(Benchmarking and Productivity" with Tim Myers (4/30/15)
Responses to Audience Questions

Our facility recognizes 3 ways of doing things; 1) the right way, 2) the wrong way, 3) their way.

Sometimes a tough and difficult hurdle to get over when it comes to #3. But today's world of healthcare reform and value based purchasing provides the opportunity to change the status quo. Often times, it involves in educating those in the C-suite to the processes and nuances of a respiratory care department. In the past, those in the C-Suite may have been reluctant to listen, but with the changes and challenges in healthcare today, C-Suite folks cant afford to listen to ideas and thoughts that improve efficiency, productivity, quality and safety of those they are trusted to care for in their facilities.

If I am benchmarking myself for improvement I need administration to give me the correct metrics (more patients per time)?

These conversations are very important and cannot be ignored in today's healthcare setting. But be prepared to realize that they may not fully "understand" the business of respiratory care. That is why there are some key sources that you should bring to the discussion table to start the dialogue around initiatives that

1. Align with Strategic Plan and Goals of your Institution
2. Align with National Patient Safety Goals
3. Align with efficiency, productivity and financial goals and targets
4. Specify the unique characteristics of caring for patient's with chronic respiratory diseases

Benchmarking ignores quality patient care. This process would work better if there were a mid-point for the two areas to meet. We are a care giving entity, not a number counting industry (there was much pro/con discussion amongst the participants on this topic).

No real disagreement here---Patients MUST come first, and be provided safe and efficient care at the highest level of quality. That being said, today hospitals (and respiratory care departments) cannot be ostriches and stick their heads in the sand to ignore finances. No matter what the "business" or service provide does in today's world, the ability to operate in a negative financial arena and live off reserves is a formula for failure and closure. They must go hand-in-hand and hopefully that is what value-based purchase will bring to the table.

People will no longer be rewarded for volume (large numbers, admissions, etc.), but for the quality and care they provide with positive outcomes. This is a game changer in hospitals todays and for respiratory care departments that have transition from revenue centers to cost centers over the last 3-4 decades. The ability to bring value (quality, decrease readmissions, decrease length of stay, remove unnecessary care that adds cost, etc.) all offer hospitals benefits, savings and "bonuses" in a value based care environment.

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Finally, while benchmarking started with "counting the beans" in healthcare and respiratory care. That doesn't mean it has to stay there. Many internal and external benchmarking metrics today also focus on the *quality of care* provided. A short list of relevant metrics for respiratory departments may be:

1. COPD Readmissions
2. Ventilator Associated Events
3. Accidental extubations
4. Missed treatments
5. Education initiatives
6. Time to treatment
7. Decrease patient errors

Does AARC's Uniform Reporting Manual (URM) discuss Evidence-based Medicine (EBM) and or best practices? Or is a compilation of average times?

The URM is an invaluable tool to determine productivity, track trends in the utilization of services, establish personnel FTE requirements and measure demand and intensity of service. By comparing activities based on relative workload intensity, the URM provides an objective means of assessing staffing adequacy.

So while it does not measure or provide EBM in the various departments it contains in the URM, it does allow for some adaptation of best practices when one uses the data compared to their current models of care, its delivery and staffing models.

http://appserver.aarc.org/WEB/Online/Online/Store/ManualsCDsAndBooks.aspx

The AARC benchmark is too expensive for us 25 bed hospitals?
I would agree with you and also state that there would probably not be a large comparsion group to benchmark against. That being said, it makes it even more critical that a facility of this type develop its own internal benchmarking process to monitor against themselves on a standardized basis.

Does efficiency include non-scheduled procedures (eg. a stat abg)?
Absolutely…..it includes any and all things that are determined to be "input" in the definition provide (input/output). So as a real life example, any procedures (schedule or unscheduled, billable or non-billable) would be "counted" as respiratory care procedures per unit of worked hours.

Isn't transport time billable?
While not a coding expert, there is a clarification necessary here. ANYTHING you do in the hospital setting could be considerable "billable" as longer as the institution's C-suite agrees to it and documentation is provided. That being said, it does not have a CPT code associated with it and will not be recognized by most payers. So it will be denied and/or written off.

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While not an AARC product, we do offer CPT coding manuals from MedLearn (experts in the field) at a discount to AARC members.

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We measured benchmarks in cardiac surgery for decades and frequently missed the mark for extubations. It turned out that surgeons were accepting high-risk patients with no oversight. That led to a surgical ethics committee for high-risk patients to be accepted for surgery and improved our extubation benchmark

This is an excellent example of how benchmarking (or number counting industry) can actually have a value based impact on the quality and care provided. Had your institution not participated in this type of benchmarking, this would have gone unnoticed with potential impacts on quality, safety, or financial outcomes. But the "numbers" indicated that something was amiss with your program that led to a continuous quality improvement (CQI) process that uncovered some of the issues.

When therapy that increases efficiency is introduced, how do you stop orders for the old methods of therapy such as manual CPT?

This is a great question and one that has been raised hundreds, if not, thousands of times across the country. The key to making this happen comes from a number of standpoints. Strong leadership from both the respiratory care department and from physicians first and foremost. Evidenced-based medicine and best practice standards in the literature or professional associations (like CPGs) help facilitate the argument.

We have also had the good fortune and my previous employer to not only have the two items above, but being permitted to conduct continuous quality improvement initiatives to collect data that measure outcomes of procedure A versus procedure B. Often there was no intent or desire to publish or present these findings, but to provide a rationale for our choices or care and treatment.

So much so that many of our orders for routine respiratory care procedures (oxygen, airway clearance, aerosol therapy, etc) in our hospital system's electronic health record stated…."Respiratory Care: See, evaluate and provide "*procedure XYZ*" every *X* hours and as necessary with the appropriate device per respiratory therapy evaluation and protocol".

From there we had protocols (signed off by medical leadership) that provide assessment and determination for the "device" used on patients. When and how to evaluate. And when to change or modify the treatment and/or the "device".

Could you argue that some value metrics are subjective in nature, that is seen by one department differently than another?

This is an absolutely correct statement. While the ideal it to compare the proverbial apples-to-apples, we know that there are "different" types or brands of apples that make even this

type of fruit different. The potential beauty of these systems if established properly is through transparency of information and sharing of practice models. What I mean by this is that if you have the ability to contact another facility and or respiratory department about the "value metrics" and their differences. A dialogue pursues and often times it leads to answers immediately or the need to drill down deeper into the differences and nuances of those two data sets.

Unfortunately, most 3rd party, proprietary consulting groups do not provide you your benchmark or comparison group---just their data and rankings. To me, this is an injustice and does not allow for true process improvement or facilitate better patient care. The question than becomes, while would C-Suite decision-makers continue to contract with these types of consultants?

A perfect example of the question you raise, and a transparent process was offered by would of our participants. Go back to the question/statement about extubations in a CT Surgery population and what benchmarking and CQI discovered.

Do you have a way to track time for non billable procedures, but is also charged to the pt? How do you measure staff engagement on a monthly basis? We do a survey every 18 months.

We were able to convince our leadership that "non-billable" procedures were critical to the appropriate leadership and management of our respiratory care department and staffing. They had to agree as we produce data that documented it accounted for 33-40% of the procedures we were performing in the clinical environment on a daily basis. To not account for these items meant that our productivity would be off. We were able to enter these metrics into our electronic health record/billing system as $0 items with the appropriate time/volume standards that we were using for CPT-based procedures.

Great question (related to the internal benchmarking system created at my previous employer based on strategic plan and goals) about staff engagement. We also measured staff engagement at a longer interval (every 12 months). And we used that metric over time in our benchmarking data. That being said, if that value fell below a specified threshold, we were required to develop an Action Plan to address and hopefully correct the deficient. While I only had this in 1 of my 13 departments (and fortunately not RT), part of our Action Plan was to monitor staff engagement our a quarterly basis with metrics that were agreed upon with leadership.

Can an individual use that concept for personal improvement?

While I may not fully understand the question or make a wrong assumption, I will try to give this one a shot in the dark. I think a "benchmarking" or CQI assessment can be used on an individual basis if the metrics are appropriate to the measured outcome.

I tried to provide an example or analogy through athletics during the webcast. Most sports or events, regardless of being team-oriented to individual oriented, have this ability to

monitor and measure the individual. In competition, there will always be 1 winner and everyone else….but the ability to personal improve ones time, score, etc….may be the best and most important metric in this situation.

As an example, I may never win or place in a 5k run, but the ability to lower my personal race time is a better benchmark for me personally.

We are switching to EPIC, We made sure that unbillable procedures were included so we received the credit for work load

Preaching to the choir on this one….and will allow your department to accurate monitor and assess your department's true productivity and operations. The hope is that ALL electronic records will eventually moved to this and companies like EPIC will promote this as Best Practice in future departments.

How can you capture if you are a non revenue-generating department, like nursing?

Great question. Having come from a previous employer where I had responsibility for 13 different departments (2 of which were strictly nursing departments), the metrics used in these different departments were all different. They were dependent on the operations and services of those teams and the care they provided. A quick, brief explanation is that nursing metrics are largely based on "patient hours". Which is obviously dependent on census or volume.

Data appears to be king. We need to be more aware of our data so that we can present ourselves as a value added department.

Great conclusion and summary. Could not have said it better myself. In fact, the summary I provide was:

- Stay involved and informed
- Know your department and all it's processes
- Lose the defensiveness!
- Be suspect of consultant data
- Know your data, identify opportunities
- Identify reason for variances
- Network with other RC directors