CSRC Safe Staffing Standards

Position Statement

The Position Statement has been composed with one overarching goal in mind: to ensure that the safety of patients to whom respiratory care is administered in the state of California is guaranteed. This goal, in turn, is optimized when that care is delivered by competent caregivers

The California Society for Respiratory Care (CSRC) recommend that the following guidelines be observed to implement safe and effective staffing levels in organizations and settings in which patients may require the scope of respiratory services and treatment defined by the California Respiratory Care Board (RCB).

1. **CSRC recommend any staffing system must account for all activities of the RCP workday.** Physician orders or medical staff approved protocols, which include assessment regimens must be accounted for regardless of CPT code or of eligibility for CMS payment. If physician or protocol obligates RCP performance, that performance must be accounted for in determining staff required.

2. **CSRC recommend staffing programs and systems be based on national RVU time standards, such as the AARC's Uniform Reporting Manual (URM).** Respiratory Care procedures, along with any RC staffing/productivity system should be based upon Relative Value Units (RVUs) for all the services provided by an individual department. RVUs provide the ability to define the time required or percent of staff that should be allocated to a specific procedure as defined in the American Association for Respiratory Care Uniform Reporting Manual (AARC URM). RVUs were specifically chosen due to the variability of time required to perform different procedures. Alternate metrics correlate poorly with RVUs and should not be used to determine staffing and productivity[8]. RVUs have been adopted by the Centers for Medicare and Medicaid Services (CMS) for physician reimbursement and provide another mechanism for weighting specific procedures[9].

3. **CSRC recommend department staffing plan based upon RVUs.** Driven by an RVU-based staffing plan such a system provides the flexibility to direct patient care staff based upon actual facility service needs. The assessment of work demand, should be geared to specific procedure volume with associated RVU values used to drive staffing decisions. Peer-reviewed, evidence-based research indicates that a daily, RVU based, flex-staffing system met staffing requirements for patient needs and reduced cost by approximately $250,000 per year (5 FTE) in a 400-bed Acute Care hospital[10].

4. **CSRC recommend "core-staffing" or "minimal staffing" be determined and utilized.** Core staffing provides for emergency response and other services in a timely manner. Core staffing requires consideration as well as some level of exclusion from being managed through a flexible staffing model.

6. **CSRC recommend staffing be provided for unscheduled procedures.** Based upon historical data and work rate, unscheduled events, which require RCP services, can be both quantified and qualified. Literature[11] suggests that unscheduled Respiratory Care activities, such as Emergency Department procedures, patient transports, rapid response calls, etc., may account for up to 40% of workload. Failure to include unscheduled procedures in staffing projection, results in mathematically impossible workloads with subsequent negative cascading events (patient care compromise, understaffing, departmental, delays in provision of service and facility cost increases)

7. **CSRC recommend adequate numbers of both administrative and support staff be determined to a support the provision of services. At a minimum, administrative support staff as defined by California Title 22 shall be in place. The AARC URM provides both Non-Allocated and Support functions and task that should be considered in determining the classification and number of these staff.**

8. **CSRC recommend the use of Patient-Driven Protocols.** Programs that identify the medical necessity for care are recommended for the provision of staffing resources to administer. Assuring appropriate utilization of services optimizes care on a continual basis and minimizes RCP provided therapy not considered efficient or productive. The use of RVU-based staffing in conjunction with Patient-Driven Protocol type systems assures resources are only consumed in the provision of evidence-based care.

   As defined by the American College of Chest Physicians, respiratory care patient driven protocols have been designed to allow assessment by properly

trained and credentialed respiratory care practitioners, and for initiation and adjustment of treatment within guidelines previously decided by the physician. In a number of hospitals these protocols have proved highly efficient, safe and cost-effective. (1992 ACCP Position Paper "Respiratory Care Protocols")

9. **CSRC recommend any setting in which patients may require the provision of respiratory services as defined in the Respiratory Care Practice Act, that qualified RCPs are available to provide such care.** In settings such as clinics and home care where an RVU based system may not be practical secondary the wide variability in time requirements and cross utilization of duties, the staffing model should be structured to ensure that competent practitioners are available number sufficient practitioners based on quality outcomes/safety metrics. Staffing adjustments, driven by any metric/benchmark/system, must include mechanisms to assess the impact of staffing on patient outcomes. Monitoring such quality outcomes as length of stay, COPD or asthma readmissions, pneumonia readmissions, missed therapy, delays in treatment, and other complications provide indicators to validate adjustments toward safe as well sufficient staffing. A reduction in bedside clinical staff, without mechanisms to assess the impact of such reductions, represents practice that can place patients at risk.

10. **CSRC recommend realistic metrics, staffing models, evidence-based, utilizing recognized benchmarks for data-driven organizations, which provide care to patients with cardio-pulmonary impairment.** Organizations, which embrace these guiding concepts, will be best able to develop comprehensive, yet realistic: metrics, staffing models, and benchmarks, in capturing the full range of activities required of RCPs. This will push forward, not only realistic staffing models with consistent, safe, cost-effective, high quality care but; will build the quality metrics to improve healthcare delivery.

11. **CSRC recommend the value of care drive the role of the RCP in all staffing models.** This value, defined as quality in relation to cost may be recognized through data driven RVU staffing models that demonstrate the productivity advantage and flexibility of the RCP in meeting the unique needs of this patient population. Value may also be demonstrated in the measure of specific clinical outcomes in which the provision of services by an RCP resulted in improvement. In addition, organizations can demonstrate value when the use of an RCP in a specific role allows for avoidance of financial penalties and new revenue opportunities afforded by health care reforms, such as those incorporated in the Affordable Care Act.