

# **PROCESS BENCHMARKING INITIATIVE**

**CLIENT ENGAGEMENT AND RETENTION**

**FINAL REPORT**

**NATIONAL COUNCIL  
FOR COMMUNITY  
BEHAVIORAL HEALTHCARE**

**Report Prepared By**

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**Introduction**

A process benchmarking initiative was conducted by the National Council for Community Behavioral Healthcare in partnership with Behavioral Pathway Systems. The overall purpose of the project is to identify organizational strategies and practices that are associated with effective client retention/engagement. For the purposes of this initiative, retention/engagement was operationally defined as a planned discharge, rather than a unilateral termination by the consumer. This is an issue of vital importance since failure to successfully engage and retain the client represents a lost opportunity for providers, those served, and the broader community.

**Method**

Process benchmarking<sup>1</sup> is a structured applied research technique that is employed to identify potential best practices. The procedure involves identifying top performing organizations and then examining the methods and strategies that distinguish those top performers from others. The tactics that prove to distinguish between top performers and the rest may then be regarded as potential best practices.

A web-based survey was established to examine the practices that might be associated with the effective engagement and retention of adults receiving outpatient behavioral health services. Those receiving specialized services such as intensive outpatient, specialized case management, residential, etc. were excluded.

Participating organizations were asked to respond to a series of questions, such as, "Does your organization have a centralized scheduling system for the initial session?" with yes/no responses. The survey also solicited the percentage of adult outpatients with a planned discharge (rather than unilateral termination by the client).

The responses of those organizations with the highest retention levels were contrasted with a comparison group of organizations with a lower retention level. This was done by calculating the percentage of "yes" responses of top performing organizations to each question and comparing that value to the percentage of "yes" responses of the comparison group. Then the difference between the two percentages was calculated, producing a "Difference Index Score".

The Difference Index Score is used to gauge the degree to which each practice distinguished between top performers and others. The maximum Difference Index Score is 100, where 100% of top performers report employing a tactic in contrast to 0% of the comparison group. A Difference Index Score of 20 is regarded as suggestive of a potential best practice.

Notice of the on-line survey was disseminated via e-mail to the National Council's membership listing on September 4, 2008. The deadline for responding was September 26, 2008.

## **Findings**

The on-line survey brought 184 respondents of which 178 completed the survey items related to potential best practices. Of those that completed the survey, 72 provided the key engagement/retention percentage. To optimize the contrasts between top performers and the comparison group, a range of respondents in the middle of the distribution was excluded from the analysis. Therefore, the average engagement/retention rate of the top performers was 90.6% versus 52.9% among those in the comparison group. These two groups therefore presented real differences in performance and, as it will be demonstrated below, their methods as well.

Thirty-two organizational tactics that might be related to client retention/engagement were explored using the process benchmarking approach. Difference Index Scores were found to range from 35 to -23. The findings are presented in Appendix A. It may be seen that the difference index scores of eight of the methods exceeded 20, which is suggestive of a potential “best practice”. Top performers were up to eight times more likely to make use of these promising methods than those in the comparison group.

The methods that were indicative of potential “best practices” were as follows, in descending order of Difference Index Score:

- Having clinicians call clients that no-show or cancel two times in a row
- Limiting the initial intake process to an hour or less, on average
- Making it a standard practice to personally introduce a client to a member of his or her treatment team during or immediately after the intake
- Having clinicians routinely call clients before the initial face-to-face appointment to introduce themselves and establish rapport
- Having staff routinely assess and discuss potential barriers to care with the client as part of the intake process
- Establishing an ACTIVE ongoing discharge planning process that is defined by policy and/or training
- Avoiding the use of voicemail at least 95% of the time when persons make their initial call to request outpatient services
- Implementing a standard, scripted approach that is used by clinicians when a client requests to reduce or terminate treatment

It should be noted that tactics that failed to produce high difference index scores may still be quite effective. This is particularly true of methods endorsed by high percentages of both the top performer and comparison groups (such as actively involving clients in the development of their treatment plans). While these methods apparently do not elevate the performance of top performers over others, as “customary practices” they may very well raise the level of performance across all organizations.

### **Break-Outs By Functional Category**

The thirty-two organizational tactics examined in this initiative fell into 4 functional categories: (1) initial telephonic request, (2) the intake process, (3) clinical service delivery and (4) staff qualifications and training. The following table presents the number of potential best practices that were identified in each category.

### Potential Best Practices Broken-Out by Functional Category

	Number of Survey Items	Number of Best Practices Identified	Percent
Initial Telephonic Request	7	1	14.3%
The Intake Process	9	4	44.4%
Clinical Service Delivery	11	3	27.3%
Staff Qualifications and Training	5	0	0%

The various functional categories varied considerably in terms of their contributions to potential best practices. Among the categories, practices associated with the intake process revealed themselves to have the greatest influence on client engagement and retention. Much has been written about the impact of first impressions in all facets of life. The intake process is where the first substantive impressions of the organization are formed. Organizations wishing to enhance their level of client engagement and retention may therefore wish to place special focus on the intake process.

#### Break-Outs by Population

Differences related to the substance abuse population were found to exist. Therefore, a separate analysis focused on organizations reporting that over 50% of their clients have a substance abuse diagnosis. Where notable disparities from the overall findings reported above were found to exist, they are noted in the discussion section below.

### Discussion

#### Review of Potential Best Practices

- **Having clinicians call clients that no-show or cancel two times in a row.** It is not surprising that this tactic emerged as the most compelling (Difference Index=35) of the potential best practices that were identified. After all, having the clinician call clients that have no-showed or cancelled twice ensures that concern and caring are communicated to those that are at the very greatest risk of dropping out. What is surprising, however, is that this practice is employed by so few organizations. Among the comparison group, only 32% of the organizations employ this method. Even among top performers, it is utilized by only 67%. There is much opportunity for more providers to adopt this method and nip potential drop-outs in the bud. This finding is highly actionable in that it would take relatively little incremental effort for organizations to adopt this measure. The initial attempt to call the client can be made during the hour of the missed appointment. It should be noted that, among substance abuse-oriented settings, a meaningful Difference Index score of 30 (57% vs 27%) was also found with respect to the practice of the clinician making calls to clients after every no-show.
- **Limiting the initial intake process to an hour or less.** This finding replicates a previous process benchmarking finding related to client engagement<sup>1</sup>. Organizations reporting the use of this method were three times more likely to be top performers. It appears to be very important to avoid overwhelming the client during his or her initial entrée into the system. Overpowering the client with an undue burden of questions, forms, and administrative requirements when rapport and trust need to be developing apparently enhances the risk of unfavorable outcome. This practice is also employed in relatively few organizations.

- **Making it a standard practice to personally introduce a client to a member of his or her treatment team during or immediately after the intake.** This finding again speaks to the vital importance of effectively establishing rapport at the outset of care. Fifty-three percent of the top performers use this method in contrast to only 24% of the comparison group. It also demonstrates that even a brief introduction to the primary caregiver, probably lasting no more than a few minutes, can favorably impact clinical outcome weeks or months later. This tactic was found to be particularly impactful in organizations focusing on substance abuse. In such settings the Difference Index was 56 (86% vs 30%).
- **Having clinicians routinely call clients before the initial face-to-face appointment to introduce themselves and establish rapport.** Organizations employing this method were over eight times more likely to be top performers. In fact, only 4% of the comparison group reported employing this method in contrast to one-third of the top performers. This finding represents further evidence of the importance of the initial rapport-building process. Again, this strategy was particularly effective in substance-abuse oriented settings where the Difference Index was 43 (43% vs 0%). This strategy represents one of the “leading edges” of best practice in the realm of promoting client engagement and retention. In process benchmarking studies conducted over the past few years, this tactic has evolved from being rarely reported to occupying a solid and consistent position as a contributor to positive outcomes, such as favorable discharge status and reduced no-show rates.
- **Having staff routinely assess and discuss potential barriers to care with the client as part of the intake process.** Ninety-three percent of top performers reported using this method as opposed to only 64% among the comparison group. In many instances, when clients suddenly discontinue services, the clinician is mystified as to the reasons. Carefully assessing and openly discussing potential barriers to care places these issues on the table and allows them to be addressed directly.
- **Establishing an ACTIVE ongoing discharge planning process that is defined by policy and/or training.** Eighty-seven percent of top performers employ this method while only 60% of the comparison group follow suit. Almost all clinicians would agree with the importance of ongoing discharge planning. What may account for the effectiveness of this particular practice is that it is not simply an ideal—it is a specific expectation defined by policy or training.
- **Avoiding the use of voicemail at least 95% of the time when persons make their initial call to request outpatient services.** While this tactic is observed by a large majority of organizations across both groups, it still differentiates between top performers and others (93% vs 71%). The “personal touch”, especially when first impressions are being formed, is apparently a determinant in successful outcome long after the initial call is made.
- **Implementing a standard, scripted approach that is used by clinicians when a client requests to reduce or terminate treatment.** This approach is not well-represented among either top performers or others (27% vs 4%). Yet those that reported employing this tactic were almost seven times more likely to be top performers. When a client raises the issue of termination, particularly when it is unexpected, it may be helpful for clinicians to have available guidelines for evaluating the clinical appropriateness of the request and collaborating with the client on a prudent decision.

- **Motivational Interviewing.** In the analysis of substance-abuse oriented settings, it was found that organizations that train their staff in motivational interviewing are more likely to be among the top performers in terms of engagement (86% vs 55%). This popular approach was developed specifically for those with substance abuse difficulties and the current data supports its differential use with that population.
- **Scheduling an initial appointment within 5 days of the initial call at least 75% of the time.** An INVERSE relationship was found to exist between the provision of prompt access to services and client retention/engagement (33% vs 56%). Paradoxically, organizations with better access demonstrated less favorable retention/engagement. This counter-intuitive finding may be due to the effect of self-screening on the part of clients. When delays are experienced in the provision of services, individuals with more marginal motivation might be more likely to screen themselves out prior to entering the system. That would leave the more highly motivated individuals in the system, producing higher rates of engagement/retention. While it would be unconscionable to suggest a policy of forced delays to screen out those with questionable motivation, some organizations have established an “intake group” to reduce the impact of no-shows for the initial intake and to provide information designed to assess and enhance the clients’ motivation for help.

### Evolution of Best Practices

The findings nicely illustrate the evolutionary nature of “best practices”. Some best practices appear to be in an early, emerging stage of adoption. An example of this is the tactic of having clinicians call clients prior to their initial session to introduce themselves and establish rapport. While organizations employing that practice were over 800% more likely to be “top performers”, the overall rate of adoption across all providers is very limited (under 20%). In contrast, other potential best practices evidence a more mature evolutionary state. For example, the practice of avoiding the use of voicemail in the intake process was found to be broadly utilized among both groups (over 75%), even though it did differentiate between top performers and the others. Over time, this method may very well continue to evolve into a customary practice, where it can be found in virtually all organizations, and no longer distinguishes between top performers and others.

### Summary of Findings

A broad array of strategies and tactics were identified that appear to drive client engagement and retention. However, appropriate caution must be used in interpreting and generalizing these findings. Findings should be regarded as hypotheses to be considered, tested, and experimented with in the ongoing pursuit of best practices and ongoing organizational improvement.

### Implementation Follow-Up

An examination was conducted of the impact of adopting the potential best practices that were identified in the process benchmarking exercise. Shortly after the exercise, a survey was sent to participants to solicit volunteers for a follow-up study. The objective was to determine if adoption of the practices that were identified would bring about improvement in engagement/retention. A total of 185 organizations responded. Of them, 178 reported that they would be implementing at least one of the potential best practices identified in the process benchmarking exercise. However, only 63 provided the requisite data to establish a baseline measure for engagement/retention.

Six months later, a follow-up survey was sent to the 63 individuals that had provided baseline data to solicit information about the potential best practices that were either adopted or

strengthened. A post-implementation measure of engagement/retention was also solicited at that time. There were 29 responses to the survey. However, only 11 provided the critical post-implementation measure of engagement/retention. Of those, only 9 could be matched with a submitted baseline measure. One respondent did not report implementing any of the potential best practices. Therefore, only 8 pairs of engagement/retention scores were available to determine the impact of implementing or strengthening potential best practices on engagement/retention.

Among those 8 organizations, it was found that engagement/retention improved slightly from a baseline rate of 69.25% to a six-month follow-up rate of 71.00%. That difference represents a positive change of 2.53%. However, due to the very small sample size, that difference was not found to be statistically significant ( $t=.2368$ ,  $df=7$ ,  $p=.8196$ ).

While a quantitative assessment of the impact of implementing potential best practices did not yield positive results, qualitative data offered by the respondents did point to substantive gains. Narrative comments were as follows:

- By focusing and implementing the best practices we have focused on, it has allowed us to strengthen our continuous quality improvement structure. We have also received more staff buy-in due to implementing these best practices and, most importantly, our addressing more of our client needs to improve the quality of their lives.
- The best practices that we strengthened have increased direct service hours for the clinicians
- Outreach to clients who no-show has helped keep some people in treatment longer, and it has eliminated people who really did not want to commit to treatment. We were unable to locate a large number of our drop-outs, so we do not know what led to their discontinuing treatment too soon.
- The no-show rate for intake appointments has improved considerably, thus providing more access to potential clients.
- I think it has made our workers more aware that there are practices that can impact treatment retention. I was surprised at some staff resistance to implementation. Staff seem to have a difficult time with change!!
- More clients are getting treatment that need it.
- Better communication, increased participation by clients, improved coordination of care
- We are hoping to see decreases in the no-show population but are still trying to see longitudinal data on these practices.
- People come for services not to help us with required documentation. The more we can quickly get to the former and the less time we spend on the latter then better.
- We are still developing EBP to work with the Providers in our System of Care Plan

In retrospect, it might have been helpful to build-in some type of vehicle to sustain the interest and commitment of the participants over the course of the project. It is quite possible that, with a larger sample size, statistically significant results might have been obtained. It should also be noted, however, that this initiative took place at a time of economic upheaval due to a severe recession and that participation may have lagged due to understandable focus on more immediate concerns.

Nevertheless, this project resulted in the likely implementation of potential best practices in almost 200 organizations throughout the United States. While the findings related to the impact of adopting such practices were inconclusive, narrative data point to meaningful and broad benefits. At the same time, the investment of time and resources in this project was minimal. Each participant completed three 10 minute surveys and read a brief report of the findings. Process benchmarking demonstrated its versatility in successfully identifying potential best practices and prompting implementation in the absence of any face-to-face


involvement among the participants. Therefore, “return on investment” appears to have been substantial. This initiative demonstrated the potential value of process benchmarking as a vehicle for organizational change in behavioral health and human services settings.

**APPENDIX A  
NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE  
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OCTOBER, 2008**

	Top Performers	Comparison Group	Difference Index Score
Do your organization's clinicians call clients that no-show or cancel two times in a row?	67%	32%	35
Does your organization's intake process take an hour or less, on average?	47%	16%	31
Is it standard practice in your organization to personally introduce a client to a member of his or her treatment team during or immediately after intake?	53%	24%	29
Do your organization's clinicians typically call clients before the initial face-to-face appointment to introduce themselves?	33%	4%	29
In your organization, do your staff routinely assess and discuss potential barriers to care with the client as part of the intake process?	93%	64%	29
Does your organization have an ACTIVE ongoing discharge planning process in place that is defined by policy and/or training?	87%	60%	27
Does your organization avoid the use of voicemail at least 95% of the time when persons make their initial call to request outpatient services?	93%	71%	23
Is there a standard, scripted approach used by clinicians in your organization when a client requests to reduce or terminate treatment?	27%	4%	23
Do your organization's clinicians call clients each time the client no-shows without canceling?	53%	40%	13
Does your organization consider itself an active proponent of the recovery model of care?	100%	88%	12
In your organization, is the time between the intake and the initial clinical service five days or less?	47%	36%	11
Does your organization have a centralized scheduling system for the initial session?	73%	64%	9
Does your organization have a "script" or standard description that is used by staff to explain the client's role or expected level of involvement?	53%	44%	9
Does your organization provide group intake sessions where general information about services, client responsibilities, etc. is provided?	20%	12%	8
Are your organization's staff specifically trained in motivational interviewing?	67%	60%	7
Do Medicare recipients constitute more than 15% of your organization's client population?	40%	33%	7
Do 70% or more of your organization's clinical staff have at least 3 years of experience?	93%	88%	6
Are your organization's clients ACTIVELY involved in the development of their treatment plans? (Client signature does not necessarily constitute active involvement)	93%	88%	5

	Top Performers	Comparison Group	Difference Index Score
Are the staff in your organization that handle initial requests for services able to provide an appointment time 95% of the time without having to call the client back?	60%	56%	4
Is it standard practice at your organization to conduct intake/assessment and the initial clinical service on the same day?	20%	16%	4
Does your organization provide staff with any special training in client engagement?	53%	52%	1
Does the client typically make contact with fewer than three staff during the triage and intake process in your organization?	87%	88%	-1
Does your organization use a signed agreement that explicitly outlines a client's participation and role in their care?	73%	76%	-3
Do staff within your organization receive specific training in principles of recovery?	73%	76%	-3
Does your organization have an annual operating budget for mental health/chemical dependency services exceeding \$20 million?	13%	17%	-3
When an individual makes the initial call to your organization for services, is the phone answered by a "live" person, as opposed to an automated system that will direct their call?	80%	84%	-4
In your organization, is an initial treatment plan known by the client at the conclusion of the intake?	60%	64%	-4
Is your organization able to schedule a face-to-face appointment within 10 days of the initial call at least 75% of the time?	87%	92%	-5
Do those that call for services get connected to the individual that will schedule their appointment without being transferred to somebody else at least 90% of the time?	73%	80%	-7
Is your organization's intake process typically conducted in one session?	80%	92%	-12
Do 50% or more of your organization's staff providing clinical services possess a Masters Degree?	67%	80%	-13
Does your organization have a dedicated intake team (as opposed to intakes being spread among outpatient staff)?	53%	68%	-15
Does the initial clinical session following the intake session typically last at least one hour in your organization?	80%	96%	-16
Is your organization able to schedule a face-to-face appointment within 5 days of the initial call at least 75% of the time?	33%	56%	-23

### Key

Very possible "best practice"		Possible "best practice"		No apparent relationship		Possible inverse relationship	
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## Reference

<sup>1</sup> Lefkovitz, Paul M. Process Benchmarking: Moving Beyond 'the Numbers'. Behavioral Healthcare Tomorrow, 2005, 14 (5): 18-23