In the mid 1950s when Xerox originally invented benchmarking as a formal process within their organization, it was all about getting better through the adoption of best practice.

The notion of a best practice is not new. Frederick Taylor said as much nearly 100 years ago: “Among the various methods and implements used in each element of each trade there is always one method and one implement that is quicker and better than any of the rest.” This viewpoint came to be known as the “one best way.” Today investigation and adoption of best practice are processes now part of any successful business, including health care.

While benchmarking in health care is often associated with the assessment of opportunities to reduce cost, it is really about assessing what others may be doing better than you. Benchmarking opens departments to new methods, ideas, and tools to improve their effectiveness. It helps crack through resistance to change by demonstrating methods of solving problems other than the one currently employed, and demonstrating that they work because they are being used by others. Learning how others do business allows the respiratory care manager to develop plans on how to adopt best practice, usually with the aim of increasing some aspect of performance, including decreasing expenses and improving both productivity and service.

Benchmarking in respiratory care is predominately performed through independent agencies and consultant groups whose systems provide performance metrics without direct access to what the better performers are doing. A problem for managers and administrators responsible for respiratory services is that there has not been a system that integrates the reporting of both benchmarking and best practice together... until now.

Integrating benchmarking and best practice

The AARC Benchmarking System, a Web-based service designed for respiratory care departments, brings both performance measures and best practices together. Managers can now use productivity performance metrics to assess how they compare to others and easily view a detailed department profile to learn what the better performers are doing. The AARC Benchmarking System is unique in bringing this information together through a click on a linked field. Users can investigate management and staffing structure, operational programs, and clinical practices being utilized by any department within their selected compare group. In becoming a user of the AARC Benchmarking System, each facility is required to complete a detailed hospital/department profile (see Figure 1). The questions in the profile were carefully designed by the members of the AARC Benchmarking Committee and expert managers who assisted in early testing and review of features and capabilities.

All users have access to all profiles listed within their compare group to view department practices as they relate to organizational structure, staffing, budget, clinical services, and general operations. Information included in these primary aspects of department operation include:

- Management and support structure
- Scope of services
- Provision of biomedical support, research, and equipment control
- Budgeted FTE (full-time equivalent) per job classification
- Credential and skill mix
- Use of contract labor and per diem staff
- Training and education provided and resources

About the Author

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The AARC Benchmarking Hospital Profile includes key demographic elements and more than 50 questions about department operation, most of which can be used to assess best practice.

- Use of time-based productivity systems
- Use of respiratory care information systems
- Recruitment and retention practices
- Frequency of ventilator checks and circuit changes
- Use of protocols.

These key topics represent a small sample of what you can learn about other departments by navigating through profile questions. Using AARC Benchmarking, you can take your investigation a step further by using the Compare Group Configuration tool in the report section to select the best practices you are interested in. You can develop and save a custom compare group that incorporates the structure or practices you are investigating. The resulting report will include a list of all centers that employ the practice(s) specified, and you can assess how they compare to you or identify those managers you can network with to learn more. Users have total access to all profile data and the configuration of compare group reports.

Productivity metrics are usually the first focus in benchmarking any hospital service, and the AARC does include key indicators of department activity as described previously by Robert Chatburn in this ongoing series. Bridging the informational gap from reporting metrics to the best practices has been the challenge, but with the AARC program it could not be easier.

Figure 2 is a partial screen shot of the Current Summary Report generated by the AARC Benchmarking System. The summary report includes numerous metrics, ratios, the determination of opportunity cost, and a summary of ranking within the compare groups as shown. The user can perform two important functions directly from this report. First, the user can select View Data to look at the raw data and derived metrics from the desired facility. A quick glance at the data will demonstrate if the variation in ranking is a result of entries related to hours or units of service. A metric derived in the AARC system is Standard Hours per Variable Hour, with standard hours calculated from the AARC “Uniform Reporting Manual for Acute Care Hospitals.” This is a primary metric that reflects the demand for services in relationship to variable hours worked. Wide variations exist in the compare group in Figure 2. However, the user can easily screen the raw data entry of anyone in the compare group to assess reasons for the variance. The view data link makes it easy to check out the data. Second, the
user can select View Profile and be directed to the actual profile of the selected facility. Any aspect of department operation can be explored, and the best practices described in the profile can be investigated.

Assessing and implementing best practices

With this new level of functionality, managers can utilize AARC Benchmarking not only to see how they stack up but what others are doing to achieve improved performance. Managers can utilize the information obtained to justify new programs, methods, and techniques. Proposals for implementing best practices, prepared by managers using AARC Benchmarking, can provide reliable information to better assess “community practice” as a means to justify their program or initiative. If the program or initiative can be directly associated with a particular performance metric achieved by a department incorporating the best practice, the managers can use that information to assess the positive impact on efficiency that could result by best practice adoption.

In assessment of best practice, it is also worth noting that best practices do not always result in better performance metrics. Most would agree that the implementation of patient-driven protocols is a best practice. Through protocols you ensure treatment is given only when medically indicated, that variation is reduced by a standardized approach, and that there are clear indications for alterations in the care plan and physician notification. Protocols represent best practice and in most situations result in significant net decreases in the number of treatments provided, while requiring some additional support staff to maintain the program. As the number of treatment units provided decreases, so will some component of variable staff; however, total hours worked, secondary to the fixed and support component, may not fall to the same degree. For many, the implementation of protocols can actually result in an increase in cost per unit of service. The metric to capture for departments using protocols is cost per respiratory patient; however, it is nearly impossible to capture this data, and it can be a complex undertaking without a respiratory care information system.

<table>
<thead>
<tr>
<th>Institution</th>
<th>Standard Hours per Variable Hour</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital A</td>
<td>2.1148</td>
<td>1</td>
</tr>
<tr>
<td>Hospital B</td>
<td>0.6987</td>
<td>2</td>
</tr>
<tr>
<td>Hospital C</td>
<td>0.4574</td>
<td>3</td>
</tr>
<tr>
<td>Hospital D</td>
<td>0.3688</td>
<td>4</td>
</tr>
<tr>
<td>Hospital E</td>
<td>0.3551</td>
<td>5</td>
</tr>
<tr>
<td>Hospital F</td>
<td>0.2499</td>
<td>6</td>
</tr>
</tbody>
</table>

*The user can directly view the hospital profile and department practices directly from the benchmark report by clicking on View Data or View Profile.*

*Compare Group Results - Performance Metrics Export to Excel*
It is also difficult to capture and count the patients in which RC treatments were ordered, but protocols determined there was no medical necessity and treatment was not initiated. These patients are most difficult to capture and report as some do not incur any respiratory billing to be included as a “respiratory patient.” The solution is not to defer implementing a protocol program but to set up your compare groups so you only compare yourself to departments with protocol systems and support structures similar to yours. You can use the AARC Compare Group Configuration report tool to do just that. RC managers, in the adoption of best practice, need to carefully assess the impact the practice will have on reported metrics. Access to both metric and profile data through AARC Benchmarking provides the needed information to better anticipate what impact (good or bad) the practice will have on how you compare with others.

The best respiratory care managers are always seeking better ways of providing care, achieving workplace excellence, and controlling expenses. AARC Benchmarking provides another tool to assess best practice. Now such information is only a click away. For more information about AARC Benchmarking, log on to https://www.respiratorybenchmarking.org/login.aspx.

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REFERENCES

AVAILABLE RESOURCES

Also see a previous “Observations” column regarding the Benchmarking Service: “Documenting Efficiency” by S. Giordano (May 2006).