Benchmarks:
Using Benchmarks to create a High-Performing System
Agenda

• Our Ultimate Goal
• Types of benchmarks
• Uses of benchmarks
• Examples of benchmarks...in ACTION!
Ultimate Goal
“The goal is to provide affordable health care by rewarding providers for healthy outcomes rather than volume,” Jeppesen said.

Source: https://www.idahopress.com/eyeonboise/new-idaho-h-w-chief-many-people-have-asked-me-why-i-took-this-job/article_be64bf7f-9306-5321-9f30-94d30835c33c.html
Benchmark Types
Benchmark Types

Two major types:

• Norm-referenced

• Criterion-referenced
Norm Referenced

- Benchmark based on group performance
- The ‘norm’ typically refers to a performance average
- May also refer to an accepted industry standard

Source: Institute for Healthcare improvement
**Criterion Referenced**

- Benchmark based on external criterion
- Typically, this criterion is, or predicts, a meaningful outcome

*Source: Institute for Healthcare improvement*
In this example, if our standard was the system norm, half the programs would not have to improve even though none are at the Criterion Benchmark of an effective system.

Even worse, we would likely never reach the Criterion Benchmark of an effective system.

So how do we effectively use these two types of benchmarks to improve system performance?
Benchmark Uses
Benchmarks typically used for change

• Benchmarks are used to see how far a program is from a standard for care

• Then we can see how much change is necessary to meet the standard

• A frequently forgotten variable in the rush to use benchmarks for change is... Resources
Benchmarks typically used for change

• It’s hard for people to shift habits, even harmful habits

• The more different the practice standard is from people’s current habits, the more time and effort needed to change current habits

• New practices have to compete with current ones
Matching Resources to Change

*Systems consistently underestimate the need for clear messaging, policy review and improvement, and ongoing re-skilling of practitioners.*

<table>
<thead>
<tr>
<th>Resource – Change Alignment</th>
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<tbody>
<tr>
<td><strong>Small Change (5-10% improvement)</strong></td>
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<tr>
<td>Outcome monitoring, ongoing multi-level discussions, local responsibility for solutions</td>
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<tr>
<td><strong>Medium-sized Change (10-15% improvement)</strong></td>
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<tr>
<td>Outcome monitoring, multi-level consultation w/ outside experts, specific evidence-based practices targeted for use</td>
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<tr>
<td><strong>Large Change (15-20% improvement)</strong></td>
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<tr>
<td>Fidelity and outcome monitoring, multi-level competency-based training with ongoing consultation (CoP), buy-out of staff time, evidence-based practices with local adaptations, state policy alignment with new practices</td>
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*for IDHW*
Benchmarks at Work

- **System** would need high resources and effort for **five-six years** to hit criterion benchmark
- Some programs could get there in as little as a **year**; others would take **25 years**
Change Timeline = 
(Criterion Benchmark – Normative Benchmark) 
/ Level of Resources
Improve from 30% effectiveness to 60% effectiveness

Means *doubling* current effectiveness

100% Change / 20% Change per Year = 5 Years
(based on High Resources for change)
The NORMS based benchmark tells us that as a system we need to generate sustained effort at change for the next five years to become a high-performing system.
We also need to target expected change based on current performance.

One size does **NOT** fit all.
Variation in Approach

- The same approach will not work for programs at different levels of performance.
- Using same approach would mean some never change, others never achieve.
<table>
<thead>
<tr>
<th>Resource Level</th>
<th>High Resources</th>
<th>Medium Resources</th>
<th>Low Resources</th>
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<tbody>
<tr>
<td>20%</td>
<td>1 Year</td>
<td>2 Years</td>
<td>4 Years</td>
</tr>
<tr>
<td>100%</td>
<td>5 Years</td>
<td>10 Years</td>
<td>20 Years</td>
</tr>
<tr>
<td>500%</td>
<td>25 Years</td>
<td>50 years</td>
<td>100 years</td>
</tr>
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As a system you have to define your approach for high performing average-performing and deeply underperforming programs.
You kill the will to change when you treat a high-performing program like an underperforming program.
Benchmarks in Action
Benchmarking Ex.: Initial Tx Dose

What type of benchmark would we use to figure out where we’re at right now?

- Normative or Criterion

What type of benchmark tells us where we want to be?

- Normative or Criterion
Benchmarking Ex.: Initial Tx Dose

Right now we’re at:

• 30% of youth receive 3+ Tx sessions in the first 30 days of care (normative benchmark – our average across all providers)

We want to be at:

• 60%+ of youth receive 3+ Tx sessions (because it predicts effectiveness, and high-performing systems effectively treat 60%+ of the youth they serve – a criterion benchmark)
Benchmarking Initial Tx Dose

What do we still need to know to begin to set up an effective system improvement response?

a)  
b)  
c)
Benchmarks: Our Goal

- **Criterion-based** benchmarks focus attention on creating effective care (healthy outcomes)
- **Norm-based** benchmarks help us gauge the effort needed to get to the criterion

“The goal is to provide affordable health care by rewarding providers for healthy outcomes rather than volume,” Jeppesen said.
References

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