Benchmarking: Friend or foe

Key words: CRNA administrative managers, benchmarking.

Healthcare today requires strong, knowledgeable, dedicated, and visionary CRNA administrative managers. As the new millennium approaches, these same CRNA administrative managers are faced with major pressures of financial issues, less staff to cover the staffing patterns, physician concerns, declining surgical volumes, the need to meet standardization regarding practice, and less job security. As CRNA administrative managers, we must look for tools to make the workload more manageable and less frustrating. Benchmarking information can become either a friend or foe to the CRNA administrative manager depending on how he/she chooses to participate in the process and utilizes the information that is available.

What is benchmarking? Benchmarking is an approach of reducing costs while improving productivity. It is a process of organizations learning or measuring their organization against the leaders in the industry to improve performance outcomes in a defined service area while keeping costs to a minimum. Examples of benchmarking parameters include room time, long or short stay for laparoscopic cholecystectomy patients, or time to extubate the patient following open heart surgery.

Over the years, CRNA administrative managers have used long-term and short-term budgeting plans to conduct and evaluate their respective businesses. As we face new challenges in cost-effective quality patient care, CRNA administrative managers must go beyond old ideas and reach new levels of excellence. Benchmarking is one means to reach these new levels. Six advantages of benchmarking are that it:

1. Avoids reinventing what already exists.
2. Achieves breakthroughs on great ideas by putting several groups of information together (the whole is greater than its pieces).
3. Helps drive and direct reengineering processes by using the best from many outstanding organizations.
4. Allows for everyone to stretch for new goals, that is, moving from the highest percentile of practice to the lowest percentile of quality cost-effective practice.
5. Helps overcome the “not invented here” and “it will not work in any situation” syndrome by demonstrating things can and do work well. This approach helps to persuade the resisters to make the needed changes.
6. Heads off new competition because you can not beat the competitors if you are continually following them in change.

Some definitions

What data do you need when starting the process of benchmarking? Well-defined definitions are key components to superior benchmarking. These definitions provide for accurate comparison of
services by comparing like parameters. Without the definitions and understanding, comparisons will lack credibility. A few definitions that will assist the CRNA administrative managers in working through the benchmarking process are:

1. **Staffing ratios and configurations**—current staff schedules and skill mix.

2. **Workload and service intensity**—type and complexity of care required by patient population.

3. **Labor productivity ratios**—equals paid salary dollar per adjusted discharge which will give the cost of providing the service.

4. **Cost ratios**—taking all things to account, salary dollars, supply expenses, and nonlabor expenses divided by adjusted discharges.

Before an organization begins to benchmark, it is imperative to find similar organizations which perform better. These variations will help to move the organization into making changes in the proper time line.

Benchmarking is a step-by-step process that will not occur instantly; it will take many steps, patience, and perseverance. CRNA administrative managers must understand their own information, then compare it to the best in the practice, remembering differences do exist between organizations. They must identify the differences and develop a plan to overcome these issues. Planning should involve the staff of the organization, developing a good organization as a partner, making onsite visits to the partner organization, and discussing definitions and how the organization is able to reach and maintain the level of success. Every organization has good areas as well as areas that can be improved.

**Myths of benchmarking**

There have been concerns expressed by individuals within a health center regarding the merits of benchmarking. One myth is that benchmarking is too expensive, but in reality it is far more cost effective to improve your processes. The second myth is that benchmarking is only for large companies. Small and large companies can and do benchmarking to improve processes. CRNA administrative managers who believe quality benchmark indicators do not exist for our industry are individuals who resist change and may be looking for new positions in the near future. A third myth of benchmarking is that is does not promote creative problem solving or thinking “out of the box.” Benchmarking helps everyone to see new ways to provide services in a cost-effective manner. Additionally, achieving hospital performance improvement beyond current expectations is determined by comparing your facility to other successful performance measurements within the industry.

**Conclusion**

In summary, CRNA administrative managers must be the proactive source in institutions, always focusing on ways to improve. Benchmarking, along with total quality management and reengineering, is here to stay. Therefore, it is wise for CRNA administrative managers to embrace benchmarking as a positive tool in our management styles. Utilizing this focus will not only meet the demands of today’s changes, but will also spring us into the future with confidence in providing cost-effective, highly efficient, quality patient care.

“Benchmarking: the practice of being humble enough to admit that someone else is better at something and wise enough to learn how to match and even surpass them.”

**REFERENCE**


**ADDITIONAL READING**


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EMLA Cream should not be used in infants under the age of 1 month or in those rare patients with congenital or idiopathic methemoglobinemia or in infants under the age of 12 months who are receiving treatment with methemoglobin-inducing agents.

Please see brief summary of prescribing information on following page.

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EMLA CREAM (lidocaine 2.5% and prilocaine 2.5%)

CONTRAINDICATIONS

EMLA Cream is contraindicated in patients with a known history of sensitivities, especially if the etiologic agent is uncertain.

Allergic Reactions: Allergic and anaphylactic reactions associated with EMLA Cream have occurred. If a patient has a history of sensitivity to lidocaine or prilocaine, EMLA Cream should be used with caution.

Localized Reactions: During or immediately after treatment with EMLA Cream, the skin may become erythematous and edematous. Reddening may be attributable to direct depressant effects of these local anesthetic agents on the cardiovascular system.

Tuberculosis: Administration of small doses of EMLA Cream in patients with tuberculosis may cause the disease to become latent.

Impairment of Fertility: See Use in Pregnancy.

Use in Pregnancy: Teratogenic Effects: Pregnancy Category B.

Reproduction studies have been performed in rats and have revealed no evidence of harm to the fetus (30 mg/kg subcutaneously, 22 times SDA). Reproduction studies with prilocaine have been performed in rats and have revealed no evidence of harm to the fetus (30 mg/kg intramuscularly, 188 times SDA). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, EMLA Cream should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Use in Labor and Delivery: Neither lidocaine nor prilocaine are contraindicated in labor and delivery. Should EMLA Cream be used concomitantly with other products containing lidocaine and/or prilocaine, total doses contributed by all formulations must be considered.

Adverse Reactions:

Local: Reactions to EMLA Cream may be expected in patients receiving Class I antiarrhythmic drugs (such as lidocaine and procainamide) since the toxic effects are additive and potentially synergistic.

Prilocaine may contribute to the formation of methemoglobin in patients treated with other drugs known to cause this condition (see Methemoglobinemia Subsection of WARNINGS).

Systemic: Hypotension, Impairment of Fertility

Reproduction studies have been performed in rats receiving subcutaneous administration of 80 mg of EMLA Cream to 400 mg for 3 hours to a small pregnant (SDA). The application for one or two applications for the management of excitatory (2.5 or 5 mg/kg) or 12/4 or 2 mg/kg of this in an adult is observed. In animals treated with subcutaneous administration of the fetus (300 mg/kg SDA), the increase in incidence of congenital abnormalities and anencephaly, noted above, was predicted to occur at a rate of 0.75 to 1.5 times the human dose.

A two-year oral toxicity study of 2,6-xylidine, a metabolite of lidocaine, has shown that in both male and female rats and neoplastic nodules of the liver in the female rats with a significant positive trend. Therefore, controls were included with Fisher’s Exact Test should be considered.

Vaccines has not been observed in humans. However, covalent binding studies of DNA from liver and ethmoid turbinates in rats (90 mg/m3; 6 times SDA) and control groups, no nasal tumors were observed. A rhabdomyosarcoma, a rare tumor, was observed in the nasal cavity of both male and female rats at the high dose of 900 mg/m3. In addition, the combination of subcutaneous fibromas and/or fibrosarcomas in both male and female rats and neoplastic nodules of the liver in the female rats with a significant positive trend, pairwise comparisons using Fisher’s Exact Test should be considered.

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Cardiovascular: Cardiovascular manifestations may include bradycardia, hypotension and/or cardiovascular collapse leading to arrest.

OVERDOSAGE

Peak blood levels following a 60 g application to 400 cm2 for 3 hours are 0.05 to 0.18 µg/mL for lidocaine and 0.55 to 1.0 µg/mL for prilocaine. Toxic levels of lidocaine (>5 µg/mL) and/or prilocaine (>0.5 mg/mL) cause decreased in cardiac output, total peripheral resistance and mean arterial pressure. These changes may be attributable to direct depressant effects of these local anesthetic agents on the cardiovascular system. In the absence of massive topical overdose or oral ingestion, evaluation should include evaluation of other etiologies for the clinical effects or overdose from other sources of lidocaine, prilocaine or the local anesthetic.

REFERENCES


2. Rice LJ, Craven J. Reversing the pain and anxiety of needle injections—experience with EMLA Cream (lidocaine 2.5% and prilocaine 2.5%) dermal anesthetic. Today’s Therapeutic Trends. 2002:11:175-189.
