special Committees or Representatives to External Organizations may be appointed by the President to carry out specific activities, subject to ratification by the Board of Directors.

Policy Amplification:

1. The President may appoint a Special Committee, Task Force, Focus Group or Panel to complete specific charges related to the needs of the Association or the profession.

2. The Executive Director, Board of Directors, Board of Medical Advisors, House of Delegates, Chartered Affiliates, Specialty Sections or member may request that the President appoint a Special Committee, Task Force, Focus Group or Panel to perform specific charges.

3. In the event of vacancies occurring in Special Committees, Task Forces, Focus Groups or Panels, the President may appoint members to fill such vacancies, subject to ratification by the Board of Directors.

4. Representatives of the Association to such external organizations as may be required shall be appointed by the President, subject to ratification by the Board of Directors.

5. In the event of vacancies occurring in any representative position to external organizations, the President may appoint members to fill such vacancies, subject to ratification by the Board of Directors.

6. Trustees of the CoARC, ARCF and NBRC :

   A. Shall not serve as voting members of more than one of the above identified organizations during any single term of appointment.
   B. Presents and communicates the positions, policies and concerns of the AARC.

C. Desired qualifications include:

1) AARC Member for five (5) years.
2) Knowledge of AARC bylaws, positions, policies and philosophies.
3) One year previous experience at the AARC level, e.g., Board of Directors, House of delegates, special representative, committee chair or member.
4) Ability to communicate effectively.
5) For CoARC: Previous management/supervisory experience as faculty of a CoARC accredited respiratory care program.

DEFINITIONS:

ATTACHMENTS: