

The IMPACT!™ Peer Group Selection Process

“Apples-to-Apples” Concerns and Peer Group Selection

Department directors have an understandable interest in assuring that the peer groups used to develop staffing comparisons are as much “like” their own hospital and department as possible. This is the challenge of benchmarking: Selecting peers that produce meaningful comparisons while recognizing the essential reality that all departments truly are unique. Literally hundreds of factors work to differentiate one department from another. IMPACT’s *Profile* database does not attempt to control for all of these factors because it is a practical impossibility¹. Instead, the peer group selection process focuses on the much smaller subset of productivity-defining factors found within basic organizational characteristics and the nature of the work to be done.

“Intrinsic Factors”

“Intrinsic factors” are those factors that broadly describe the work to be done. Here is an example applying both hospital-level and department-level intrinsic factors: “Provide inpatient nursing care to an average of 15 adult oncology patients in an urban teaching hospital with a case mix index of 1.2064.” IMPACT begins its peer group selection process on the assumption that all departments that generally match this set of intrinsic factors face the same basic challenges.

Hospital-level intrinsic factors are first used to select a potential peer group. These include such things as size, teaching status, setting (urban vs. rural), and case mix index. Then, within that group of initially-selected hospitals, a search for peers is launched employing department-level intrinsic factors such as the main work of the department, the amount of workload, and the number of locations staffed. It is worth noting that the department manager normally cannot change intrinsic factors, at least not routinely, and there are relatively few of them. *Intrinsic factors define the data points used by IMPACT in the peer group selection process.*

¹ Let’s walk through the process of putting together an *IMPACT* benchmarking report for a surgical nursing unit in a relatively small teaching hospital to illustrate the consequences of adding selection criteria to any peer group selection process. We begin with an IMPACT database of 25,886 department records. When we ask the database to list *all inpatient nursing units*, we find there are 5,724. When we add setting and teaching status to the selection criteria by asking *IMPACT* to list *all inpatient nursing units in urban teaching hospitals*, the number of eligible records shrinks to 1,603. Adding hospital size to the selection criteria by telling the database to list *all inpatient nursing units in urban teaching hospitals with an average daily census equal to or greater than 75 and less than or equal to 150* reduces the number of qualifying records to just 272. But we are looking for a particular type of inpatient nursing unit, so we ask *IMPACT* to list *all inpatient nursing units in urban teaching hospitals with an average daily census equal to or greater than 75 and less than or equal to 150 that are surgical nursing units* and we find that only 79 qualifying records remain. However, we know that a nursing unit’s average daily census has a tremendous impact on paid hours per unit of service, so we add unit census and ask the database to list *all inpatient nursing units in urban teaching hospitals with an average daily census equal to or greater than 75 and less than or equal to 150 that are surgical nursing units with a nursing unit average daily census that is equal to or greater than 17 and equal to or less than 25*. *IMPACT* lists 52 nursing units that fit all selection criteria. Please note that we have used only intrinsic factors to create the peer group. If we begin adding additional factors, the size of the peer group will shrink so much as to be statistically useless.

“Elective Factors”

Hospital governing bodies, managers and clinicians make choices in deciding how to do the job identified by the intrinsic factors. These decisions produce another set of factors (“elective factors”). Examples include (in all possible combinations and variations) the design of standard work processes, the information and clinical technology chosen, the mix of part-time and full-time staff, the qualifications and training of professional staff, staff to patient ratios, staff and work scheduling methods, design characteristics of the work place, treatment regimens and therapeutic agents chosen by clinicians, etc. There are potentially hundreds of elective factor choices and thousands of potential elective factor choice combinations available in any department. *Elective factors are not used by IMPACT in the peer-group selection process, but differences in elective factor choices always account for variations within peer groups in paid and worked hours per unit of service².* That is why systematic efforts to identify and resolve elective factors that impair optimum effectiveness (factors that can generally be changed) are recommended as a next step, beginning in those departments that report paid hours per unit of service greater than the peer group mean.

MANAGING BENCHMARKING VARIANCES

IMPACT’s peer group comparison range is defined by the mean and –1 standard deviation of observed performance as measured by paid and worked hours per unit of service. The mean was selected as the top of the range because most hospitals want to perform at least at the average level. The –1 standard deviation was chosen as the bottom of the range because it defines the lower limit of the average variance around the mean and excludes the “outlier” departments. Peer group mean and median numbers will be very close to each other assuming a normal distribution. When a department reports paid and worked hours greater than the mean, that result simply means that it is not in the lower half of departments in the peer group in terms of paid and worked hours per unit of service.

Here is a vital but often-missed fact: *The same performance limiting factors that produce unacceptable labor and other costs also create unacceptable results in the other critical outcome areas, including clinical and service quality, physician and patient satisfaction, employee relations and community image.* That is because the classical response of department managers attempting to compensate for performance inhibiting factors is to “staff up.” The popular belief that cost reduction efforts must adversely affect quality is simply wrong. So is the notion that the number of FTEs can be arbitrarily reduced without first resolving the performance inhibiting factors that led to their employment. Failure to do so will negatively affect performance in all critical outcome areas, sometimes catastrophically. *Staffing variances can be used as a marker to identify potential improvement opportunities in all critical result areas, not just in labor costs.* That is the true value of benchmarking³. Systematically identifying and resolving performance limiting factors will simultaneously reduce costs and improve performance in all critical outcome areas.

²It is possible to spend a great deal of time and money in an effort to import “best practices” solutions from other hospitals as an expedient way to improve performance quickly. Although this approach seems practical, it can be problematic. Because each hospital has unique characteristics and because of the number of complexly-related variables that define the limits of attainable productivity in any department, it is not likely that isolating and importing a “best practices” solution from another hospital will produce a better result than improving variance producing factors internally. Mercedes-Benz may have the very best suspension system available, but it won’t help improve your ride if your car is a Buick and the Mercedes-Benz system doesn’t fit.

³IMPACT’s follow-on services employ comparative data, systems thinking, and progressive management methods to promote positive cultural change and improve organizational effectiveness. The numbers are only the beginning. Call (816) 587-2120 for additional information.