Some of you may have read recently that the costs of health care in the United States will rise to about 20 percent of our gross domestic product (GDP). You old-timers may recall 20 or so years ago when our country was fretting over the possibility of health care costs hitting the 12 percent mark, and then along came profound changes in our system of reimbursement for health care.

Diagnosis related groups (DRGs) were activated over 20 years ago for hospitals under the Medicare program; and in the years since, we’ve seen prospective payment applied virtually across the board. Managed care still looms large over the health care reimbursement landscape. After initially slowing the rate of increase of health care costs, care delivery expenses have been ticking up significantly over the past several years.

No doubt new technology and some fantastic new medications have been key drivers; but unfortunately, the pressure is still on health care providers to squeeze every penny of unnecessary expense out of the equation in order to stay financially viable.

Human resources targeted

It is, therefore, not entirely unexpected that the largest component of health care expense (human resources) be targeted time and time again for reduction. Indeed, there’s an entire cottage industry of consultants who do nothing but scrutinize health care costs and generally conclude that staffing needs to be reduced and jobs need to be dumbed down or reconstituted. About 15 years ago there was a concept advanced called patient-focused care. While its goal was noble (which was to run an efficient health care delivery service without compromising clinical outcomes), the results were, by and large, a failure. Decentralization of respiratory services and other hospital departments gave way to recentralization. Unfortunately, doing the restructuring “two-step” does not constrain costs in and of itself.

Ultimately, the cost driver is the demand for services. Over the last 15 years, researchers have documented that RTs using protocols manage down demand, save money, and promote favorable clinical outcomes. Perhaps as much as 50 percent of the respiratory care delivered by RTs is done in accordance with protocols.

The pressure is still on health care providers to squeeze every penny of unnecessary expense out of the equation in order to stay financially viable.

If that’s the way you provide care, you’re fortunate because you’ve got a massive amount of scientific literature to support your continued existence. Now, if you’re not delivering respiratory care by protocol, it will be difficult — if not impossible — to document your value as a utilization gatekeeper. The future of respiratory care resides in the practice of protocols, but that’s another story.

Even if you deliver care by protocol, there is still a need to document the efficient use of respiratory care department personnel. There is still a need to provide benchmarking, or other comparison information, relating your productivity and efficiency to similar organizations and...
benchmarking companies have recognized the complexities associated with our services. The new system platform, minimum data sets, etc., are all excellent.

However, the credibility of the system in the real world will be only as good as the number of persons and institutions that participate in the system. Larger numbers mean more reliable, comparable information.

Some of our colleagues are reluctant to subscribe to a reporting system because, after all, won’t that mean that their efficiencies will be monitored? I suppose one could make a case for non-participation, but ultimately those who do not subscribe will be victimized by a management consultant firm with their phantom benchmark hospitals that may consist of less than a dozen facilities. You’ve all heard those horror stories. You really won’t know whether the institutions you’ll be compared with have similar characteristics to yours; but most assuredly (as we saw in the 1990s), hospital CEOs gobbled up the recommendations to downsize based on such an unscientific benchmarking system. The bottom line is that benchmarks are nothing to fear if you’re doing your job right; because even if you may not hit every benchmark, you’ll still get the benefit of having a tool that could help you undertake whatever tactics are necessary to compare favorably to other health care delivery organizations with similar traits. The new system will begin a new era in the delivery of respiratory care services, and ultimately it will assist you in having adequate numbers of the most valuable resource you could employ to reach your patients — that is, of course, the persons who must provide the service.

Welcome, once again, to the 21st century.

A new monthly column, “Benchmarking for Success,” begins in this issue of AARC Times. Its purpose is to increase awareness of the importance of benchmarking and make managers more knowledgeable about the issues associated with benchmarking.