The Critical Importance of Benchmarking

As healthcare costs skyrocket, healthcare providers are under intense pressure to increase the quality of care, enhance consumer safety, and improve operational efficiencies. While healthcare reform is debated and legislated, the concept of “accountable care” is at the forefront of the healthcare dialogue. Accountable care will serve as a key dynamic in the future of benchmarking.

Accountable care has emerged as a descriptor for an approach to healthcare delivery that addresses the three goals of healthcare reform:

1. Improve healthcare quality and outcomes for consumers
2. Improve the overall health status of the population
3. Manage and reduce healthcare cost inflation

Accountable care is centered on the consumer and empowers and holds providers accountable for consumer outcomes and quality across the full continuum of care and for delivering those results in a cost-effective manner. The goal of accountable care is that consumer care will become more proactive and consumer-centered. There is an emphasis on wellness to improve quality and consumer outcomes and lower costs. As healthcare organizations become more accountable for the care that they provide, engaging consumers in their personal health, wellness and medical decisions will become more important. The more engaged and informed that consumers are about their own health, the more likely they are to make sound care decisions and improve/maintain their health.

The role of data will grow markedly in this era of accountable care. Provisions of the new law mandate increased use of data in health care decisions at all levels. No longer will providers be able to “go with their gut” in making all management decisions. No longer will organizations continue to receive deficit funding to support questionable performance year after year. Data will have a hand in bringing about key changes in accountability and performance.
Definition of Benchmarking

Benchmarking is a quantitative management approach that can be used to enhance any facet of organizational or individual performance. At the core of benchmarking is a formalized comparative process that sheds light on organizational strengths and opportunities for improvement. These insights, in turn, lead to concrete plans for improvement and the illumination of best practices to help guide the path.

Gift and Mosel (1994), in their volume entitled “Benchmarking in Health Care,” define benchmarking as “the continual and collaborative discipline of measuring and comparing the results of key work processes.” This definition embraces a number of key concepts:

- **Continual** – Benchmarking is an ongoing process that is employed over time. Unlike formal empirical research, benchmarking does not conclude when a report is produced. That is when it shifts into high gear.

- **Collaborative** – Benchmarking is inherently a communal experience. One cannot really participate in benchmarking in isolation of others. At the very least, data coming from other organizations is required. Ideally, those involved in benchmarking cooperatively learn from one another on a regular basis.

- **Comparing** – Comparisons are the essence of identifying organizational strengths and opportunities for improvement, as well as discerning best practices.

- **Measuring** – Benchmarking relies on disciplined measurement that produces reliable and trusted information as the basis for comparisons.

- **Key Work Processes** – Benchmarking is meaningful only when the focus is on dimensions of performance that are critical to success.

The Rationale for Benchmarking

All behavioral health and human services organizations measure their performance. Yet, when one considers the collective impact of available performance data in behavioral health and human services settings, there is general consensus that data does not drive day-to-day decision-making and it does not shape strategic vision. Given the considerable time and expense that goes into gathering performance data, this can be perplexing.

To explain this phenomenon, consider this: How helpful would a thermometer be as a measure of your health, if you didn’t know that 98.6° is normal? In the absence of a context, data is simply a bunch of numbers. Benchmarking provides that vital context that transforms static numbers into actionable information. Since most behavioral health and human services settings do not have comparative benchmarking data available, they are left with difficult to interpret numbers, which are generally filed away with little impact on the organization. Therefore, the rationale for benchmarking is that it brings meaning to performance data and provides the impetus for ongoing organizational improvement.

The Status of Benchmarking

In virtually every industry around the globe, including health care, benchmarking is regarded as an essential management tool. Benchmarking can be found in every corner of commerce and service delivery. In stark contrast, however, in the behavioral health and human services realm, benchmarking is still in the early phases of its evolutionary journey. Behavioral health and human services leaders see themselves as being more people-oriented than “widget-” oriented. For that reason, many have been slow to warm up to the use of data. While regulatory requirements mandate the reporting of data, that is generally not the case for benchmarking.
The Joint Commission, at one time, mandated the submission of behavioral health benchmarking data. However, that requirement was dropped for behavioral health providers in the face of resistance and a quagmire of methodological complexities.

Therefore, in the behavioral health arena, benchmarking is currently practiced largely by those enlightened individuals who recognize its value. However, the number of practitioners is growing as the benefits of benchmarking become more widely recognized and its availability increases. Momentum for benchmarking is building significantly and steadily. The Joint Commission recently re-instituted mandates for the submission of benchmarking data for inpatient psychiatric providers. The outlook looks bright for benchmarking. In the final section of this paper, the future of benchmarking is discussed.

The Benchmarking Process

Benchmarking is conducted in both informal and formalized venues. An informal benchmarking collaborative can easily be established by participants from a handful of organizations that agree to certain principles and practices such as metrics included, operational definitions, data-sharing methods, frequency of sharing, vehicles for communication (e.g., in person, conference call, email), and the use of technology. These endeavors are often very rich in support but the resultant information derived, by its very nature, tends to be more qualitative than quantitative.

To better harness the true science of benchmarking, an organized initiative affords a multitude of advantages. Data submission and report generation are confidential, automated, and conducted under controlled, rigorous standards to help ensure uniformity and accuracy. Sample sizes are generally much more substantial, leading to more reliable and valid comparisons. The resultant deliverables are highly beneficial, both quantitatively and qualitatively.

It is important for benchmarking to include a balanced representation of metrics from across different realms of performance, including clinical, operational, financial, and organizational climate. Each of these four domains inter-relate with one another in ways that are difficult to predict. In order to derive a complete picture of organizational performance, parallel tracking of all four domains should take place.

In each of the four performance domains, there are certain “favorite” metrics that enjoy particular popularity. In the Clinical Domain, popular dimensions include discharge status, suicide rate, hospitalization rate, client satisfaction, and certain standardized clinical tools. In the Operational Domain, favorites include outpatient productivity, access, and no-show rate. In the financial arena, much attention is paid to days cash on hand, current ratio, administrative overhead, days in accounts receivable, and unit costs. In the Organizational Climate arena, particularly valued metrics include staff turnover and staff perception surveys.

Most often, data is submitted via an online encrypted survey. In some instances, data submission is fully automated through direct data transfer. Data validation should be present to filter out metric values that are likely to be inaccurate.

Reports of different types are generally made available to suit a variety of purposes. Typically, a utility report is made available featuring a broad array of detailed normative metrics (e.g. sample size, mean, median, standard deviation) and comparative statistics (percentile rankings, typically broken out by various peer groups). In addition, a brief executive-level report is typically made available that provides highlights of the findings for use by executive leaders and boards.
Percentile rankings represent the key comparative metric in benchmarking. Through percentile rankings, an organization knows exactly where it stands, compared to others. Percentile rankings are easy to understand and may be communicated broadly throughout the organization. Nobody wants to be “bringing up the rear.” Percentile rankings serve to motivate and focus organizational resolve.

**Shared Learning**

Benchmarking can provide a robust variety of opportunities for participants to learn from one another. Regularly scheduled webinars provide opportunities to ask questions, make announcements, provide training, and share in decision-making. In this venue, “top performers” can be given the opportunity to discuss the practices that have contributed to their success. Another vehicle to connect benchmarking participants is to arrange for individual contacts between organizations seeking assistance and top performers in the area of inquiry. Mutual learning can also occur through the dissemination of regular newsletters and other informative materials. Finally, “process benchmarking” (Lefkovitz, 2005) is an investigative method that brings benchmarking participants together in a quest for best practices.

**The Impact of Benchmarking**

Benchmarking has demonstrated its power in a multitude of behavioral health and human services settings across the country. Individual organizations have reported substantial improvements in a broad variety of realms. In one example, the rate of restraints in an adolescent residential setting was reduced by 90% over a nine-month period. That improvement was attributed entirely to benchmarking, for the provider had no idea its rate was high before becoming involved in benchmarking. Through that improvement, hundreds of occurrences of restraint per year are now being averted.

In another example, organizational climate data led to significant changes in how leadership functioned. In a six-month period, the organization’s survey scores went from one of the least favorable in the country to well above average. Comments such as “What a difference six months can make!” were expressed by many staff.

State-wide improvements have also been reported in response to organized benchmarking efforts. For example, in two different states, performance improvement initiatives were independently established to reduce the incidence of initial no-shows. Best practices gleaned from benchmarking data were used as the basis for the improvement efforts. It was found that the incidence of initial no-shows dropped by almost 30% in both states.

In another state, a 90-minute process benchmarking exercise was conducted to identify potential best practices to improve the timeliness of access for the initial appointment. It was found, one year later, that those organizations that implemented at least one of those best practices, improved access by a full 50%. In those settings, the number of days that elapsed from the initial request for services to the scheduled intake was cut in half.

**The Future of Benchmarking**

In the introductory paragraphs, it was asserted that the imperatives for accountable care would have a significant impact on the practice of benchmarking. However, cynics will counter that they have heard all of this before. Why is this era of “accountable care” different than others that similarly called for a more data-driven and accountable climate? The difference is that previous changes were market-driven, such as the emergence of managed care. The same market forces that brought about managed care also operated to dilute its impact when the public rejected the staff HMO model. This era of accountable care is different in
that it is not market-driven. It has been established by the United States Congress as the law of the land. While implementation may change course a bit and vary from state to state, the role of data and accountability in this new era will undoubtedly be galvanized.

Another important factor is that recently enacted Federal laws provide broader financial support for information technology along with more stringent expectations. A more solid technology infrastructure in behavioral health will provide further fortification for the use of data. Technology will also help streamline the acquisition of benchmarking data by automating the manual processes that are often in place for submitting such data.

In this emerging climate, benchmarking will be called upon to help reward successful providers and offer assistance to struggling organizations. Benchmarking will serve to identify best practices and help disseminate those practices throughout the industry.

Therefore, benchmarking is poised to become an increasingly important catalyst in achieving the ideals of accountable care. As one of the most powerful, appealing, and affordable forms of data management, benchmarking is well-positioned to move to center stage as an essential management tool for behavioral health and human services leaders throughout the United States.

About Netsmart
Through innovative and interactive solutions and services, Netsmart leads the health and human services industry in transforming the way care is delivered. Our expertise in helping organizations navigate their way through Meaningful Use and Accountable Care shows our commitment to partnering with organizations of all sizes to ensure they have the technology and know-how they need to deliver the highest level of care to those they serve. Healthcare today is an ever-changing, rapidly-evolving world. Organizations must seek technology partners who understand their current needs and have their pulse on the industry to envision how needs can be met in the future. Our obligation is to guide our clients through this rapidly changing environment by providing them with solutions and services that help improve outcomes and reduce costs. We will help each of our clients adapt to these changes so that they can reach their goals and improve the health of the populations they serve.

At Netsmart, we are at the forefront of healthcare innovation and moving forward at the speed of thought. We continue to evolve our services and solutions to meet the needs of our clients today and in the future. We are committed to ensuring that our clients in behavioral health, public health, substance abuse and addiction services emerge from the healthcare reform era as leaders in their respective fields of specialization.

About the Author
Paul M. Lefkovitz, Ph.D., is the general manager of Benchmarking Services for Netsmart. He is a licensed clinical psychologist whose work has encompassed clinical, administrative, research, and consultative roles in the areas of behavioral health service delivery and performance measurement. He served as chairperson of the Joint Commission’s Professional and Technical Advisory Committee (Behavioral Health). He was also an associate professor of Psychology (Psychiatry) at the Indiana University School of Medicine for over twenty-five years. He has been an active contributor to the professional literature and is a frequent presenter at regional and national conferences. Dr. Lefkovitz is active in behavioral health advocacy groups and serves as a board member of associations at the local, regional, and national levels.

References