STANDARDS FOR BENCHMARKING ALLIED HEALTH SERVICES

April 2003
Developed under the auspices of the National Allied Health Casemix Committee and with the assistance of the Commonwealth Department of Health and Ageing

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The catalyst for the development of this document was a recognition of the need to appropriately inform the development of best practice models and meaningful benchmarking. Underpinning this objective was the requirement for standardized data collection and methods of analysis. In the absence of a standard, inconsistent and inappropriate "benchmarking" methods have been employed by health administrators and external consultants in Australian Allied Health Departments.

In April 2001 a working party was convened to draft a Standard for the benchmarking of Allied Health services. The purpose was to add value to any future benchmarking processes, to assist health unit administrations to take an appropriate and valued view of Allied Health services and resource utilisation, and build capacity within Allied Health to contribute actively to these processes.

The working party recognises that benchmarking in health is a complex process that can be applied to each facet of any health-related activity. In Allied Health terms for example, it can focus on activity inputs (such as staff numbers, patient attributable time, equipment & consumables), on processes (for example, how units are organised, types of intervention/procedure) and on outcomes (for example, rate of return to mobility following stroke, improvement in fluency of speech following stuttering therapy).

Benchmarking can be carried out with the primary objective of clinical improvement in which case, the focus is likely to be on the outcome and/or process of an activity. Equally, benchmarking can have the goal of achieving excellence in administration and management of a service in which case, the focus will be more heavily on inputs. The working party acknowledges that this document has a bias towards the measurement and comparison of inputs as opposed to processes and outcomes and this directly reflects the catalyst for its development.

This bias is also a recognition of the continued struggle in the health field to develop outcome measures which accurately capture the effect of a specific intervention in terms which are useful for the clinician/manager and which also reflect the perspective of the client.

The collaborative project was initiated with contributions from the National Allied Health Casemix Committee (NAHCC), Allied Health managers from New South Wales, Victoria and South Australia, the Commonwealth Department of Health and Ageing and the National Allied Health Benchmarking Consortium.

The Standard is designed to promote a process that is cooperative, correct, precise, and transparent and leads to enhanced performance of the Allied Health service being benchmarked.
- Cooperative - there is a willingness to cooperate by the parties involved
- Correct - in accordance with the standard
- Precise – exact in measuring and recording
- Transparent – is open and easily understood
1. **SCOPE**

This Standard specifies requirements for the process of benchmarking of Allied Health services in the acute health care setting but it may be applied in other settings.

Benchmarking may encompass any activity of comparison of the efficiency and effectiveness of an Allied Health service, although the rationale or goals of that comparison may vary from project to project.

2. **APPLICATION**

The standards are for use by Allied Health managers, health service managers or external consultants.

3. **SPECIFICATIONS**

3.1 **Parties involved in benchmarking**

The benchmarking process shall be consistent with best practice and total quality management at all stages and should involve any party that will be affected by the outcome of the process. All parties shall agree to the goals, purpose and methodology of the work at the commencement of the benchmarking process. This includes agreement on what is to be benchmarked, what is to be measured and how results are to be analysed and used. Analysis and interpretation of data shall involve the relevant Allied Health managers.

3.2 **Data collection complies with reference documents**

3.2.1 Data should comply with definitions contained in Australian documents including:
- NAHCC Health Activity Hierarchy
- National Health Data Dictionary (NHDD)
- National Hospital Cost Data Collection (NHCDC)

Standardised data facilitates confident comparison and supports sound decision-making based on that data comparison.

3.2.2 Data should reflect all aspects of clinical care provided in the scope of the study regardless of whether the individual patient or group is present or not. Clinical care includes, but is not limited to, preparation for an Allied Health activity, documentation, interaction with other service providers, liaison with family or carers, ordering of products, referral to other services.

3.2.3 Data used in benchmarking should be accurate, reliable, complete, and consistent using the following definitions:
- Accurate – free from error
- Reliable – produces the same results when repeated
• Valid – measures what it intends to measure
• Complete – all related and necessary elements are included

3.2.4 Data comparisons should recognise variations in the casemix of the patient populations for the benchmarking project. Where a methodology can be determined, an adjustment for casemix should be made. This is particularly relevant when using whole of organisation indicators such as Occupied Bed Days, Length of Stay etc.

3.3 Data extraction and submission

3.3.1 Data used for benchmarking may be extracted from a routine collection or may be a sample collected for the purpose of the benchmarking study.

3.3.2 Data used for benchmarking should be submitted electronically to facilitate data manipulation and comparison of data with other relevant information.

3.4 Definition of patient population

3.4.1 The patient population should be identified as defined in NHDD and NHCDC principles eg acute, ambulatory, emergency, intensive care, sub-acute care, rehabilitation, palliative care, mental health. Account should be taken of differences in admission policy for day stay patients, such as occurs in oncology and renal treatment because they may be considered inpatients or outpatients.

3.4.2 Data should be compliant with standardised statistical discharge practices according to NHCDC product type definitions at the benchmarked sites.

3.4.3 Data should be interpreted according to statistical classification of patients eg local day stay, day surgery and day-of-surgery practices and statistical discharging practices within each organisation.

3.5 Description of environmental factors

3.5.1 Data should be interpreted in the context of whether various services outside of the acute sector may influence admission and discharge practices, including:
• Ambulatory
• Community
• Post-acute care services in the home
• Rehabilitation
• Step-down
• Palliative care
• Home-based therapy
• Specialist service not generally located in other services

3.5.2 Data should be interpreted in the context of services available outside of normal business hours because the availability of weekend or evening services may influence the level of activity.

3.6 Description of Allied Health staff

3.6.1 The Allied Health staff population included in the scope of benchmarking should be specified. Adjustment should be made for variations in the inclusion or exclusion of staff for example, those who are:
• employed within an Allied Health department in the organisation
• employed by other departments within the organisation
• contracted into the organisation
For example, a dietitian working in a diabetes centre may be employed by the hospital nutrition department, whereas in another hospital they may be employed by the diabetes centre. The activity of both should be considered to allow meaningful comparison.

3.6.2 The labour categories of staff included in the scope of benchmarking should be identified including:
• professional
• technical/aide
• administrative
• student
The data entered by each category should be able to be identified to allow exclusion according to agreed process. If student or other category of data is entered at one site, this could inflate the activity level relative to a site where that data was not entered.

3.6.3 Data analysis should use actual staff numbers and hours available during the study period rather than budgeted staffing levels or approved FTE. Account should be taken of variations in award hours in the staffing groups included in the study. Account should also be taken of unpaid overtime worked during the study period.

3.7 Performance Measures

3.7.1 Performance measures may include the following:
• time spent in clinical care, clinical service management, teaching and research
• costs of salary and wages, and goods and services
• types of activities

3.7.2 Occasions of service (OOS) data are unreliable and inappropriate to be used as a measure of activity except in the context of other performance measures. There is a high degree of variability in the
definition of OOS and in the interpretation of the definition of OOS even within a single jurisdiction.

3.7.3 Measures of outcomes should be used where possible, rather than measures of output.

3.7.4 Correlation of Allied Health performance measures with hospital wide performance measures such as length of stay should be done with caution.

3.8 Expression of time

3.8.1 Data related to time spent in Allied Health activity should be reduced to a common factor ie actual time in minutes or equivalent time units.

3.8.2 Agreement should be reached on how to treat data related to group activity, taking into account delivery by several disciplines to one client at one time, a single discipline and multiple providers, or more than one discipline to multiple recipients

3.9 All Allied Health activities are considered

3.9.1 Data related to non-individual patient-attributable care, clinical service management, teaching/training or research should be measured in time units. Where time based data is not available the method for estimation should be transparent and tested for validity.

3.9.2 Data related to time spent in non-individual patient-attributable care or clinical service management should be apportioned on best estimate approach to the relevant classifier as follows:

- Across all AN-DRGs or to specified AN-DRGs for inpatients
- Across all Service Types or to specified Service Types for outpatients

3.9.3 Program Fractions (PFRACS) are calculated for each profession on the basis of the proportion of Clinical Care Time (IPA plus NIPA) attributed to each Program relative to the Total Time inclusive of all activities (Clinical Care, Clinical Services Management, Teaching and Training and Research). The methodology for PFRAC calculation is consistent with methodology employed in the National Allied Health Service Weights Project and National Hospital Cost Data Collection.
GLOSSARY

Standard
‘A Standard is a published document which sets out specifications and procedures designed to ensure that a material, product, method or service is fit for its purpose and consistently performs the way it was intended to.’

Benchmarking
The ongoing, systematic process to search for and introduce best practice into an organisation. Benchmarking is generally used to compare an organisation or service with similar leading organisations or services to provide a catalyst to improve performance.
National Health Performance Committee (NHPC) (2001), National Health Performance Framework Report, Queensland Health, Brisbane
‘A continuous, systematic process to identify and introduce best practice into an organisation, conducted in such a way that all members of the organisation understand and achieve their full potential. The identification may be of products, services, business practices and processes, of competitors or those organisations recognised as leaders, in the industry.’
Australian Best Practice Program, 1995
‘The pursuit by organisations of enhanced performance by learning from the successful practices of others. Benchmarking is a continuous activity; key internal processes are adjusted, performance is monitored, new comparisons are made with the current best practice performers and further changes explored.’
(Francis, Holloway and Hinton, 2000)
‘A method for organisational improvement that involves continuous, systematic evaluation of the products, services, and processes of organizations that are recognised as representing best practices.’

Best practice
‘How leading edge organisations manage the delivery of outstanding performance in all aspects of their operations. The concept of continuous improvement is integral to best practice. Best practice can be identified through a comparison of performance indicators.’
ACHS EQuIP Guide 1999

‘Best Practice: in the health sector, this means the highest standards of performance in delivering safe, high quality care, as determined on the basis of available evidence and by comparison among health care providers.’
Process
A process is the way organisations undertake work to achieve outcomes. A process:
- consists of a chain of activities with each activity made up of a group of tasks
- is generally across a number of functions in an organisation and are undertaken by different people at different stages
- is measurable

NSW Health Benchmarking Activities in the NSW Public Health System 1999

Outcomes
The results that occur from a service or intervention. These results may or may not have been intended’

ACHS EQuIP Guide 1999

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