



# AARC White Paper on Concurrent Therapy

## Introduction

The American Association for Respiratory Care (AARC) has been made aware of the practice of concurrent therapy (sometimes referred to as "stacking") within the context of respiratory care. The following information is made available because there are major concerns of respiratory therapists which center on the issues of patient safety and quality of care.

This paper outlines causes, ramifications and alternatives to providing respiratory therapy concurrently.

## The Current Health Care System Places Increased Demands on Health Care Providers

Patients with cardiopulmonary diseases need access to safe, cost-effective care. Respiratory therapists provide care that can improve patient outcomes and reduce morbidity, mortality and costs.

Under the current health care system, increasing demands are placed on providers due to the aging population and a decrease in the supply of health care professionals. Respiratory therapy is impacted by these shortages as well. In 2000, we observed a 5.9% vacancy rate of staff positions for respiratory therapists. This fact, when coupled with the lack of sufficient respiratory therapy graduates to fill these vacancies has resulted in increased workloads for respiratory therapists.<sup>1,2</sup> In some cases, respiratory therapists feel pressured to provide treatments concurrently (stacking) although it is against their best professional judgment. In providing care, respiratory therapists are bound by ethical and professional principles, and in most cases, state practice acts.<sup>3</sup>

Although today's health care system demands increased efficiency, it is imperative to balance that demand with the need for appropriate, effective and skilled patient care. In order to provide safe, cost-effective care, the respiratory therapy profession must address the issue of concurrent therapy (sometimes referred to as "treatment stacking").

In respiratory therapy, concurrent therapy occurs when one therapist administers treatments utilizing small volume nebulizers, metered dose inhalers, or intermittent positive pressure treatments to multiple patients simultaneously.

The Joint Commission on Accreditation of Health Care Organizations (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. Concurrent treatments, when

provided in order to meet the convenience needs of the respiratory therapy staff, is considered inappropriate by JCAHO.<sup>4</sup>

## **The Federal Government's Response to Concurrent (Stacking) Therapy**

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 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 than one individual at a time. Concurrent therapy is distinguished from group therapy, because all participants in group therapy are working on some common skill development and the ratio of participants to therapists may be no higher than four to one."**<sup>5</sup>

Furthermore, CMS goes on to state **"A beneficiary who is receiving concurrent therapy with one or more beneficiaries likely is 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."**<sup>5</sup>

## **Sources of Concern Regarding Concurrent (Stacking) Therapy**

**Medical Errors:** The appropriate administration of respiratory therapy involves assessing and monitoring the patient. Assessment and monitoring include the need for therapy, administration of medications, the type of medication delivery device, patient education, patient tolerance, patient coordination, and outcomes documentation.<sup>6,7,8</sup> Concurrent therapy may encourage the elimination of one or more of these essential elements and could result in medical errors. According to recent reports by the Institute of Medicine, there are serious problems associated with medical errors, particularly medication errors.<sup>9</sup> These errors are often associated with inadequate staffing levels. Again, an increased demand for efficient care coupled with work force shortages, has resulted in increased workloads. In some instances, such demands far exceed a facility's resources.

**Billing Errors:** Concurrent therapy can cause billing problems and result in possible fraud. According to Medicare policy for Medicare Part A services (i.e., hospital inpatient services, skilled nursing facility services and intermediate care services), "respiratory therapy services cannot be recognized when performed on a mass basis with no distinction made as to the individual patient's actual conditions and need for such services."<sup>5</sup> This language, in addition to the concerns raised by CMS in the May 10, 2001 *Federal Register* notice cited previously indicate 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.

## **Alternatives to the Practice of Concurrent (Stacking) Treatments**

The American Association for Respiratory Care (AARC) appreciates the fact that even though human resources temporarily may not be adequate to meet the demand for

respiratory services, there exist service delivery models and strategies which can close the gap between the demand for services and an institution's ability to meet that demand without jeopardizing patient safety, care quality and cost containment objectives. Brief descriptions of alternatives to concurrent therapy are presented in the following paragraphs.

## **Protocols**

The use of established protocols may help respiratory therapists deliver appropriate and efficient care under conditions of an increased workload. Protocols are based on scientific evidence and include guidelines and options at decision points.<sup>10</sup> The use of protocols can help assure that all treatments have established indicators but also are highly effective in reducing the volume of unnecessary care. Evidence based literature exists supporting the use of protocols to minimize unnecessary treatments<sup>11</sup> and provide self-administration options for patients who demonstrate their ability to do so as documented by the respiratory therapists.<sup>12</sup> Research has shown that there exists a high percentage of misallocated respiratory therapy treatments. Indeed the range of misallocation, according to the scientific literature, goes from a low of 25% to a high of 60% depending on the modality.<sup>13,14</sup> It is important to note that numerous studies have concluded that protocols can reduce the volume of unneeded care, and therefore, contribute to an overall reduction in workload. For patients who require bronchodilator therapy, protocols can be effective in switching patients from small volume nebulizers, to the less time-consuming metered dose inhalers administered via hand held spacer devices. Other technology such as breath-activated nebulizers can be incorporated into protocols to increase efficiency without jeopardizing patient safety or quality of care.

## **Developing a Formal Procedure to Assess Patients' Needs**

The AARC recognizes that not all health care provider organizations are in a position to take advantage of the benefits of patient-driven protocols. The Association recommends that a policy and procedure be developed which governs the application of the practice of concurrent therapy. This policy should include assessment of the appropriateness of the order for respiratory therapy utilizing AARC's Clinical Practice Guidelines (CPGs). Numerous studies have observed that CPGs are an invaluable tool in assessing whether the therapy in question is an appropriate allocation of resources. Moreover, if the therapy is appropriate, frequency of its administration should be evaluated as well.

Assessment of the patient is an indispensable component to this process, with patient safety and quality of care foremost. The patient's cognitive status, understanding of therapeutic goals, coordination and tolerance of the therapy must be considered. Moreover, the patient's attitude and ability to cooperate with the therapy should be recognized as indispensable to the success of the treatment itself. The incidence of cognitive impairment among older people ranges from 30-50% in acute care hospitals, and 50-80% in skilled nursing facilities.<sup>15</sup> Finally, the proximity of the therapist should be taken into consideration, to assure adequate monitoring for quality and safety purposes.

## **Self-Administration**

There are many instances where patients can be transitioned to a self-treatment program and thus avoid a significant demand for the therapist's time. You are encouraged to investigate this alternative in order to decrease workload for respiratory therapists without

compromising care quality and patient safety. Policies and procedures must be developed which govern patient self-administration of respiratory therapy treatments. This process should include a thorough assessment of the patient similar to the one described in the previous alternative. Patients can then be categorized as those who require the services of a respiratory therapist or those, who after appropriate instruction from a respiratory therapist can self-administer their therapy. Patients in the first group would be treated the traditional way, while those in the latter group should be assessed and observed on a daily basis in order to assure that the therapy ordered is still appropriate, the patient's clinical condition has not worsened and the patient can still demonstrate correct technique regarding self-administration of the treatment.

The foregoing alternatives are not intended to be all-inclusive. The recurrent themes contained in each are patient assessment, safety, quality of care, appropriateness of the order, monitoring all aspects of the patient's response to therapy, and organizing a formal policy and procedure to implement the alternative in question.<sup>16</sup>

## Conclusions

Patient safety is the primary reason for respiratory therapists not to deliver care via concurrent therapy without a thorough patient assessment. Indiscriminate use of concurrent therapy may lead to declines in quality and may jeopardize patient safety. Aerosolized medications administered during treatments have potential adverse reactions. Recognition of these reactions is not possible if the patient is left unattended and thus a safety hazard exists.

Action should be taken to remedy situations that cause concern for patient safety and appropriateness of care. Possible actions include establishing protocols and other procedures, as well as conferences with managers and supervisors, if necessary. Additional actions may include reporting unsafe practices to appropriate authorities within the hospital or other health care agencies. Concurrent therapy may not only adversely affect quality of care and patient safety, but can lead to a decline in job satisfaction and a loss of trained personnel. Such adverse results further exacerbate the health care work force shortage. Ultimately, it is the ethical and professional responsibility of respiratory therapists to assure their patients receive both safe and effective care of the highest quality.

## References

1. American Association For Respiratory Care Human Resources Survey, 2000, <http://www.aarc.org>.
2. Costello, Demand for respiratory therapists exceeds supply at nation's hospitals, AHA News, February 1, 2002. <http://www.ahanews.com>
3. AARC Position Statement. AARC Statement of Ethics and Professional Conduct. March 2000, [http://www.aarc.org/resources/position\\_statements](http://www.aarc.org/resources/position_statements)
4. Tracking JCAHO's problematic respiratory standards. Accreditation Connection ID 18289. [http://www.accreditinfo.com/content.cfm?content\\_id=18289](http://www.accreditinfo.com/content.cfm?content_id=18289)
5. Medicare Manuals: Section 230.10 Pub. 12 (SNF Manual); Section 210.10 Pub. 10 (Hospital Manual); Section 3101.10 Pub. 13 (Intermediary Manual).
6. AARC Clinical Practice Guideline. Selection of Aerosol Delivery Device. Respir Care 1992; 37:891-897.
7. AARC Clinical Practice Guideline. Delivery of Aerosols to the Upper Airway. Respir

- Care 1994; 39(8):803-807.
8. AARC Clinical Practice Guideline. Assessing Response to Bronchodilator Therapy at Point of Care. *Respir Care* 1995 40(12); 1300-1307.
  9. The Quality of Health Care in America Committee, Institute of Medicine, To Err is Human: Building a Safer Health System, September 1999 report.
  10. AARC Position Statement. Respiratory Therapy Protocol Position Statement. May 16, 2001, [http://www.aarc.org/resources/position\\_statements](http://www.aarc.org/resources/position_statements)
  11. Kollef M, Shapiro S, et al. The Effects of Respiratory Therapist-Initiated Treatment Protocols on Patient Outcomes and Resource Utilization. *Chest* 2000; 117: 467-475.
  12. Jasper A, Kahan S, Goldberg H, Koerner S. Cost-Benefit Comparison of Aerosol Bronchodilator Delivery Methods in Hospitalized Patients. *Chest* 1987; 91: 414-418.
  13. Stoller JK. Haney D. Burkhart J. Fergus L. Giles D. Hoisington E. Kester L. Komara J. McCarthy K. McCann B. Physician-ordered respiratory care vs. physician-ordered use of a respiratory therapy consult service: early experience at The Cleveland Clinic Foundation. *Respir Care* 1993; 38(11):1143-54.
  14. Stoller J, Mascha E, et al. Randomized Controlled Trial of Physician-directed versus Respiratory Therapy Consult Service-directed Respiratory Care to Adult Non-ICU Inpatients. *Am J Crit Care Med* 1998; 158: 1066-1075.
  15. Kane R.L., Abrass I.B., *Essentials of Clinical Geriatrics*, third edition McGraw Hill, New York. 1994.
  16. Giordano, Sam P. What We Say Versus What We Do. *Respir Care* 1996; 41:6 504-505.

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