



HEALTHCARE

Benchmarking In Hospitals: More Than a Scorecard

by **Victor E. Sower**

If you look at many hospitals' websites and other resources they make publicly available, you will often see charts, graphs or tables showing hospital performance on some metric compared with a national standard.

An example is Table 1, which was taken from a hospital website and compares patient satisfaction in numerous areas with the national average. The hospital highlighted the areas in which it exceeded the national average.

In 50 Words Or Less

- **Benchmarking should not just involve comparing your hospital with national averages; it should involve looking at best in class hospitals and finding out what they do.**
- **Hospitals shouldn't limit their benchmarking to just the healthcare industry; there's much to learn from the service industry, too.**

TABLE 1 Benchmarking Outcome Measures

Item	Our hospital	National average
Overall patient satisfaction	84.9	82.5
Check-in	82.0	79.0
Nurses	79.3	84.4
Doctors	84.1	85.4
Tests	85.5	85.8
Family or friends	88.9	85.5
Waiting time	83.6	87.5

Black: Our hospital lower than national average

Blue: Our hospital higher than national average

The term "benchmarking" is often mentioned in hospital quality literature, but the process of benchmarking is often misunderstood. True benchmarking is not simply comparing outcome measures with industry averages.

ASQ defines benchmarking as "a technique in which a company measures its performance against that of best in class companies, determines how those companies achieved their performance levels and uses the information to improve its own perfor-

mance. Subjects that can be benchmarked include strategies, operations and processes.”¹

Doing a simple comparison with a national average is more like a scoreboard showing who is winning. It only answers the question “Am I above or below average?” This doesn’t tell the hospital how to improve operations. The approach might be of interest to the general public, government and accreditation agencies, but it is of limited value as input to a hospital’s process of continuous quality improvement (CQI).

Ask yourself which would contribute more to your CQI program: knowing your hospital is slightly above average nationally in controlling Methicillin resistant Staphylococcus aureus (MRSA) or understanding the processes that the University of Virginia Hospital used to achieve best in class MRSA control?²

There is value in comparisons with national averages. Residents of the hospital’s service area can judge the quality of the hospital compared with national averages. The hospital’s quality director and quality improvement teams can use this information to determine which areas most need improvement. The improvement efforts’ progress can be monitored over time to determine whether the actions taken are effective in closing the gaps between a hospital’s performance and national averages.

However, for all its usefulness, comparison with national averages is insufficient. Meeting the national average does not equate excellence. It might not even equate sufficiency.

A Canadian study found that 7.5% of patients experienced at least one adverse event because of medical errors in 2000.³ If your hospital has a medical error rate of 7%, it is better than the national average. Is that sufficient? Wouldn’t it be better to know what the error rate is at the best hospitals? Wouldn’t it be even better to understand how those best in class hospitals achieved the benchmark standard medical error rates?

The Leapfrog Hospital Quality and Safety Survey found that 50% of hospitals do not have procedures to prevent bedsores.⁴ If your hospital has any such procedures, you are above the national average. Is that sufficient? Wouldn’t it be better to know what the procedures are at the hospitals with the lowest incidence of bedsores?

Without information about the processes that the

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best hospitals use, we must approach improvement by reinventing the wheel. We are doomed to make the same mistakes other hospitals have made and learned from.

A problem with national averages is that we don’t even know which hospitals are the best performers and we don’t know what best in class performance is. National averages provide no measure of variation in performance and no information about the level for best in class performers. Variation in performance can be a bigger problem than average performance.

The Nebraska Medical Center’s interventional radiology department undertook a project to improve major problems in treatment delays, which were creating patient dissatisfaction and patients’ seeking treatment elsewhere.⁵ The department found it took an average of 1.4 calls to schedule an appointment. Further analysis revealed the standard deviation was 0.989 calls, with a maximum of seven calls.

After several improvement projects had been completed, the average was still 1.4 calls. However, the standard deviation had been reduced to 0.52 calls with a maximum of three calls. If they had used a comparison to national averages, the significant improvement in this process would not be visible.

Benchmarking is an improvement process in which an organization measures its performance against that of best in class organizations within or outside its industry, determines how those organizations achieved their performance levels, and uses that information to improve its own performance. Benchmarking can be a valuable tool in moving beyond national average performance to best in class performance.



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Best In Class

While it is useful to discuss improvement efforts with other hospitals that are nearby, easily accessible or otherwise convenient, to aspire for excellence you must compare yourself with excellent hospitals. One such best in class hospital is Robert Wood Johnson (RWJ) University Hospital in Hamilton, NJ.

RWJ received a 2004 Malcolm Baldrige National Quality Award. It had a quality program in place in 1999 that was based on five pillars of excellence—service, finance, quality, people and growth. But, looking for ways to better serve its customers, the hospital's management decided to use the Baldrige criteria as a "framework for leadership and acceleration of [its] quality journey."⁶

One of RWJ's achievements is best in class service in its emergency department (ED). Its 15/30 program guarantees every patient will see a nurse within 15 minutes and a doctor within 30 minutes of entering the ED. RWJ backs this program with an extraordinary guarantee—if it fails to meet the guarantee, the ED portion of the bill will be waived upon patient request. The hospital's payout is less than 1%, indicating it has a process in place to achieve the desired results. Patient satisfaction with ED increased from 85% in 2001 to 90% in 2004. Because 70% of the hospital's inpatients enter through the ED, this program has contributed to overall hospital success.

Another hospital has an average time from entering the ER to seeing a physician of 47 minutes. The graph on its website shows this is better than the national norm of about 55 minutes. Clearly, this is an above average hospital. But it is not best in class. It should benchmark against RWJ's best in class performance—not the national norm.

Inside or Outside the Industry

While numerous hospitals have been recognized for excellence—four have received the Baldrige award since 2002—other hospitals need not restrict their searches for benchmarking partners to other hospitals. Joseph Juran wrote, "As the health industry undertakes ... change, it is well advised to take into account the experience of other industries in order to understand what has worked and what has not. The health industry is different ... however, the decisive factors in what works and what does not are the managerial

processes, which are alike for all industries."⁷

For example, hospitals share several processes with hotels. The Ritz-Carlton Hotel Co., which received a Baldrige award in 1992, has approaches to employee training, room service, custodial services, customer orientation and quality metrics that hospitals could learn from. Disney is well known for employee training and customer orientation—both important to hospitals. Both of these organizations were used as benchmark standards by Bronson Methodist Hospital in Kalamazoo, MI—also a Baldrige recipient.⁸

Benchmarking is not just copying what other successful organizations are doing. It involves not just understanding what best in class organizations' goals are and how they have achieved those goals through process and operations improvement; it is also taking that information back to your own organization to determine how to achieve comparable results given your unique internal and external conditions. This process will make yours a better hospital.

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