

# Beyond Outcomes:

## Benchmarking in Behavioral Healthcare

The ongoing pursuit of performance improvement in behavioral healthcare may be aided by an emerging new weapon in its arsenal: benchmarking. Gift and Mosel (1994) define benchmarking as “the continual and collaborative discipline of measuring and comparing the results of key work processes with those of the best performers.” The ultimate objective of benchmarking is to identify “best practices” associated with high levels of performance and to see those practices find expression in organizational redesign and enhancement.

H. James Harrington (1996), who introduced benchmarking as a management tool in the late 1960s, explained its rationale this way: “We are all in an automobile race of sorts, but most organizational drivers don’t know, and many don’t care about, where they are positioned in the track. They look around and see a competitor in the race car behind them and take comfort in believing they are in the lead, not realizing the competitor is about to lap them.”

Formalized benchmarking has been enthusiastically embraced within the American industrial community by numerous Fortune 500 companies such as Alcoa, AT&T, Boeing, Caterpillar, DEC, DuPont, Eastman Kodak, Johnson and Johnson, IBM, L.L. Bean, 3M, and Motorola. These organizations have used benchmarking techniques to improve the quality of their products and the efficiency of their processes.

Like other management tools, benchmarking has seen its application to healthcare come more slowly. However, some initiatives in the healthcare arena have taken place. For example, the SunHealth Alliance, a purchasing cooperative consisting of 240 hospitals, carried out benchmarking activities in the mid-1990s. In behavioral health, benchmarking is a management practice that has seen application in very few organizations.

Ironically, behavioral health benchmarking informally takes place on a day-to-day basis. At professional meetings and conferences, leaders can regularly be observed “comparing notes” and inquiring about each other’s outcomes. “How are your outpatient therapists doing in terms of productivity?” is a question that has been asked untold times among such leaders. Confidential calls to obtain information about salaries, staffing models, collection rates and the like are commonplace.

The answers to these questions are critical to leaders who must know how to manage limited resources and produce optimal outcomes with them. Nobody wants to be “bringing up the rear” in this competitive and unforgiving industry.

It is little wonder, therefore, that more formalized benchmarking efforts have been undertaken by professional organizations and societies in an attempt to more systematically and scientifically answer these questions. Benchmarking surveys have been conducted by a number of organizations, such as Mental Health Corporations of America (MHCA), the National Association of Psychiatric Health Systems (NAPHS), the American Psychological Association (APA), and the Association for Ambulatory Behavioral Healthcare (AABH). Unfortunately, these benchmarking efforts, along with the valuable data they yield, are largely unknown outside of the membership of the sponsoring organizations.

Notable benchmarking work in behavioral health has also been carried out by governmental entities. Foremost among them are the National Institute of Mental Health (NIMH) and the Survey and Analysis Branch of the Center for Mental Health Services’ (CMHS’s) Division of State and Community Systems Development. Under the ongoing leadership of Ronald W. Manderscheid, Ph.D., enormous contributions to the science of measurement in behavioral health have taken place.

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Recent initiatives include the Mental Health Quality Report and Decision Support 2000+, developed under the auspices of the Mental Health Statistics Improvement Program (MHSIP; see related article on page 38). These initiatives have established an infrastructure for common nomenclature, operational definitions, and measurement methodologies. This foundational work will prove to be seminal in the implementation of benchmarking efforts.

Behavioral health benchmarking has also been carried out by regulatory and grant-funded entities. The National Committee for Quality Assurance (NCQA), which accredits managed care organizations, publishes a set of benchmarks annually inclusive of a few behavioral health indices. An extensive grant-supported multi-state benchmarking project for children's mental health services has been generating and disseminating valuable data since 2000 (Perlman, Nechasek and Dougherty, 2001). However, thus far, data emerging from federal, regulatory and grant-supported entities have been more applicable to system planning and policy development efforts than to the management of individual clinical settings.

Therefore, the potential value of benchmarking is not well-known to the behavioral health practitioner and leader. In order to better grasp and understand this potential, it is helpful to delineate three types of benchmarking: descriptive benchmarking, comparative benchmarking and process benchmarking.

### **Descriptive benchmarking**

Descriptive benchmarking is a process by which normative or "average" performance is defined. By far, this is the most common form of benchmarking. Typically, descriptive benchmarking reports provide means, medians, and sometimes minimum and maximum scores.

These are useful indices, but they have serious limitations. They only allow for an "eyeball analysis" of an organization's outcomes relative to the obtained norms and do not provide any information about the magnitude of any departure from those norms.

To illustrate these limitations with a hypothetical example, let's assume that a national benchmarking survey determines that the mean seclusion and restraint occurrence rate for a given population is 2.5 incidents per 1,000 bed days. An organization with a measured occurrence rate of 3.5 per 1,000 might feel a bit concerned about the fact that it exceeds the mean. However, without further statistical data, it would not know the extent of its departure

from the norm. For example, it would be quite possible that the rate of 3.5 was just a tad off the average. On the other hand, it could also be the very worst rate among the organizations surveyed. The implications of those two scenarios would be quite different.

In order to know more precisely what a particular value means relative to the average, it is necessary to know something about the variability among the measurements, most commonly expressed statistically as the standard deviation. It is very uncommon for standard deviations to be presented in benchmarking reports, and when they are, relatively few understand what to do with them. However, there is a method of reporting variability in a non-statistical way that is clear to almost everybody: percentiles.

In the vignette above, if it is known that the seclusion and restraint rate of 3.5 represents the 52<sup>nd</sup> percentile (meaning 52 percent of the organizations had a lower occurrence rate and 48 percent had a higher rate), that might be a cause for minor concern. If, on the other hand, it is known that the rate of 3.5 represents the 99<sup>th</sup> percentile (meaning virtually no other organization had a rate that high), that will likely be a cause for alarm. The relationship of the value to the broader norm can dramatically affect its implications.

### **Comparative benchmarking**

Comparative benchmarking, therefore, is a form of benchmarking that permits specific and meaningful comparisons between an organization's outcomes and the broader norms. Comparative benchmarks generally incorporate the use of percentile rankings. At a minimum, data tables presenting various percentile values are included. Such data at least allow for a determination of the quartile that defines an organization's measured performance.

Preferably, comparative benchmarking is a more precise undertaking in which individualized reports are made available to organizations, providing detailed percentile rankings with respect to each dimension measured. A very clear picture of strengths and weaknesses relative to other organizations in the survey sample can then quickly emerge.

While comparative benchmarking offers many advantages over descriptive benchmarking, the vast majority of benchmarking data that are available are descriptive in nature.

While comparative benchmarking is vastly superior to descriptive benchmarking, it too presents certain important limitations. While comparative benchmarking offers

organizations a better understanding of what is done well and where improvement is possible, it does not offer any insights as to *how* to improve. One has to look to a different type of benchmarking for such insights: process benchmarking.

### **Process benchmarking**

Process benchmarking goes beyond the measurement of outcomes to encompass the processes that underlie them. The objective of process benchmarking is to identify the procedural and functional characteristics of organizations that demonstrate the best performance with respect to the outcomes being measured. By determining the processes that distinguish top performers from others, “best practices” can be discovered.

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Moreover, it is likely that different organizations will excel at different facets or components of the outcome under scrutiny. Therefore, the processes that drive best performance may come from different organizations. Combining the “best of the best” allows for the creation of process sets that previously did not exist, opening the door to what is known as “breakthrough performance.” It is this aspect that takes benchmarking “beyond outcomes.”

A process benchmarking study is constructed differently from its descriptive or comparative counterparts. The survey needs to delineate process dimensions that might be associated with outcome. These process dimensions need to be quantifiable to avoid findings that are subjective and impressionistic. Respondents also need to have the opportunity to describe processes that are not represented in the survey. If there are different components of the outcome being studied, a distinct set of process dimensions for each needs to be incorporated into the design.

For example, the outcome of “providing prompt access to service” consists of several components, such as how initial calls are taken, scheduling, the clinical process,

and others. Each of those components is influenced by processes that either enhance or impede favorable outcome. For example, the handling of initial calls is affected by staffing resources, staff training, hours of operation, characteristics of the telephone system, types of questions asked of the caller, handling of financial issues, etc.

Those process variables affect that particular component, while scheduling introduces a whole new set of dimensions, such as manual vs. electronic schedules, centralized vs. decentralized scheduling, and so on.

In a process survey, all of the salient components and the processes that drive outcome must be incorporated into the design. For this reason, process benchmarking surveys are more limited in scope. They also require careful data analysis to tease out the relationships between the process variables and the outcomes in question.

Process benchmarking surveys should provide participating organizations with a clear picture of how their processes compare to a set of “best practices.” Adverse impacts associated with departures from the recommended processes should also be evident. The resultant data can provide a systematic road map toward improved performance.

### **Process benchmarking in action**

Where would a behavioral health leader start in the pursuit of process benchmarking? For many, one’s own organization provides the initial breeding ground. Internal benchmarking is the practice of comparing similar functions within a single organization. Internal benchmarking offers the advantage of ready accessibility to personnel, records and data. Dialogue can easily be pursued.

For example, in one not-for-profit general hospital-based psychiatric setting in the Midwest, it was learned that an adult partial-hospitalization program was experiencing a decline in full-time enrollment and a corresponding increase in “part-time” patients in its three-hour intensive outpatient program (IOP). Its patient mix had declined to 20 percent partial-hospitalization days vs. 80 percent IOP visits. This trend became a pressing concern, so it was decided to carry out an informal internal benchmarking study with the two other adult partial-hospitalization programs in the system.

Both outcome and process variables were reviewed. While it was found that the other two partial-hospitalization programs were also experiencing a shift in patient mix, their ratio was holding at a much more favorable 50/50 between partial hospitalization and IOP patients. A meaningful difference was found among the three, suggesting a potential loss of substantial revenue and possible

undertreatment of numerous patients in the program with a marked shift in utilization.

In terms of process variables, the declining program reported less success gaining approval from managed care companies for partial hospitalization than did the other two programs. It was anticipated that the differences might be explained on the basis of payer mix or clinical variables. However, the payer mix proved to be almost identical in all three programs. Clinical factors did not distinguish among the three programs either.

The only variables that were found to differ among the three programs were characteristics associated with the pre-certification process. The clinicians in the declining program did not know the managed care case managers personally, were not familiar with the managed care companies' admission criteria, spent less time on the phone pursuing approvals, were more likely to engage in argumentative discussion with case managers, and endorsed a negative view of managed care. In contrast, the clinicians in the other programs reported that they felt they knew the case managers reasonably well, had familiarized them-

selves with the admission criteria, felt comfortable providing more information to justify an admission, avoided confrontational dialogue, and harbored a generally positive attitude toward managed care. This factor "jumped out" as the salient process variable distinguishing the declining program from the other two.

Therefore, a performance improvement initiative was implemented, starting with a presentation of the obtained data to the head of the declining program. He was surprised at the findings and was not aware that attitudes might have affected pre-certification outcomes. He established a plan to implement the "best practices" demonstrated by the other two programs and, within three months, the patient mix in his program was approaching the same 50/50 partial hospitalization/IOP ratio reported by the other two programs. This improvement provided some validation for the findings of the study and the value of the benchmarking project.

Internal benchmarking, however, has serious limitations as a performance improvement tool. Most systems are not large enough to provide sufficient comparison

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points with respect to process variables. Also, there tends to be a good deal of homogeneity within a given organization. “Best practices” may prove to be elusive. Therefore, benchmarking generally requires looking beyond the boundaries of one’s own organization.

Organized systems of care and professional associations provide good opportunities for like-minded individuals to pursue process benchmarking efforts. There are many psychiatric hospitals and mental health organizations that function relatively autonomously and yet are part of a regional or national system. These systems provide an excellent basis for communication and coordination of efforts in support of benchmarking endeavors.

Professional organizations present similar opportunities. Mental Health Corporations of America has implemented an innovative voluntary “peer review” program. Its purpose is to establish small teams of mental health organizations that site-visit one another and provide helpful feedback. While not a quantifiable process benchmarking study per se, this informal system clearly draws on the value of comparative data.

### **The role of technology**

The Internet represents an invaluable new vehicle for a vastly greater presence of process benchmarking efforts. Even fairly complex comparative or process surveys can quickly and relatively easily be web-administered to large numbers of organizations throughout the United States (or globally).

Data can be downloaded directly into databases and efficiently analyzed. Findings can promptly be disseminated electronically to participants. While process benchmarking efforts have historically taken months and even years to plan and implement, now these initiatives can often be carried out and completed in a matter of weeks.

### **The future of benchmarking**

Benchmarking as a management tool may be poised for a period of heightened visibility and popularity. In the past five years, there has probably been more foundational work carried out in the benchmarking arena than in any previous period. Professional associations, the federal government, and grant-funded projects are introducing greater numbers of individuals to the power of benchmarking. With the Internet as a major catalyst, the potential seems virtually unlimited.

Behavioral Pathway Systems (BPS) is an organization that recently expanded upon its role as an ORYX (Joint Commission on Accreditation of Healthcare Organizations) performance measurement system to devote significant energies to behavioral health benchmarking. BPS is preparing to make available to the industry an extensive array of comparative and process benchmarking data spanning the operational, financial and clinical domains.

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British novelist George Eliot once said, “We judge others according to results; how else? — not knowing the process by which results are arrived at.” The practice of benchmarking now offers the potential to take us “beyond outcomes” by opening the door to the processes that underlie them. In doing so, benchmarking can offer significant contributions to excellence and efficiency in behavioral healthcare. This appears to be a propitious time for the further development of benchmarking as an art and a science. ©

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