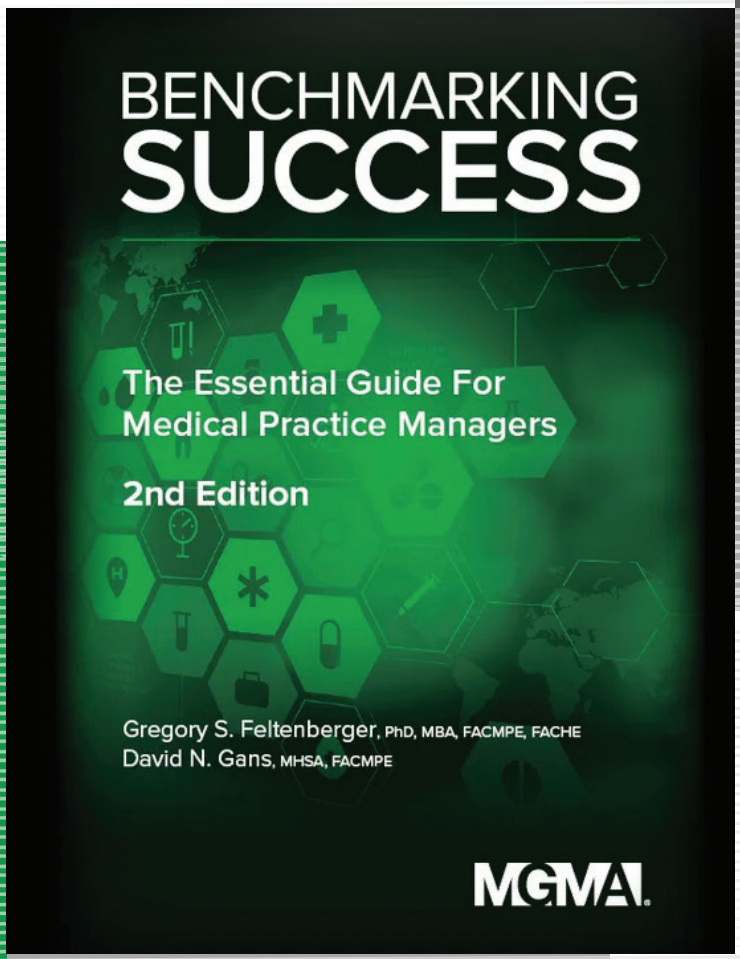
WHY BENCHMARK?

CHAPTER 1



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"When you're finished changing, you're finished." — Benjamin Franklin

"Insanity: Doing the same thing over and over again and expecting different results." — Albert Einstein

Why benchmark? There are many reasons to benchmark (compare a selected set of criteria against a given standard) in any medical practice. For example, a practice may want to determine how the billing office performance or physician productivity compares to other practices. Practices use benchmarking to gain a deeper understanding of where they are, where they want to go, and how to they will get there. The complexity of healthcare dictates practices use more sophisticated and accurate methods of measurement, analysis, comparison, and improvement. Since a practice's long-term success is directly related to its ability to identify, predict, and adjust for changes, benchmarking, when used properly, is the best tool for overcoming these challenges.

This book is meant to be a desktop reference for medical practice benchmarking. It hopes to "set the standard" by eliminating ambiguity in healthcare measurement.

Two key principles of benchmarking are

1. If you don't measure it, you can't manage it and
2. if you don't value it, you won't change it.

These principles have been applied to other industries for many years and are ideally suited for use in healthcare. It has been said that healthcare is the only service industry that doesn't treat itself like one. The healthcare industry may appear separate from other business sectors, but there are more similarities than differences. In the classroom, students are taught that managers manage processes and leaders lead people. The same can be said of the healthcare field—there are processes to be managed and people to be led. Like other service industries providing customers with services, healthcare too has customers (patients) who expect services (procedures and treatments).

IF YOU DON'T MEASURE IT, YOU CAN'T MANAGE IT

To manage something, it is necessary to know what it is, where it is in relation other things, and describe how it got there. This can be accomplished through measurement and benchmarking (see Exhibit 1.1). Proper practice management requires the use of subjective and objective measurement, analysis, comparison, and improvement.

For example, if you want to reduce a given set of supply costs, you would first identify and define these costs. In this case, supply costs are defined as any disposable medical item used to provide clinical services to patients. Supply cost can then be calculated using a formula for average daily cost of supplies used per provider and per patient. Comparing this to historical data, it is possible to determine whether costs are increasing and to what degree. If costs are increasing, it would then be necessary to explore the context surrounding this increase—increase cost of items in question, increase in number of patients treated, etc.

Exhibit 1.1 Questions to Help Answer, "How It Got There?"

- How important are the supplies to the providers?
- How long has the practice done business with the supply company?
- How competitive is the local supply market?
- How was the practice's business arrangement with the supply company setup?
- Does the practice have a contractual agreement with the supply company? If yes, when does it expire?
- What internal controls are in-place to manage costs for purchasing and inventory functions?
- What factors could be causing high supply costs (e.g., theft, waste, disorganization, spoilage [pharmaceutical inventory], obsolescence, or kickbacks between the supply company and clinic personnel)?

IF YOU DON'T VALUE IT, YOU WON'T CHANGE IT

Driving change in a practice will affect every member of the organization and many will resist; therefore, the value of instituting a change must outweigh the status quo. Measurement and benchmarking are not the final step in the process—they simply enable the process to evolve toward action. Measuring and benchmarking is an activity performed in vain if something isn't done with the findings. Ideally, the results should be used to support change; however, they can be used to validate past changes or support the current status quo. Once the benchmarking process is finished, the practice can select the areas to focus its efforts, create buy-in, and start the process of improvement—or repeat the entire benchmarking exercise in the process of continuous improvement.

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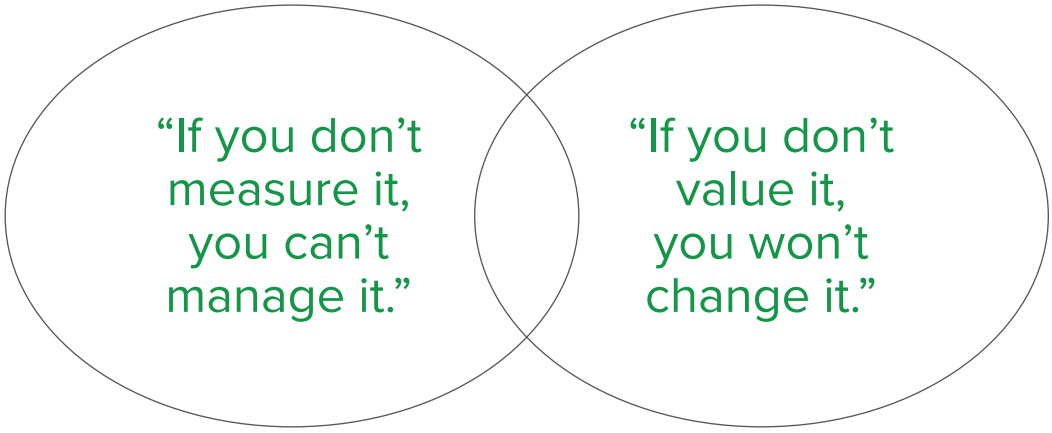
What can be done with the findings? Options include:

1. Drive and/or support change,
2. educate staff,
3. gain credibility with your physicians.
4. validate the past.
5. build buy-in with the staff.
6. conduct performance reviews, and
7. plan for the future.

When using the key benchmarking principle — "if you don't measure it, you can't manage it" and "if you don't value it, you won't change it," it is imperative to understand interrelationships (see Exhibit 1.2). First, proper management requires some degree of measurement to ensure the thing you're interested in measuring is well understood (for example, is an FTE clearly defined as working 40 hours/week or only 32?). Second, once measurement is taken, management must decide whether the value of pursuing change is worth disrupting the practice's normal routine in the quest for improvement. And third, if management feels value can be realized by making a change, it is important that a sense of value be instilled with physicians and staff—without their commitment, the change will never be fully realized.

This is key. Processes can easily be changed, but it is only with the support and buy-in of physicians and staff that real improvement can be achieved. It is an old U.S. Army saying that, "If you take care of your people, your people will take care of you." Conversely, if you don't take care of your people, your people won't take care of you.

Exhibit 1.2 Relationship Between Key Benchmarking Principles



People naturally resist change and there are several reasons for this. They may fear a loss of control or discomfort from uncertainty.1 If the change comes as a surprise to the staff, they will likely resist and/or seek to undermine any changes.[1] Some staff might be emotionally invested in a current process or may consider change a threat to their abilities or competence.[1] Change can often be interpreted as a disruption that will create more work.[1]

Organizational commitment is necessary to drive change (see Exhibit 1.3). That is, the organization must feel strongly that change is needed, be focused on discovering what it wants or needs to change, and has developed a vision and expectations for the organization's future.[2] Acceptance of the change's benefits, ability of the organization to change, and a commitment to improve can be demonstrated best by showing disbelievers an organization that has already implemented the proposed change—via a field trip, for example.[2]

Exhibit 1.3 Methods of Facilitating Change[1]

- Involve providers and staff in the process
- Communicate, communicate, communicate
- Communicate early and regularly
- Explain purpose
- Establish expectations
- Ask for comments, suggestions, and involvement in process
- Dissect and implement change into manageable parts
- Be patient
- Identify “star performers” and recognize them publicly
- Ensure resources and training is available to achieve goal
- Remain flexible
- Focus on the future; don’t dwell on the past

The importance of creating buy-in and facilitating change must be seriously considered and built into the change process. For instance, the change driver (typically an administrator) must understand staff will have strong emotional reactions toward change and will often perceive it as a threat.[1] Therefore, the administrator must fully explore the underlying feelings and perceptions of providers and staff.[1]
To maximize acceptance, the administrator should

- Solicit providers and staff for feedback and suggestions,
- explain the reasons behind the need for change, and
- involve all members in the process as much as is reasonable based on the planned timeline.[1]

1. D. Balestracci and J. Barlow, Quality Improvement, Practical Applications for Medical Group Practice, 2nd ed. (Englewood, CO: Center for Research in Ambulatory Health Care Administration, 1998).
2. R. Camp, “Best Practice Benchmarking: The Path to Excellence.” CMA Magazine, 72, no. 6 (1998): 10.