

Hospital Performance: Theory, Evidence and Implications

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Roadmap

A. Theory (why, what, how)

- Why are we so interested in performance?
- What do we know about performance?
- How can performance be measured?

B. Evidence

- The French case

C. Implications

- Organizational, policy and conceptual

The why question

Why are we so interested in performance?

Renewing public administration

Changing the paradigm

“From the welfare state to the efficient state”

- A series of crises:
The crisis in public finance, the rise of neo-liberalism, questioning the role of the state, privatization vs. public services, patient safety
- A solution: The new public management

Looking at ways to improve
public service administration by introducing
management models from the private
sector

Consequences

Focusing on how to measure and improve the performance of public services

- Greater emphasis on outcomes and patient satisfaction
- New accountability mechanisms: The scope of accountability has grown from the traditional **analysis of means** (e.g., following budget rules) to an **analysis of outcomes**. The result is a broader accountability for achievements.
- Technical developments to operationalize the performance measure:
 - Quality of care, pay for performance, dissemination to the general public/hospital rankings

The what question

What do we know about
performance?

In management, there are 4 major views of how to define performance

Rational goal attainment model	Organizational performance depends on attaining organizational goals.
Internal process analysis model	Performance is measured by the quality of production processes and the quality of coordination in the organization.
Resource acquisition model	Performance is measured by the organization's ability to obtain the resources it needs to remain viable and develop.
Human relations model	Organizational performance is measured by the quality of the human dimension of work and the quality of the values shared across the organization.

Performance is therefore...

- Fundamentally multidimensional
- Partly oppositional
- The result of an optimal equilibrium rather than efforts to excel in all its dimensions
- Subject to different interpretations

A performance appraisal model should therefore be broad (complete, detailed, multidimensional) and integrated (understand the tensions and allow trade-offs) so that multiple views can be taken into account.

Inter-organizational performance

Networks, continuums of care, patient paths, etc.

- Relevance of concepts of inter-organizational performance
- Plus,
 - A need to distinguish 2 levels of analysis:
 - At the overall level (the entire network)
 - At the local level (the organizations themselves)
 - These levels generate inherent conflicts (oppositions) between the dimensions of performance
 - Presence of organizational cliques in the network

The how question

How can performance be
measured?

One solution:

Integrative performance appraisal models

- A case can be made for simultaneous consideration of apparently contradictory views of performance
- Reconciling the models of organizational performance

**There is a need for a holistic, configurational approach
manage the tensions between opposing requirements**



**ALL MODELS MUST BE
APPLIED AT THE SAME TIME**

A comprehensive integrated performance appraisal model

- Acquiring resources
- Adjusting to the public's needs
- Attracting clients
- Mobilizing the community
- Innovating, transforming

ADAPTING



- Effectiveness
- Efficiency
- Health equity
- Public satisfaction

ATTAINING GOALS

MAINTAINING VALUES

- Consensus on system values
- Organizational climate
- Work environment
- Health status of employees
- Job satisfaction

PRODUCING

- Volume of care and services
- Productivity
- Integration of production:
 - Technical quality:
 - Safety
 - Accuracy
 - Competent execution
 - Non-technical quality:
 - Continuity
 - Humanity
 - Comprehensiveness
 - Accessibility

Some applications of the model in Quebec

- **Commissaire à la santé et au bien-être du Québec**
 - A government function that measures health system performance (www.csbe.gouv.qc.ca)
 - Applied in 17 health regions
- **Provincial association of health facilities**
 - Conducts appraisals of all health facilities
 - Disseminates results to the general public
 - Promotes a continuous performance management process
- **Four regional health agencies**
- **Some two dozen health facilities**

Evidences

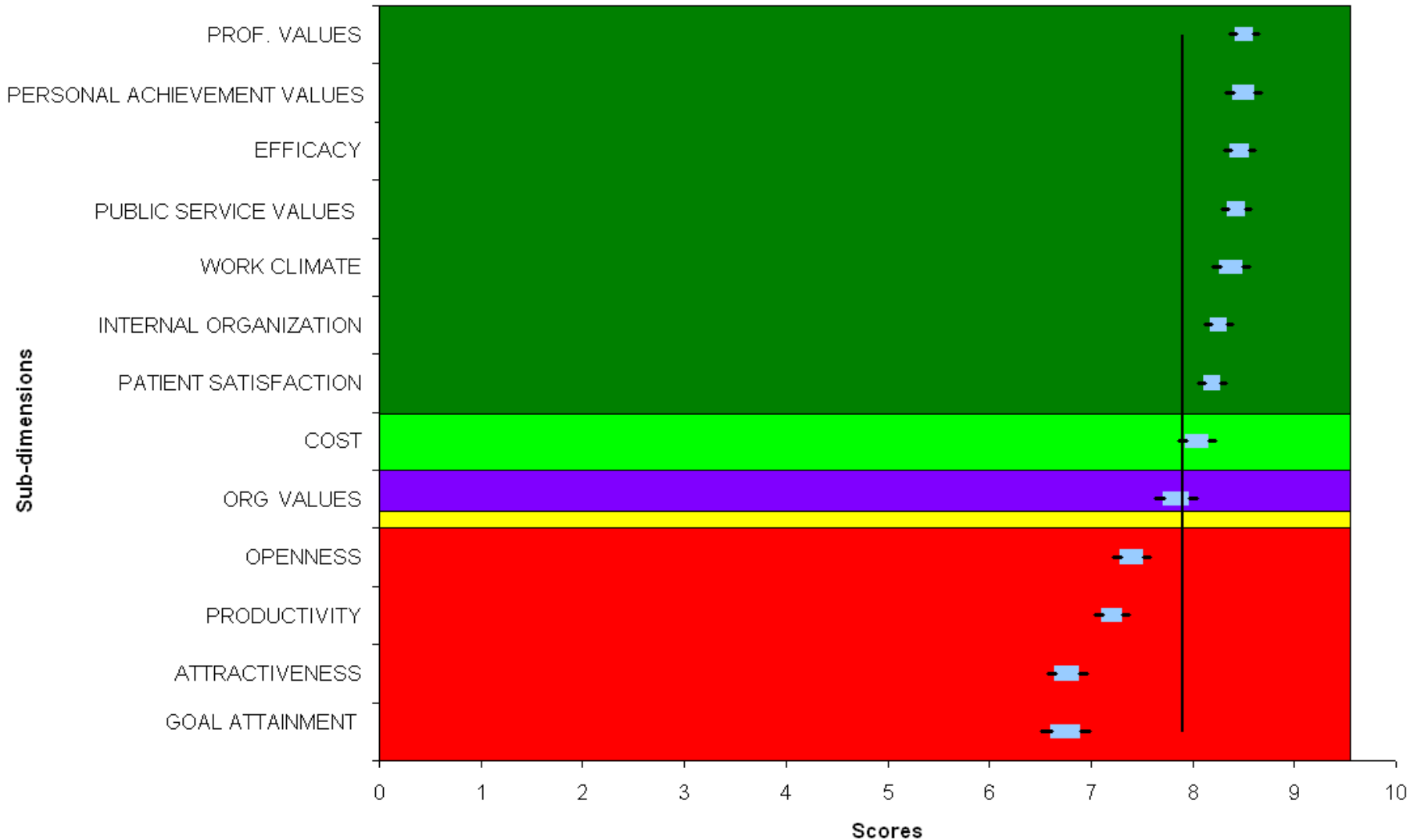
The French Case (2000-2001)

Hospital Performance: Competing or Shared Values? Minvielle E, Sicotte C, Champagne F., Contandriopoulos AP, Jeantet M, Préaubert N, Bourdille A., Richard C. *Health Policy*, 2008, 87: 8-19

Study design

- Bicêtre Hospital = a teaching hospital
- Qualitative Analysis (80 interviews) : key-stakeholders, Canadian framework, Transcription with Nud'Ist logiciel
- Quantitative analysis (questionnaire) :
 - Response rate: 46,6% (419/900)
 - Validation of the questionnaire: Factor analysis with varimax
 - Comparison of stakeholder: Rank order

Ranking of the 13 sub-dimensions into 5 groups (according to the confidence intervals of mean scores)



Five « best » and « worst » items

5 items with highest mean scores

M

- | | |
|--|------|
| 1. Staff preserve patient dignity and confidentiality | 9.31 |
| 2. Providing care at all times and continuity of care | 9.21 |
| 3. Staff is empathetic to patients | 9.15 |
| 4. Striving to improve both curative and preventive care | 9.08 |
| 5. Providing care to all patients without discrimination | 9.05 |

5 items with lowest mean score

M

- | | |
|---|------|
| 1. Well regarded by the media | 4.93 |
| 2. Attracts the most renowned hospital managers | 4.94 |
| 3. Develops a large service volume to maximize reimbursement | 5.52 |
| 4. Short length of stay compared to peer healthcare organizations | 5.79 |
| 5. Care unit managers are widely renowned | 5.94 |

Mean score for each sub-dimension and ranking of sub-dimensions by stakeholders

Sub-dimension (Dimension)	Mean score			Ranking		
	n	Mean	SD	Care-givers (n=300)	Physi- cians (n=54)	Administr ative staff (n=48)
1. Professional values (IV)	402	8.51	1.09	1	2	3
2. Personal achievement values (IV)	402	8.50	1.30	2	1	1
3. Efficacy/Effectiveness (I)	402	8.46	1.13	3	5	4
4. Public service values (IV)	402	8.43	1.11	5	3	5
5. Work climate (IV)	402	8.38	1.41	4	8	2
6. Patient satisfaction (I)	402	8.27	1.09	6	4	6
7. Internal organization (III)	402	8.25	1.05	7	6	7
8. Costs/efficiency (I)	402	8.04	1.38	8	7	9
9. Organizational values (IV)	401	7.84	1.58	10	9	8
10. Openness (II)	402	7.40	1.36	9	11	10
11. Productivity (III)	402	7.20	1.30	11	10	12
12. Attractiveness (II)	402	6.77	1.51	12	12	13
13. Goal attainment/Output (I)	402	6.75	1.84	13	13	11

Findings

- Shared Values (professional and public service) and Organizational climate ++
- Consensual view of hospital performance among stakeholder groups
- Further studies for validation

Implications

The
organizational
implications

1. Feasability of building a performance system

- How to implement the data collection in daily activity ?
 - Practical work is time consuming
 - Same indicators for different objectives
- Who is involved in the design and the monitoring phases ?
- Which priorities ?
 - Institutional (e.g. cost control)
 - and/or Internal (e.g. organizational climate) ?

1. Feasibility of building a performance system

Suggestions:

- Small number of targets
- Foster self-comparison and benchmarking
- Professionals should be involved in the assessment of comparative performance

2. Information System

- Depends on Infrastructure and skills
- Quality of information systems determines the scientific credibility of measures

**Expand human resource skills in information and IT,
but:**

- (Doesn't) Start with data in hand – (and) but don't neglect better indicators
- The cost of building up such data systems must not be

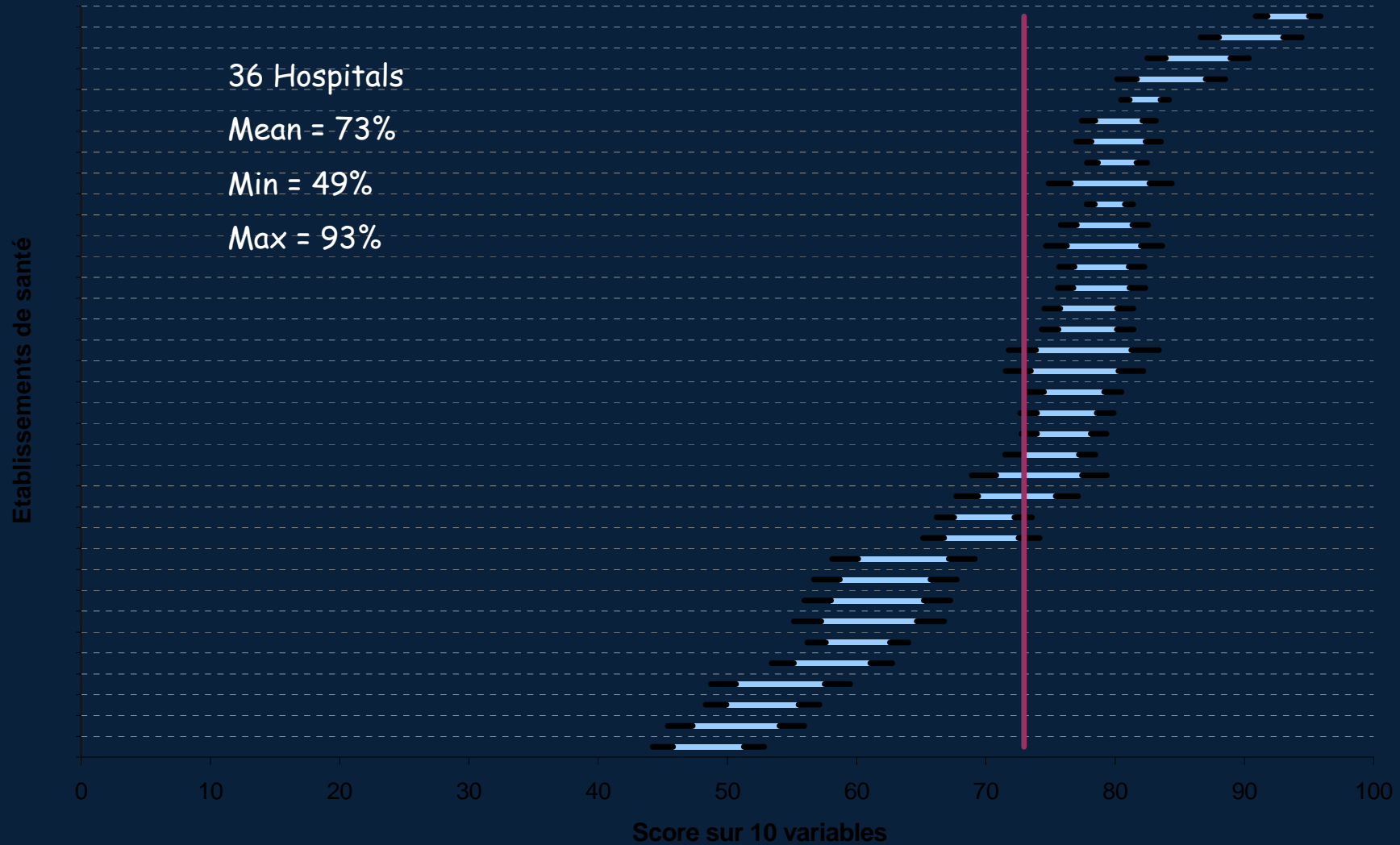
3. Statistical constraints

- Parsimony before comprehensiveness:
Analysis before adjustment
- Think “outcomes”; use “output” and “process” indicators as proxies

Variability between hospitals

« Quality of the Patient record »

Aggregated Score (10 variables)



Source Compaq-2005

4. Measurement and Performance Improvement

- Indicators= “Flag”
- Time lag between action and evaluation
- Possibility to identify corrective actions behind the evaluation
- The notion of ” Sense-making ”

Implications

The policy
implications

1. Accountability and Performance improvement

- Less professional 's autonomy, more public control=

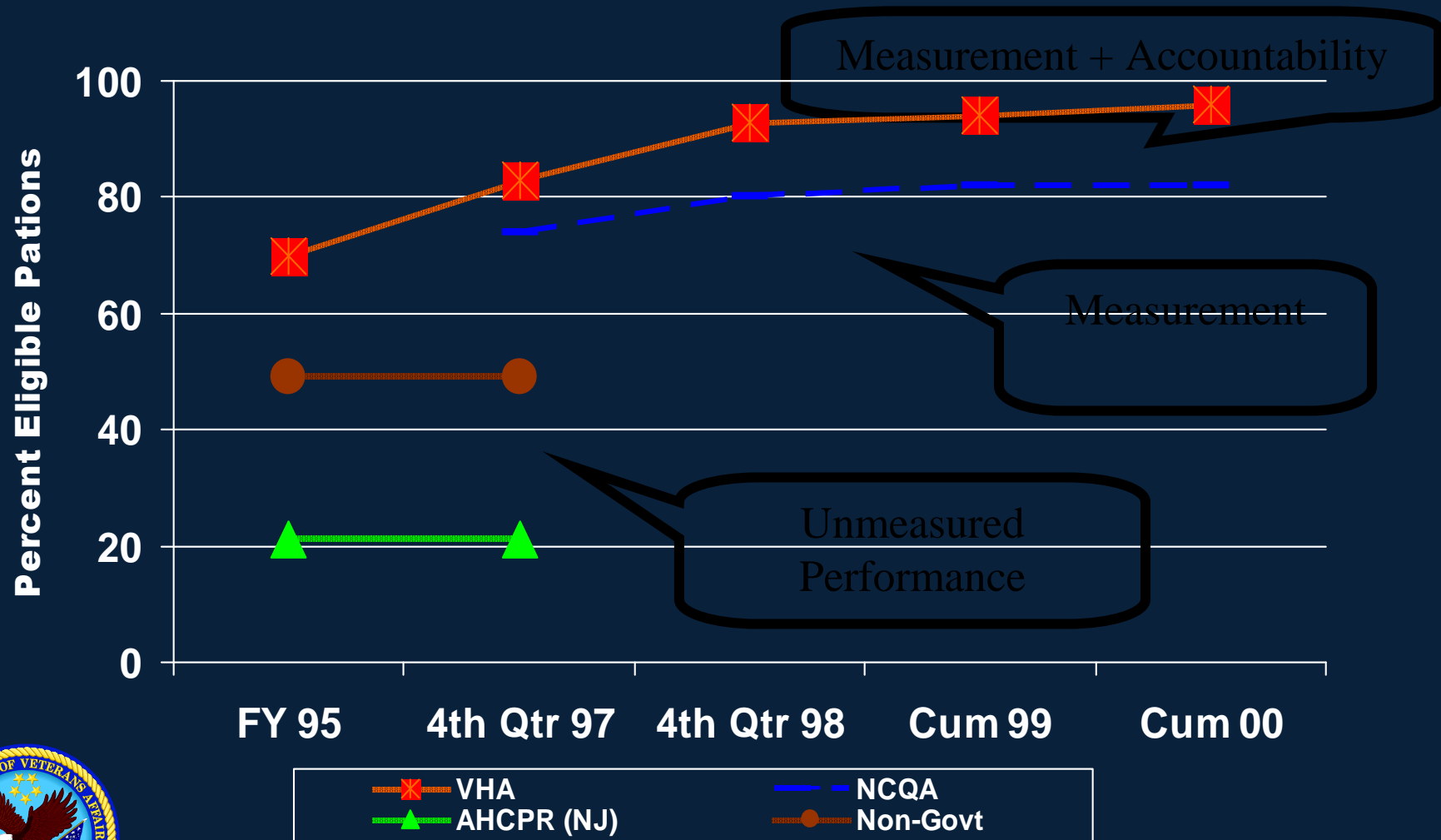
Accountability

- Objectives of Accountability :
 - Transparency (democratic rationale) ++
 - Consumer choice (concurrence rationale) +/-
 - Professionnal incentive (competitive rationale) ++

1. Accountability and Performance improvement

- Governments wish to aggregate and go quickly
- Patients wish to disaggregate and go quickly
- Providers wish to analyze and go slowly

Beta Blocker following AMI in VHA Medical Centers



AHCPR: Soumerai *et al.* JAMA 1997;277(2):115-21
 Non-Govt: Krumholz HM *et al.* Ann Int Med 1999;131(9):648-54

2. Improving Performance: A dilemma for policy-makers ? The case of cost-quality trade-off

Expected results:

- Choice of providers according to a cost/quality ratio;
- Ability to reward and to penalize providers
- Selective contracting:
 - A given provider can be performing well on a given set of activities, but not for all.

2. Improving Performance: A dilemma for policy-makers ? (2)

The public monopoly:

- There is political pressure to offer high quality by all providers;
- If a provider has low quality and low costs, the payor has to fund quality improvement
- Low quality and high costs providers should be penalized
- High quality and low costs serve as references
- What about high quality/high cost providers?

2. Improving Performance: A dilemma for policy-makers ? (3)

- In any cases, average quality and costs increase
- But high quality does not systematically mean high costs. (e.g. high volumes may be associated with high quality and lower unit costs)
- Different quality also requires different incentives:
 - iatrogenic risk = a minimum level required
 - satisfaction = excellence

Conceptual implications

- Getting beyond simple lists of a-theoretical performance indicators
- Need for restraint: the tension between a reductive vision and a detailed vision
- Search for coherence between how performance is conceived within the organization and how it is conceived outside the organization
- The quality/performance/efficiency chain

Comments
&
Questions