This month we review some interesting questions from our members.

### Dear Gabby

Maybe you can answer my question. I’m not sure if my facility should be participating. We are an acute rehabilitation facility that treats SCI, TBI, CVA, and ortho patients (both adult and pediatric). We do not have an ED, OR, or ICU settings. We do have ventilator and BiPAP patients. – **Acute Girl**

**Dear Acute Girl:** I would suggest that you participate if you can describe your department using any of these options (from the Profile section of the Benchmarking web site):

1. **Hospital Class**
   - Rural
   - Suburban
   - Urban

2. **Hospital Organization**
   - Academic (University based)
   - Children’s Hospital
   - City/County
   - Community
   - For Profit
   - Military/Other Federal Government
   - State
   - University Affiliated
   - Veterans Administration

3. Check all the services your hospital provides:
   - Ambulance Service
   - Angioplasty
   - Birthing Room – LDR Room
   - Burn Care Unit
   - Cardiac Catheterization
   - Cardiac Intensive Care Unit
   - Chiropractic Service
   - CT Scan
   - Emergency Department
   - Freestanding Out-Patient Center
   - Hemodialysis
   - HIV/AIDS Service
   - Hospital-Based Out-Patient Clinics
   - Medical Surgical Intensive Care
   - Neonatal Intensive Care Service (Level 1)
   - Neonatal Intensive Care Service (Level 2)
   - Neonatal Intensive Care Service (Level 3)
   - Neurological Service
   - Obstetrics Service
   - Open Heart Surgery
   - Orthopedic Service
   - Outpatient Surgery
   - Pediatric Intensive Care Service
   - Psychiatric Service
   - Radiation Therapy
   - Sleep Center
   - Transplant Service
   - Trauma Center (Level 1)

**Dear Gabby:** I signed up for the free introductory look [introductory period is now over] at the new benchmarking tool that is being offered. After reading some of the e-mails, I noticed that this service seems to be geared toward department managers and directors. I am a staff therapist and am wondering if I am your target audience. I don’t want to throw off your data if I am not an appropriate user, especially since I am not privy to all of the “nuts and bolts” of my department.

The purpose of my curiosity about this tool is we do not have any system in place at our hospital to determine appropriate staffing levels. As you can imagine, this has been a rather contentious issue at times when staffing levels have been deemed inadequate to the workload by the staff therapists on duty, as well as the attending physicians in the critical care units. I wanted to see if the benchmarking tool could give us an idea as to how to staff the shifts. – **Not Sure**

**Dear Not Sure:** Thanks for writing. I am sorry to hear that you have nuts in
your department. At least you have a privy. My last job didn’t even have an outhouse.

The AARC Benchmarking Project is aimed at anyone who has the authority to enter the data and create reports. Usually that is a department head, but it could be delegated by, say, your department head to you.

The Benchmarking Project is not designed to directly determine whether staffing levels are matched to workload. This is best performed by the AARC “Uniform Reporting Manual for Acute Care Hospitals,” which assigns relative value units to commonly performed respiratory therapy procedures. Rather, the AARC benchmarking system is designed to identify departments that seem to be highly productive when compared to other departments. Because labor is the single largest expense in a hospital, productivity is the metric most closely watched by hospital administrators. Of course, by definition, highly productive departments have a relatively low staff-to-workload ratio. With our current capability in benchmarking, your best hope is to first select hospitals that you think are similar to yours (that is, create a compare group) and then study their profiles to see how they are staffed.

Eventually, we hope to benchmark quality indicators and perhaps link such indicators to staffing. However, while we all believe that staffing levels affect quality, and JCAHO has tried to get hospitals to do projects to prove it, the effort to establish this link so far has been fruitless.

Dear Gabby: When presenting this program to my VP, a few questions came up that I feel you may be able to answer. Please see the following list:
1. How do they report the data?
2. Would our hospital be identifiable?
3. Where will this data be reported?
4. Who will have access to it?
5. Do we have the right to withhold data they may want to sell to payers, public sites, attorneys, etc.?
6. We purchase our productivity stats from MHRA. How will this compare to that?

Dear Cautious:
1. The web site allows users to create reports based on their own compare groups. That is, you may use a default compare group based on hospitals with similar class and size, or you may select specific hospitals, or you may select hospitals based on any of the profile data as search filters.
2. Yes, unless you check the “Keep my hospital name and contact information confidential” check box on the profile set-up page. We believe that being able to communicate with those to whom you are being compared is an extremely important component of the benchmarking process.
3. See the Privacy Statement. Get it from the link at the bottom of every page on the web site (https://www.respiratorybenchmarking.org/privacy.htm).
4. See No. 3.
5. See No. 3.
6. That will be self-evident as you become familiar with the web site. You may go to https://www.respiratorybenchmarking.org/login.aspx and see sample reports even if you are not a member. Simply place your cursor on Site Navigation, then click on “sample reports.”

Dear Gabby: I am still in the battle to get my hospital to allow us to use “zero charges” for those many “non-billable” things that the RTs do on a daily basis. I was looking at a benchmarking presentation that’s on the AARC web page and wondered if you can explain the great variation from hospital to hospital. The particular slide I am referring to is below (from another benchmarking service, not the AARC), the one where my institution goes off the page. Any help will be greatly appreciated. – Kill Bill
Dear Kill Bill: This was a tough one. I had to call in reinforcements (Rick Ford, BS, RRT, FAARC, chairman of the AARC Benchmarking Committee and a resident authority on the system you are currently using). Here is what he says:

“At the 2006 AARC Summer Forum I presented Respiratory Care Benchmarking in which numerous examples of comparative performance data were presented and discussed. Follow-up discussion took place regarding the wide variation in the reported ‘Hours Worked per 100 Billable Procedures.’ How could reported data range from 15.97 to 663.83?

“Here are some possible explanations:

“In making calls to some of the top performers whose numbers were much less than ours, I found we were not ‘that bad’ and there was a perfectly good explanation ... they report data differently. In reporting billable procedures, there is no real standard and many bill out ventilators and other continuous modalities PER HOUR. We report one billable unit for one day of ventilation, while they report 24, thus units of service for ventilation could be 24 times greater for what is the same volume of service. I also found others reporting billable units PER SHIFT. We report one billable unit for one day of ventilation, while they report three. In such cases, units of service for ventilation would be 300 percent greater than what we report, although actual volume is the same.

“Another important consideration is billing in hourly increments and converting to patient days by dividing your hours by 24. Using the “divide by 24” methodology, you could easily under-report your days by about 20 percent (see the April 2006 issue of RESPIRATORY CARE where Rob Chatburn and I quantified this issue). You will also find some centers may charge for two MDI or aerosol treatments when they give two different meds during the same bedside visit ... in our case, we only charge one. I also found some bill individually for every suctioning event. (That would add about 150,000 units to our report if we did that, but we don’t.)

“Lastly, many bill for procedures they really should not be billing for ... they have associated an activity with a CPT code that is not appropriate. The federal payer may or may not recognize it as a ‘billable procedure,’ but because the individual hospital has linked it to a CPT code, it gets reported in the billing report and transcribed to the benchmarking data. At my institution, we are very conservative and update our CDM and CPT codes annually ... and in doing so, we limit the reporting of non-allowable billable procedures and the billable procedures we report in benchmarking. Taking all that into account, if we all counted things the same there would not be the variance that currently exists.

“If you have not already done so, check out AARC benchmarking. We have designed it to minimize many of these problems and are in the process of building the number of subscribers so we have some good comparative data.”

Well gang, we are out of space for this month. Join us again when the oracle reveals all.

Robert L. Chatburn is clinical research manager of the respiratory therapy section at The Cleveland Clinic in Cleveland, OH.

AVAILABLE RESOURCES


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