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[CONTENTS](#)

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The New South Wales Medical Record Department Benchmarking Project: a work in progress

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Abstract

Benchmarking is having an increasing impact on the health information management (HIM) profession. With the current focus in healthcare on competition and outcomes, the challenge for managers of MRDs (predominantly HIMs) lies in proving that what they do, and the way they do it, achieves results which benefit the organisation and, ultimately, the patient or client. The Medical Record Department (MRD) Benchmarking Project is an initiative being undertaken on behalf of the HIM profession in New South Wales by the Health Information Management Association of Australia Limited (NSW Branch). The project has five phases and this article describes Phases 1 and 2, which comprised a survey of MRDs to identify any current performance indicator/benchmarking activities and to determine priorities for benchmarking. As the project progresses, further articles will appear in *Health Information Management*.

Key words: benchmarking; best practice; better practice; health information service; medical record department; performance indicators; standards.

Introduction

Increasingly, benchmarking is having an impact on the health information management profession.

An illustrative example occurred during a recent consultancy when two health information management professionals were asked to examine staffing levels, workload, physical facilities, work processes and practices in the MRD and compare them to established benchmarks. The consultancy proved challenging. After contacting many colleagues and the Health Information Management Association of Australia Ltd it became clear to the consultants that there were *no established benchmarks* which relate directly to one of the profession's primary roles — managing medical record departments (MRDs).^[1]

What is benchmarking?

Benchmarking is a continuous, systematic process that involves comparing an aspect of the performance of one's own organisation (such as a work process or service) to that of other organisations providing the same (or similar) work process or service against a background of established indicators (Crossley 1993; Standards Australia 1996; National Health Ministers' Benchmarking Working Group 1998; Rasa 1999). The objective of benchmarking is to determine best practice (more commonly referred to now as better practice),

leading to operational and financial improvements within an organisation.

Benchmarking is not a simple process. It is a rigorous, structured, methodical and continuous process. It requires consistent and high quality data, the dedication of those involved and the support of senior management (Standards Australia 1996; Butcher, Charles and Rush 1998).

Performed incorrectly, benchmarking can have a detrimental impact on an organisation (Clair and Gorecki 1993; Heidbreder 1993). Simply regulating organisational performance to an industry standard (benchmark) without understanding how that industry standard was achieved, or analysing how your organisation's process or service differs from that standard, demonstrates a lack of understanding of the benchmarking process. Nor does this approach support a total quality management approach (Clair and Gorecki 1993; Heidbreder 1993; O'Dell 1993; Senn 1998).

Why should the health information management profession benchmark?

Apart from the obvious enhancements to a total quality management approach, why should the profession benchmark? Toth (1998) provided one very good reason — competition in cost and quality of health services. The Victorian Government, supporting the National Competition Policy and its principles of competitive neutrality, requested all public hospitals in Victoria to produce a report on how the principles of competitive neutrality would be instituted in their hospitals. Toth describes the effect of this request and the processes undertaken to determine whether the service she managed for the West Gippsland Healthcare (WGH) Group was competitive. Benchmarking was crucial to the process. Toth discovered that, while the core functions of the health information services of the benchmarking partners were similar to those in the WGH Group, there were significant variations and this made the benchmarking process difficult. Overall, Toth found the process useful, as it enabled her to determine the key functions of the WGH Group and analyse which performance measures were appropriate. "As HIMs (health information managers) we can use this as an opportunity and prepare ourselves. If we benchmark against other services and find that we are not competitive (in cost and quality), we can then restructure and reorganise to ensure that we will be managing our services not only now but well into the future" (Toth, 1998).

What benchmarking initiatives have been conducted by the health information management profession?

Reviewing past issues of *Health Information Management* for benchmarking initiatives within Australia proved limited. In 1994 Balding urged the profession to "let's get indicating". This advice showed foresight, as performance indicators are essential to the benchmarking process. Two years later Brosi (1996/1997) defined benchmarking, concisely explained the benchmarking process and provided examples of ways in which the services provided by MRDs could be benchmarked. Both articles provided sound advice with strategies to get the profession started. However, apart from Toth's (1998) report, there were no other articles on benchmarking initiatives.

It is easy to understand why the profession is not benchmarking. Benchmarking can only be performed against a background of established indicators and none have been developed for services provided by MRDs.

Clearly, before benchmarking initiatives can be undertaken by managers of MRDs, standardised performance indicators reflective of the key processes or services performed by MRDs *must be developed and established*. As the predominant group of professionals who manage MRDs, health information managers must drive the development of these indicators.

Benchmarking initiatives undertaken by HIMAA Ltd (NSW Branch)

Benchmarking Forum

In August 1997, a Forum was convened at the request of members of HIMAA Ltd (NSW Branch) to discuss issues associated with performance indicators and benchmarking of activities within the profession. Forty-six members participated and the Forum was considered a successful professional development event.

The objectives of the Forum were to determine:

- should the profession benchmark?
- what should the profession benchmark?
- how should the profession benchmark?

Should the profession benchmark?

Members at the Forum recommended that the profession in NSW should benchmark. They supported benchmarking as a valuable quality tool, complementing existing quality improvement programs. It was considered that the establishment of standardised performance indicators would enable comparison among MRDs and the benchmarking process could be used to determine better work practices.

How should the profession benchmark?

It was recommended that a working party be convened within HIMAA Ltd (NSW Branch) to undertake a project to define performance indicators and benchmarking processes for work practices in MRDs. It was agreed that membership representative of the public and private sectors was needed on the working party.

What should the profession benchmark?

Members agreed that five core processes would represent up to 80 percent of MRDs' workload. Therefore, it was resolved that initial work should focus on five core, generic processes or services of the MRD applicable to public and private hospitals, regardless of size or structure.

It was decided that casemix and coding activities be excluded from the project on the basis that other parties are conducting benchmarking initiatives on these activities. For example, the NSW Health Department compares services provided by NSW public hospitals using casemix measures, the National Centre for Classification in Health collects benchmarking information via the Australian Coding Benchmark Audit, and HIMAA has developed clinical coder competencies.

Medical Record Department Benchmarking Working Party

HIMAA Ltd (NSW Branch) convened the Medical Record Department (MRD) Benchmarking Working Party (the 'working party') in February 1998. The core objective of the working party is to develop benchmarks for generic processes or services of MRDs in NSW that are applicable to public and private hospitals, regardless of size or structure.

Membership

Expressions of interest to join the working party were sought from HIMAA members at the Forum and a notice was placed in the Branch newsletter. Seven members responded and formed the initial working party. Subsequent nominations led to five new members joining in March 1999, an encouraging sign that the project is generating interest and active participation among the profession.

Members of the working party are listed in Box 1. All have worked in, managed, or are currently managing MRDs. All members have agreed to treat confidentially all information about individual departments obtained during the course of this project.

Robyn Ballis	Cooma Health Service
Michelle Bramley	National Centre for Classification in Health (Convenor)
Gabrielle Challis	St Vincent's Private Hospital
Wynne Chiu	St George Hospital
Margaret Cook	HIM Consultant
Katarina Jurcevic	Blacktown/Mt Druitt Hospitals
Rhonda Kealy	NIB Health Funds
Rose Livolsi	Macarthur Health Service
Gay Lysenko	HIM Consultant
Merrilyn Morris	National Centre for Classification in Health
Robyn Sheridan	Parkes Health Service
Margaret Dumaresq	Health Information Manager (CodeRight)

Terms of reference / project plan

Recommendations from the Benchmarking Forum were reworked into terms of reference for the working party. The terms of reference provided the basis for five phases of the project plan (see Box 2). The project's timelines are generous and have been revised periodically to account for the various commitments of working party members, as all work is conducted on a voluntary basis.

Phases 1 and 2 of the project were completed in April 2000 and are outlined in this article.

Phase one	
Objective:	Develop a questionnaire to survey MRDs to determine performance indicator/benchmarking activities
Time frame:	June 1998 to January 1999
Phase two	

Objectives:	1. Conduct survey to determine five key MRD activities to benchmark 2. Collect, collate and analyse data from questionnaire
Time frame:	January 1999 to December 1999
Phase three	
Objective:	Design prospective pilot study to collect baseline data
Time frame:	Activity 1: January 2000 to June 2000 Activities 2-5: To be determined
Phase four	
Objectives:	1. Conduct pilot study to collect baseline data on five key activities for MRDs 2. Collect, collate and analyse data from pilot study
Time frame:	Activity 1: June 2000 to November 2000 Activities 2-5: To be determined
<i>Note: Phases 3 and 4 are reiterative — baseline data will be collected sequentially on each of the five key MRD activities. The dates listed are indicative of data collection and analysis for only one activity.</i>	
Phase five	
Objective:	Prepare final report for HIMAA Ltd (NSW Branch) Executive Committee and NSW members
Time frame:	To be determined

Meetings / tasks

Apart from an initial face-to-face meeting and brainstorming session, the tasks of the working party have been centrally co-ordinated by the Convenor and distributed to members to action, using the postal service and occasionally e-mail. The work completed by working party members and responses made to the tasks have been centrally collated and then redistributed for comment.

This approach has ensured that rural members are afforded the opportunity to participate in the project. The other advantages have been:

- no time is lost travelling
- cost is minimal, essentially involving only postage and printing
- work is more evenly distributed amongst members
- skills are strengthened, particularly time management and written communication
- members can plan and structure workloads in line with commitments.

Identified disadvantages are:

- lack of face-to-face interaction amongst members
- increased workload for the Convenor
- no forum for open discussion or brainstorming: it is challenging to formulate ideas on paper.

The role of Convenor is crucial to the working party's success. It is important to ensure that each member of the working party is aware of the tasks that other members are working on and they each have the opportunity to comment on any issue as the project evolves. Maintaining a team spirit and keeping the level of enthusiasm high are ongoing challenges for all members of the working party.

As each phase of the project ends and a new phase begins, planning is essential and it is anticipated that it will be

necessary to conduct face-to-face meetings. Face-to-face meetings are also beneficial for both the Convenor and members to personally relate to one another and reinforce the team philosophy.

Literature review

The sheer volume of literature on benchmarking indicates its importance and widespread application. The Commonwealth, State and Territory Governments and Standards Australia have published benchmarking guidelines and standards. Although most benchmarking literature originates from the business sector, it is interesting to see the growing volume of benchmarking literature emerging from the healthcare sector. Concentrating on benchmarking literature related to the HIM profession narrowed the search.

In addition to the HIM-specific literature cited previously, the benchmarking literature of particular interest to the working party were:

- various Commonwealth initiatives on benchmarking in the healthcare sector:
 - National Hospital Outcomes Program (clinical indicators)
 - National Health Ministers' Benchmarking Working Group (health sector performance indicators addressing equity, productivity and efficiency)
 - National Goals and Targets for Better Health (health status indicators)
- two publications by the NSW Health Department (1997a, 1998) outlining better practice guidelines for the admission and discharge of patients for elective procedures and frontline complaints handling provided fuel for the imagination of members of the working party
- *Journal of the American Health Information Management Association*, 69(10) (1998) focused on benchmarking and best practice.

It appears that the Australian health information management profession is not too far behind its American counterparts. A search of previous issues of *JAHIMA* revealed only one article on benchmarking prior to 1998. The November-December 1998 issue of *JAHIMA* also launched the AHIMA Best Practices Award Program, in which cash awards are given to AHIMA members demonstrating best practice in the field of health information management. Award winners are recognised at AHIMA's national convention and featured in *JAHIMA*.

Networking is often promoted as a valuable tool for HIMs and so it is not surprising that the most relevant piece of literature to this project was discovered through networking. Perry's (1996) unpublished research thesis on the use of performance measures in Victorian health information services was submitted as a requirement for the award of Bachelor of Health Information Management (Honours) at La Trobe University. Surveying Victorian health information services with 100 or more acute hospital beds, Perry identified which activities were being measured in terms of output (workload statistics) or performance. Perry also identified the activities that Victorian HIMs believed would benefit most from the use of performance measures.

Although Perry's research was limited by a low response rate, this significant piece of work provided the working party with a survey instrument that was adapted for this project.

MRD benchmarking project – Phase I: development of survey instrument

The objective of Phase I was development of a questionnaire to survey MRDs to determine performance indicators/benchmarking activities.

Survey aims

The four aims of the survey aligned with the working party's terms of reference:

1. To collect demographic data on each MRD surveyed
2. To ascertain what performance measures and workload statistics are currently collected by MRDs
3. To identify the five activities which MRD managers consider the most important to benchmark
4. To recruit participants for future phases to develop baseline benchmarking data for the five selected MRD activities.

Survey instrument

A comprehensive three-part questionnaire was developed by the working party. An instruction sheet containing definitions and an explanation of the project accompanied the questionnaire.

For the purposes of data management and follow-up, the hospital name and hospital identification number identified each questionnaire. The hospital's identification number as used by the NSW Health Department was used for the survey. It was emphasised throughout the questionnaire and accompanying documents that individual hospitals would not be identified in results.

The person responsible for the overall management of the MRD was asked to complete the questionnaire.

Part I – performance measures

The 72 performance measures or workload statistics listed in Perry's (1996) survey instrument provided the basis of the questionnaire. After refinements and additions, 127 performance measures or workload statistics which a MRD may collect were listed in a table format and grouped under main activity headings that would be common to most MRDs:

- record filing, tracking, culling and destruction
- requests for patient information (Freedom of Information - FoI)
- requests for patient information (medico-legal requests)
- requests for patient information (other than FoI and medico-legal requests)
- investigation reports/correspondence filing (loose sheets)
- record retrieval (other than for medico-legal requests)
- medical transcription
- statistics and associated procedures
- forms control
- data collections

- discharge compilation of medical record.

Respondents were asked to tick one of three boxes (*collected*, *not collected* or *not applicable*) for each performance measure or workload statistic listed. Respondents were also given the option to add performance measures or statistics, which were not listed in the questionnaire.

The distinction between '*not collected*' and '*not applicable*' required particular emphasis in the questionnaire and accompanying instructions. Perry (1996) had highlighted difficulties in her study with the interpretation of survey data, particularly being unable to establish whether activities were not performed by an MRD (that is, '*not applicable*') or that data relating to the activities was not collected by that MRD. It was crucial to this project to identify the activities performed by each MRD *and* ascertain whether they collected performance data on each of these activities.

Part II — priorities for benchmarking

To assist respondents in defining their priorities for benchmarking, the working party drew on Balding's (1995) work and asked respondents to first ask themselves key questions:

1. Why do MRDs exist?
2. Which services performed have the greatest impact on patients and their care?
3. Which other services of major importance to the organisation does the MRD provide?

Respondents were asked to consider the characteristics of principal functions when identifying the five most important main activities of a MRD — that is, each:

- is an activity
- leads to an outcome (a product or service)
- is performed by staff, not management
- is *not* a maintenance activity (eg, budgeting, staffing, staff education)
- should be expressed in lay (simple) language, naming the function
- should be one of five functions that encompass 80-90 percent of the MRD's workload (Wilson 1992).

Coding and casemix activities were excluded from the project, for reasons mentioned previously. Management activities (for example, staff recruitment, budgeting, orientation and training, rostering, performance appraisals and quality management activities) were also excluded from the project, as these activities did not meet the definition of a 'principal function'.

In addition to the identification and ranking of the five most important MRD activities to benchmark, respondents were asked to comment on the level at which benchmarking standards should be set (minimum, achievable or absolute ideal) and whether they wished to participate in further studies to develop performance indicators.

Part III — MRD / hospital demographics

This part of the questionnaire collected the MRD staff profile, areas of responsibility and demographic data of each hospital (for example, number of separations, average length of stay, number of beds and main clinical specialties). The scope of the clinical record was also identified (for example, whether allied health and/or community health data are incorporated into the medical record or kept separately).

Sampling method

The sample was obtained from 376 hospitals and day surgery facilities submitting data to the NSW Health Department's Inpatient Statistics Collection — 217 (58%) public hospitals and 159 (42%) private hospitals/day surgery facilities. Using a non-probability (purposive) technique, the sample was selected by excluding all facilities with fewer than 50 beds, and deriving representative samples for the pilot survey (Phase I) and the main survey (Phase II).

It was recognised that excluding facilities under 50 beds would result in under-representation of private hospitals and day surgery facilities; however, working party members considered that larger facilities were more likely to collect performance measures/workload statistics on various MRD activities.

After excluding facilities with fewer than 50 beds, the remaining 153 hospitals (65% public and 35% private) were stratified into peer groups (for example, principal referral, major metropolitan, district non-metropolitan) for both the public and private sectors. This allocation was made using the 1995/96 NSW Public Hospitals Comparison Data Book (NSW Health Department, 1997b) and the Commonwealth Department of Health and Family Services Circular Default Table of Benefits (HBF518 PH 291, February 1998).

The sample was then systematically divided into pilot survey ($n=36$) and main survey ($n=117$) to ensure that the pilot and main surveys were representative of the stratified peer groupings.

The resultant sample for the pilot survey was 36 hospitals, comprising 23 (64%) public and 13 (36%) private facilities. The sample for the main survey was 117 hospitals, comprising 78 (67%) public and 39 (33%) private facilities.

Pilot survey

Thirty-six MRD managers were contacted in November 1998 seeking their agreement to participate in a pilot study of the questionnaire. Twenty-seven managers agreed to complete the pilot questionnaire, to identify any questions needing clarification and to confirm that the questionnaire and instruction sheet were coherent. Suggestions for improvements were welcomed. Respondents were also asked to record the time taken to complete the questionnaire.

Of the 27 participants in the pilot survey, 17 returned the questionnaire — a reasonable response rate of 47% (6 of 14 private hospitals (43%) and 11 of 22 public hospitals (50%)). Almost half of the respondents (47%) provided comments on the questionnaire and found the instruction sheet excellent, clear and helpful. No comments were received on the content or coherence of the questionnaire. On average, the time taken

to complete the questionnaire was 90 minutes.

One respondent commented on the layout and this led to a redesign of the questionnaire — the column for responses was aligned more closely to the column describing the workload statistics/performance measures.

Minimal problems were detected with the face validity of responses — it was confirmed that one respondent had misinterpreted the 'not collected' and 'not applicable' options due to not reading the instruction sheet.

Formal analysis of the data collected in the pilot survey was not undertaken and has not been included in the results of this article. The pilot data collected was also put to good use by the working party to develop and test the coding sheet used in the main survey. The coding sheet was developed to facilitate validity checks and consistent coding of responses prior to data entry and analysis.

MRD benchmarking project — Phase II: survey results

The objective of Phase II was to conduct a survey to identify performance measures/workload statistics currently collected in NSW MRDs, and to determine priorities for five core MRD activities to benchmark.

Survey respondents

In April 1999, the questionnaire, instruction sheet and an explanatory letter were sent to the managers of the 117 MRDs in the main survey group (67% public and 33% private hospitals). MRD managers were given a month to respond; however, the deadline was extended for two months and follow-up measures intensified (including reissuing of questionnaires) to achieve an optimal response rate.

Seventy-four hospitals responded. However, eight responses were excluded, as two questionnaires were inadequately completed and six hospitals had fewer than 50 beds (the number of beds at these hospitals had changed since the sampling was undertaken and now did not meet the criterion).

Consequently, the survey respondents totalled 66 (56% response rate). The 44 (67%) public hospitals and 22 (33%) private hospital respondents were considered representative of the overall sample.

Data analysis

A database was designed in Microsoft Access 97 to analyse the data. Microsoft Access was selected because it is simple to use, has good query and searching facilities and data can be readily imported to other Microsoft software packages (Microsoft Word and Microsoft Excel). To ensure consistent data entry, only one member of the working party performed data entry.

Simple statistics, such as frequencies and percentages, were calculated for part one of the questionnaire, and questions 2 and 3 for part two of the questionnaire. To determine the five key MRD activities to benchmark, the activities were coded and ranked according to the priority specified by respondents. Question 4 of part two of the questionnaire was open-ended and the responses were classified to common themes.

Part three of the questionnaire collected demographic data relevant only to the benchmarking process. Therefore, analysis of this data was not performed for this phase of the project, except for the qualifications of the manager of the MRD. The qualifications were analysed and classified into professional groups.

Data coding and cleaning

As previously mentioned, a coding sheet was developed to assist with face validity checks and data entry. Although no significant problems emerged in the pilot survey, the number of anomalous responses in the main survey questionnaires were higher than expected. In part one of the questionnaire listing performance/workload data collected, 48 (73%) of questionnaires were found to have inconsistent data. In part two, only 20 (30%) questionnaires listed five priorities that could be coded without follow-up by working party members.

It became necessary to apply stringent checks on the data. During the coding process the consistency of each questionnaire's responses was assessed and any inconsistencies documented. If possible, the respondent was contacted for clarification. Any issues that remained following the cross-checking process were discussed by all members of the working party and a decision on how to consistently code the responses applied. All data cleaning performed by working party members was detailed and retained in a project reference document.

Demographic data – MRD managers

Health information managers were responsible for the overall management in 54 (82%) MRDs. The qualifications of the 12 (18%) remaining MRD managers were specified as registered nurse (3), health service manager (2), clinical coder (1), and not specified (6).

Performance measures and workload statistics currently collected on MRD activities

Twenty three percent of MRDs surveyed collected at least one measure. Fifty seven percent did not collect any measures.

Measures currently collected by MRDs were predominantly workload statistics rather than performance indicators. Respondents added 25 measures. All additional measures were workload statistics and grouped to three main activities – 'record retrieval', 'requests for patient information – medico-legal' and 'investigation reports/correspondence filing'. These additional measures were not included in the analysis.

Only 17 measures (13%) were collected by more than half of the MRDs surveyed (see Box 3).

3: Performance measures/workload statistics collected by more than half of MRDs surveyed

<u>Performance measures/workload statistics</u>	<u>Main activity</u>	<u>f</u> (n=66)	<u>%</u>	<u>Public/private</u> (n=44/22)
Number of subpoenas received	Requests for patient information – medico-legal	56	85%	39 Public (89%) 17 Private (77%)

Number of subpoenas completed/sent	Requests for patient information — medico-legal	56	85%	39 Public (89%) 17 Private (77%)
Number of medico-legal requests received	Requests for patient information — medico-legal	55	83%	37 Public (84%) 18 Private (82%)
Number of medico-legal requests completed/sent	Requests for patient information — medico-legal	55	83%	39 Public (89%) 16 Private (73%)
Number of inpatient records compiled/assembled	Discharge compilation of medical record	46	70%	32 Public (73%) 14 Private (64%)
Total number of rejections/edits from NSWDOH Inpatient Statistics Collection (paper, online)	Data collections	44	67%	29 Public (66%) 15 Private (68%)
Number of requests received for medico-legal reports	Requests for patient information — medico-legal	44	67%	32 Public (73%) 12 Private (54%)
Total number of records compiled/assembled	Discharge compilation of medical record	43	65%	29 Public (66%) 14 Private (64%)
Number of duplicate MRNs (for one patient) found and/or notified	Maintaining Patient Master Index (PMI)	42	64%	32 Public (73%) 10 Private (45%)
Number of discharges received (medical records of discharged patients)	Discharge compilation of medical record	41	62%	24 Public (54%) 17 Private (77%)
Number of records filed	Record filing, tracking, culling and destroying	39	59%	29 Public (66%) 11 Private (50%)
Number of records retrieved for admission	Record retrieval (other than for medico-legal)	37	56%	21 Public (48%) 16 Private (73%)
Number of records retrieved for research/audit	Record retrieval (other than for medico-legal)	36	54%	25 Public (57%) 11 Private (50%)
Number of records retrieved for medico-legal reports	Requests for patient information — medico-legal	36	54%	21 Public (48%) 15 Private (68%)
Total number of FOI requests received	Requests for patient information — FOI	36	54%	36 Public (82%)
Number of requests processed	Requests for patient information (other than FOI and medico-legal requests)	35	53%	24 Public (54%) 11 Private (50%)
Total number of requests received	Requests for patient information (other than FOI and medico-legal requests)	34	51%	20 Public (45%) 14 Private (64%)

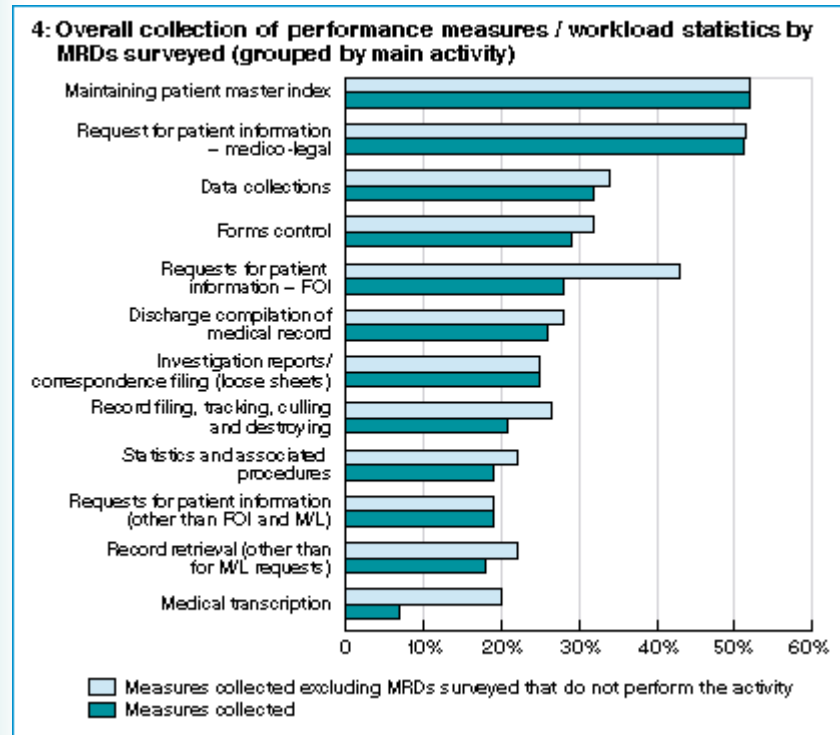
Box 4 presents the overall collection of measures by MRDs, grouped by main activity. The five activities with the most frequently collected measures were:

1. maintaining the patient master index
2. requests for patient information — medico-legal
3. forms control

6. requests for patient information — FoI
7. discharge compilation of medical record.

After adjusting the results to exclude MRDs that do not perform certain activities (that is, excluding the 'not applicable' responses) the ranking of most frequently collected measures slightly changed to:

1. maintaining the patient master index
2. requests for patient information — medico-legal
3. requests for patient information — FoI
4. data collections
5. forms control.



Activities performed by all surveyed MRDs were 'requests for patient information — other than freedom of information and medico-legal requests', 'requests for patient information — medico-legal' and 'investigation reports/correspondence filing (loose sheets)'.

Activities not performed by all surveyed MRDs included 'medical transcription', 'forms control', 'maintaining the patient master index' and 'statistics and associated procedures'. As was expected, only public hospitals performed the activity 'requests for patient information — FoI'.

'Culling' and 'destroying' were components of the activity 'record filing, tracking, culling and destroying' that were not performed by all MRDs. Similarly, there were components of the activity 'record retrieval' that were not applicable to all MRDs. These components related to secondary storage facilities, outpatient departments, accident and emergency departments and records retrieved for research.

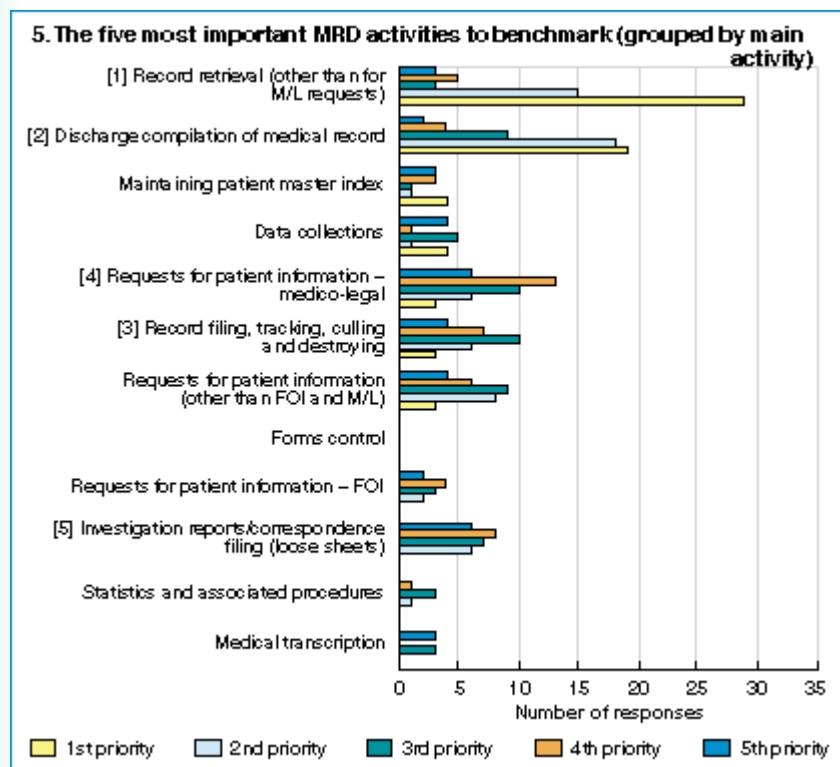
The five key activities which managers of MRDs consider the most important to benchmark

The five MRD activities considered the most important for benchmarking were identified as:

1. record retrieval
2. discharge compilation/assembly of medical record
3. record filing, tracking, culling and destroying
4. requests for patient information — medico-legal
5. investigation reports/correspondence filing (loose sheets).

Box 5 represents the responses, grouped by main activity and priorities.

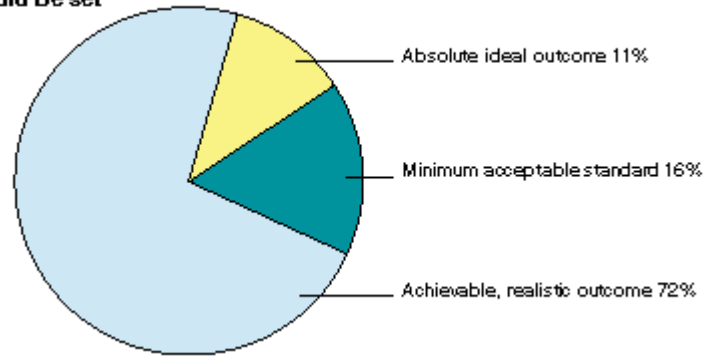
When analysing the responses across public and private sectors, the first-, second-, and fourth-ranked activities were consistent. The private sector differed only in their choice for the third- and fifth-ranked activities — requests for patient information (other than FoI or medico-legal), and data collections were ranked higher than record filing and loose sheet filing.



The level at which a benchmark or standard should be set

In anticipation of benchmarking standards being developed at the end of this project, respondents were asked at what level a standard should be set. The majority of respondents (73%) believed that standards should be set at an achievable, but realistic, outcome (see Box 6).

6: The level at which managers of MRDs surveyed believed a standard should be set



Recruitment of participants for Phase III

Thirty-eight (58%) respondents volunteered to participate in the Phase III prospective study to collect baseline measures on the five priority activities to benchmark. This figure represented 30 public hospitals and eight private hospitals.

Respondents' comments about the project

Twenty-nine (44%) respondents commented about the project. Many comments referred to the need to make comparisons with 'like' facilities and the need for consistent definitions (41%). Other comments referred to time constraints (14%) or data collection/recording issues (21%). There were six positive comments about the study (21%) and only one negative comment about the time taken to complete the questionnaire (3%).

Discussion

While the questionnaire for the main survey was based on Perry's (1996) survey instrument, the results of this survey have not been compared to Perry's study for several reasons:

- the aims of each study were different
- the questionnaire design was changed significantly — 55 measures were added and a number of measures reallocated to different main activities
- the data collected on the measures were different — our study did not collect data on thresholds (standards) applied to the measures.

Less than a third of the MRDs surveyed collected any of the measures identified in our survey. There may be several reasons why these measures are not collected:

- the focus of data collection may be on the activities excluded from this survey (for example, coding; casemix or management activities)
- insufficient volume of activity to warrant collection of measures
- no problems identified — no perceived value in collecting measures
- management culture — the benefits of collecting measures are not recognised by management
- staffing issues — time, resources, turnover, resistance to performance measurement.

When asked to comment about the project, a number of

respondents indicated that they did not have the resources (staff and time) to collect measures. One respondent explained that the trend towards a shorter length of stay had increased the throughput of patients, causing an increased demand on services provided by the MRD. Staff had little time to collect data regularly on the activities performed and preference was given to conducting audits perhaps two or three times a year. Given these results and the comments made, any performance indicators for MRD activities developed by the working party must be simple to collect and have very little impact on time. The indicators should focus on the outcome of the activity and must be of benefit to the staff performing the tasks, the MRD, the organisation, and ultimately, the patient or client.

Performance measures, more so than workload statistics, are important to the benchmarking process. Workload statistics are still a very useful tool — they can be used to identify levels of workload and can indicate workload changes when collected over time. They are also useful planning tools, especially in relation to levels of staffing. Workload statistics can become performance measures when a standard is applied (Perry, 1996).

The data items collected by MRDs were mainly workload statistics. This result is not surprising, as the measures listed in the questionnaire were predominantly workload statistics. However, it was anticipated that the performance measures currently collected by MRDs would be added to the questionnaire. All of the measures added by respondents were workload statistics.

The decision to collect workload statistics, rather than performance measures, is probably influenced by staffing levels and time constraints. Thus, the task ahead for the working party is to build on the information collected and to develop performance indicators by applying standards to the various workload statistics that are collected by all MRDs.

Of the five activities considered the highest priority for benchmarking, only two were associated with the most frequent collection of measures — 'discharge compilation/assembly of medical record' and 'requests for patient information — medico-legal'. 'Record retrieval' was the activity considered the highest priority to benchmark; however, less than a third of MRDs collected measures on this activity. 'Maintaining the patient master index' was not considered an important activity to benchmark, although more than half of the MRDs collected measures on this activity.

One reason for these apparent contradictions may be that MRD managers are collecting data on activities where data generation is a simple process, rather than focusing on activities that have the greatest impact on the department or the organisation. Automated systems, such as the patient master index, simplify the collection of data and enable routine production of statistical reports. This reasoning is supported by the comments made previously by some of the respondents about staffing levels and time constraints. It is quicker and simpler to collect data that is easy to collect; however, this may not always relate to data that is considered important to collect.

The respondents believed that standards developed by the working party should be set at a level which targets an achievable, but realistic, outcome. This recommendation aligns with the trend in the literature to remove the word "best" from the definition of benchmarking, preferring instead the terms "outstanding" or "superior" (Bennett Berry, 1998; Lorence, 1998). NSW Health (1997a, 1998) uses the term "better practice guidelines" rather than "best practice", and has guidelines for good practice, improved practice and better practice. What is *best* practice for one organisation may not be *best* practice for another given the unique situations influencing each organisation's processes (Lorence, 1998).

The next phases of the project involve a pilot study, which has two aims: to trial data collection forms and definitions and to collect baseline performance data on the five priority areas identified for benchmarking. Thirty-eight survey respondents, together with nine volunteers from the pilot study, have agreed to participate in the next phases of the project. They comprise 35 public hospitals with a range of 60-780 beds and 12 private hospitals in the 50-329 beds range. While slightly over-representative of public hospitals (74%), it is pleasing to see the private sector's willingness to participate further in the project. The participants who have volunteered for future phases of the project should therefore provide reliable information to develop performance indicators applicable to all MRDs.

It was pleasing to see that nearly half of the respondents took the opportunity to provide their thoughts about the project. The members of the working party appreciate the comments and will keep them in mind as the project progresses.

Conclusion

This article has detailed the progress to date with benchmarking initiatives being conducted by HIMAA Ltd (NSW Branch). As the project progresses, supplementary articles will be submitted for publication in *Health Information Management*.

HIMs comprise the primary professional group responsible for the management of MRDs and therefore must be active participants in the development of this project. The development of standardised performance indicators reflective of the key processes performed by MRDs can only be undertaken in consultation with those who manage the performance of those tasks and in the process thereby answering three critical questions in a sector focused on cost and outcomes:

- what do you do?
- how well do you do it?
- what is the benefit of the service to the organisation, and ultimately, the patient or client?

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References

- Balding C (1994) Quality matters. *Health Information Management* 24(4):167–168.
- Balding C (1995) *An approach to quality activities for health information services and MRDs*. Sydney: Health Information Management Association of Australia.
- Bennett Berry T (1998) Using benchmarking to support performance improvement efforts. *Journal of the American Health Information Management Association* 69(10): 26–27.
- Brosi J (1996/1997) Who benchmarks anyway? What does it really mean? *Health Information Management* 26(4): 217.
- Butcher L, Charles P and Rush S (1998) Allegiance Systems Benchmarking Workshop. Conducted at the 19th National Conference of the Health Information Management Association of Australia, Brisbane.
- Clair J and Gorecki A (1993) Can competitive benchmarking damage your organisation? *The Quality Magazine* October: 36–38.
- Crossley A (1993) Benchmarking: a management tool that delivers results. *The Quality Magazine* October: 60–63.
- Heidbreder J (1993) Looking for the light — not the heat. *Healthcare Forum Journal* January/February: 25–28.
- Lorence D (1998) An introduction to benchmarking health assessment and outcomes through applied statistics. *Journal of the American Health Information Management Association* 69(6): 42–46.
- National Health Ministers' Benchmarking Working Group (1998) *Second national report on health sector performance indicators — summary report*. Canberra: Australian Institute of Health and Welfare.
- New South Wales Health Department (1997a) *Better practice guidelines for admission and discharge of patients for elective procedures*. North Sydney: New South Wales Health Department.
- New South Wales Health Department (1997b) *NSW Public hospitals comparison data book 1995/1996*. North Sydney: New South Wales Health Department.
- New South Wales Health Department (1998) *Better practice guidelines for frontline complaints handling*. North Sydney: New South Wales Health Department.
- O'Dell C (1993) Building on received wisdom. *Healthcare Forum Journal* January/February: 17–21.
- Perry C (1996) The use of performance measures as a tool for managing quality in health information services: current use of performance measures and workload statistics for selected activities. Honours thesis submitted as course requirement for the Bachelor of Health Information Management (Honours), Faculty of Health Sciences, La Trobe University.
- Rasa J (1999) Hospital benchmarking in Australia. *National Healthcare Journal* 9(3): 25–29.
- Senn G (1998) Clinical buy-in is key to benchmarking success. *Healthcare Financial Management* May: 46–50.
- Standards Australia (1996) *Benchmarking explained — a guide for undertaking and implementing benchmarking*. SAA/SZZ HB80:1996. Homebush NSW: Standards Australia and Standards New Zealand.
- Toth A (1998) Competitive neutrality and health information services. *Health Information Management* 28(1): 20–22.
- Wilson C (1992) *Quality assurance/continuous quality improvement: strategies in health care quality*. Toronto: Saunders.

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[1] aka Clinical Information Departments (Services) or Health Information Departments (Services)

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