SECTION III
WORKLOADS AND CONCURRENT THERAPY

The Patient Protection and Affordability Act\textsuperscript{18} were signed into law on March 23, 2010 as well as the Healthcare and Education Reconciliation Act\textsuperscript{19}. These two laws represented the greatest change in the healthcare system since 1965, when Medicare was signed into law. These changes along with aging baby boomers are expected to tax the healthcare system significantly from where it currently exists. Hospitals have already been struggling to remain solvent due to decreased reimbursement from government-supported healthcare, and insurance companies in conjunction with increased costs of doing business. When Diagnostic Related Groups (DRG’s) were introduced in the 1980s as a means to control reimbursement to healthcare institutions, respiratory care departments went from revenue generating departments to cost centers. In order to control cost respiratory care departments have intertwined billable items to maximize RCP’s performance of scheduled procedures on a shift-to-shift basis. Workloads assigned to RCPs have increased as the number of billable procedures continues to decrease. Respiratory Care Departments have been forced to do more with less causing many departments to embrace or condone the practice of “Concurrent Therapy”.

Concurrent Therapy, also known as treatment stacking, is defined as performing more than one procedure at the same time by the same practitioner. This practice creates a conflict involving professional practice principles, state practice acts and professional ethical principles. Let’s explore this ethical dilemma further.

\textbf{Scenario – Workload}

RCP John is a new graduate of a respiratory care program and has landed his first job as a respiratory therapist. When asked why he chose respiratory therapy as a profession, John would enthusiastically respond, “I love helping people and I enjoy providing quality respiratory care and that is what I have been trained to do”. When John reports to work on his second week of orientation, he is informed by his mentor that they are short staffed today, due to two sick calls. As a result, John is told his orientation will be placed on hold and that he will be given a workload spread over two different floors, oncology and transitional care unit. John expresses concern with his mentor about being able to handle the workload assigned to him. John is reassured by his mentor that it will be ok; he is advised to place multiple patients on therapy at the same time. Despite performing concurrent therapy, John struggles to keep up because he is slowly adapting to computer charting. He decides to skip lunch and his break in order to compensate for the lost time charting. John strategizes his next rounds. He decides to start on TCU because most of his patients are mask treatments. He rationalizes that if he is late returning to the patient room to take the patient off therapy, the patient will not be coherent enough to complain. John’s strategy seems to be working, as he looks at his watch and examines the number of treatments remaining. He then places his last group of patients on mask therapy before heading upstairs to treat his next group of patients. Ten minutes late John hears an overhead page notifying the Rapid Response Team (RRT) to the Transitional Care Unit. As John responds to the call, he discovers that it is his patient and the patient still has the aerosol mask on. The reason a RRT was called was the patient had vomited into the mask and aspirated.

\textsuperscript{18} \url{http://www.hhs.gov/healthcare/rights/law/index.html}
\textsuperscript{19} \url{http://www.whitehouse.gov/issues/education/higher-education/making-college-affordable}
Upon learning that the department had implemented a respiratory therapy protocol with the goal of reducing around the clock therapy, John volunteered to go to the night shift. The primary goal of the protocol was for management to decrease the amount of therapy scheduled during the night shift. Upon reviewing his night shift workload, John appreciates the effect of the protocol. Since there is little therapy scheduled at night, staffing was reduced. Because of the reduced staffing, John was assigned four different floors with patients on nocturnal BIPAP. Come morning, John is very fatigued having worked his first night shift. As he sat down to perform his billing he submitted charges for all BIPAPs and CPAPs, even though some were home units. After going home and sleeping, John awakens, pours himself a cup of coffee, sits down, and reflects on his performance of his first respiratory therapist job. He realizes he is not very proud of the quality of care he provided. He decides to take a look at his textbook and begins to read on licensure and ethics.

Discussion:
John’s clinical situation has presented us both with ethical and legal dilemmas. He wants to give quality respiratory care to his patients and tries to the best of his ability. Because of the constraint in time, he abides by the recommendation of utilizing concurrent therapy as a vehicle to complete his workload.

What is the position of the Respiratory Care Board regarding concurrent therapy? They have received inquiries regarding the practice of concurrent therapy from various concerned parties. The nature of these inquires typically revolve around four basic themes: patient safety, quality of care, appropriate billing and practitioner liability. The RCB response to concurrent therapy has been the following:

“Many hospitals have chosen to implement concurrent therapy policies to control costs and address patient demands. Of course, concerns for patient safety and quality of care arise when more than one treatment is being provided at the same time. While Respiratory Care Practice Act does not address specific therapies, the board does rely upon commonly accepted guidelines and standards established by leading respiratory care organizations. In this case the American Association for Respiratory Care and the California Society for Respiratory Care have developed and published a white paper and a position statement, respectively, on this topic. Both serve as professional resources for all RCPs”

What does our National Professional Organization and our own California State Society have to say on the subject of concurrent therapy?

The California Society for Respiratory Care (CSRC) and the American Association for Respiratory Care (AARC) are very aware of the practice of concurrent therapy (sometimes referred to as “stacking”) within the context of providing respiratory care. The following information is made available as there are major concerns from practitioners which center on the issues of patient safety and quality of care.

Centers for Medicare and Medicaid Services
In a Federal Register notice dated May 10 2001, related to the Prospective Payment System (PPS) for skilled Nursing Facilities (SNF), the Centers for Medicare and

http://www.rcb.ca.gov/forms_pubs/nloct08.pdf
Medicaid Services (CMS) raised the issue of concurrent therapy. According to CMS, “Concurrent therapy is the practice of one professional therapist treating more than one Medicare beneficiary at a time—in some cases, many more beneficiaries likely are not receiving services that relate to those needed by any other participants. Although each beneficiary may be receiving care that is prescribed in his individual plan of treatment, it is not being delivered according to Medicare coverage guidelines: that is, the therapy is not being provided individually, and it is unlikely that the services being delivered are at the complex skill level required for coverage by Medicare.

If the organization uses concurrent therapy to treat Medicare patients, does that practice place the hospital at risk?

**Billing Errors**

Concurrent therapy can cause billing problems and result in possible fraud. According to federal regulations for Medicare Part A services (i.e., hospital inpatient services), “Respiratory therapy services cannot be recognized when performed on a mass basis with no distinction made to the individual patient’s actual conditions and need for such services.” This language, in addition to the concerns raised by CMS in the May 10, 2001 Federal Register notice cited previously indicated that concurrent therapy associated with respiratory services is not covered under Medicare. Although Medicare payments are made according to a prospective payment system, these payments are based on professional standards and the therapist’s time spent in providing patient care.

What does our National Professional Organization have to say about productivity and staffing?

**Best Practices in Respiratory Care Productivity and Staffing**

As the respiratory therapist national professional organization, the AARC has been instrumental in the development and promotion of the Standard Uniform Reporting Manual. This manual was meant to provide directors of respiratory care a foundation and resource in the development and implementation of a time base standard for workload determination. According to the AARC:

“Use of unweighted metrics of workload may lead to the determination of inaccurate staffing requirements. An exclusive focus on CPT coded procedures to determine staffing levels or other standards based exclusively on billable activities can lead to the omission of a significant number of non-billed activities from the estimated respiratory care workload and result in underestimating the number of staff needed”.

The AARC White Paper on Concurrent Therapy is currently under revision and is being updated to reflect changes in best practices.

**Position Statement “Concurrent Therapy”**

The California Society for Respiratory Care (CSRC), having completed comprehensive research into the practice of “Concurrent Therapy”, has concluded that, aside from

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21 Dubbs, William, A Tool for Our Times, AARC Times, March 2000
declared disaster, there is no compelling medical, ethical or safety rationale for the continuation of this practice\textsuperscript{22}.

The CSRC continues the position that concurrent therapy (CT), as defined below, should rapidly be abandoned and as needed, legislatively addressed; in the interest of patient safety, interventional efficacy and the ethical practice of Respiratory Therapy. “Concurrent Therapy” in Respiratory Care is defined as rendering simultaneous inhaled medication aerosols, to more than one patient, in unmonitored patient care areas, by one therapist.

Concerns surrounding this practice have been widely expressed, including those from the Joint Commission on Accreditation of Healthcare Organizations\textsuperscript{23} (JCAHO), Medicare/Medicaid (CMS), and the California Respiratory Care Board. JCAHO calls CT “a problem”, Medicare says of CT, “It is not being delivered according to Medicare coverage guidelines: that is, the therapy is not being provided individually.” The California Respiratory Care Board states, “We would strongly discourage any organization from adopting a policy which leaves patients unattended from administration of medication and continues, “This practice would be contradictory to safe practice.”\textsuperscript{22}

While each group addressed primarily the safety compromise of concurrent therapy, none directly speak to the ethical dilemma of conscientious therapists. This ethical morass is created when an employer requires or actively condones the practice of CT. It is for the aforementioned with patient safety concerns, that the CSRC implores the profession, healthcare providers, healthcare institutions and the public, to bring to a halt this example of misused, misguided and unsafe healthcare practice. Based on clinical data, which concluded that Respiratory Care interventions are over utilized by as much as sixty percent\textsuperscript{22,23}, the CSRC recommends the use of clinical tools to optimize utilization in an effort to diminish the perceived need of CT. Such tools may include, but should not be limited to assessment driven, evidence based and outcome oriented interventional protocols, Utilization appropriateness may also be geared toward patient education toward self-administration.

Aside from Clinical Tools, computer workload leveling tools should be considered in providing better scheduling of therapy, which is more in line with clinical and patient needs. Such tools, in conjunction with assessment based protocols as opposed to existing schedule formulation practices, may lead to a decrease in utilization as well as an improved concentration of skilled Therapist time for higher acuity patients. In summary, the CSRC advocates for patient safety, therapeutic efficiency and ethical responsibility in proposing the abandonment of the practice of CT. The CSRC supports appropriate assessment driven use of Respiratory Care services to minimize misallocation of ordering practices, to relegate the unsafe and unconscionable practice of CT\textsuperscript{24} to a thing of the past.

\textsuperscript{23} Joint Commission on Accreditation for Healthcare Organizations, \url{http://www.jointcommission.org/}
JCAHO cites concurrent therapy as a problem. According to JCAHO if concurrent therapy is done, there must be a clear indication for it and a policy and procedure that govern its application. It must be differentiated from treatments given individually.