

Hospital Report 2003-05

First Principles

The following first principles provide guidance about the design and selection of indicators for quadrants and sectors in Hospital Report. Their purpose is to encourage use of rigorous research and development processes and to increase coherence and consistency among indicators. They are not requirements but rather a set of criteria that teams can use to test whether existing indicators should be retained and to select new indicators. Below are statements of ten principles and questions that test whether indicators meet the principles.

- 1) Hospital Report is designed for use by the hospital board and senior management. The needs of the Ministry of Health, the public, and others inform but do not, alone, determine Hospital Report content.

Question: Are the board and management likely to use this indicator? If no, should it be replaced?

- 2) Hospital Report indicators relate to long-term hospital strategies and priorities that are grounded in the real world. Indicator selection is guided by what is important to hospitals and the health system. Indicators that address significant research issues are acceptable if they have practical implications for hospitals.

Question: Does this indicator relate to hospital strategies or priorities? If no, should it be replaced?

- 3) Hospital Report indicators are relevant to most services in most hospitals. It is a basic but not a comprehensive balanced scorecard. It provides a framework for a hospital to develop its own comprehensive scorecard that reflects its patient population, service mix, location and other characteristics. Hospital Report, by itself, cannot meet the balanced scorecard needs of all services in all hospitals.

Question: Is this indicator relevant to most hospitals? If no, is there a similar indicator that would be relevant to more hospitals?

- 4) Hospital Report is evaluative and not descriptive. Indicators permit an informed judgment about hospital performance to be made and do not simply describe performance. If evaluative indicators do not exist, indicators that have the potential to be evaluative are preferred.

Question: Can this indicator be used to judge performance? If no, can we generate a benchmark from the indicator that could be used to judge performance in the future?

- 5) Hospital Report uses benchmarks. The choice of benchmark could be theoretical standards, empirical findings, industry medians, best practices or other evaluative criteria. International averages are preferred to Canadian averages, which are preferred to Ontario averages, *ceteris paribus*. Average performance of Ontario hospitals is a benchmark of last resort. Benchmarks are selected on the basis of validity and relevance, and not on the basis of politics, expediency or other nonscientific reason.

Question: Does this indicator have a valid and relevant benchmark? If no, use the Ontario average.

- 6) Hospital Report indicators are theory-based (best), empirically-based (second-best), or consensus-based (third-best).

Question: Is there a theory or empirical study that justifies inclusion of this indicator? If no, is there a consensus among panel members that this indicator is appropriate?

- 7) Hospital Report indicators are theoretically or empirically related to other Hospital Report indicators. A change in a particular indicator is correlated with a change in one or more other indicators. These linkages will reflect the complexity and interrelationships of the hospital's strategy. Orphan indicators that are not related to any other indicator are eschewed.

Question: Is this indicator related to any other Hospital Report indicator? If no, should it be replaced?

- 8) Hospital Report includes core indicators and service/program specific indicators. Core indicators are common to all hospitals included in Hospital Report. They are comparable among all types of hospitals (for example, current ratio, nurse satisfaction, use of information technology). Service/program indicators are those that are specific to hospitals and programs of different types (for example, total cost per RUGS-III weighted patient day for CCC hospitals, percent of psychiatric discharges readmitted within 30 days for mental health hospitals and programs, stroke complication rate for acute care hospitals, and average total function score change by RCG and FRG for rehabilitation hospitals and programs).

Question: Is this indicator a core indicator? Is this indicator a service/program indicator?

- 9) Hospital Report includes a mix of lead and lag indicators. Changes in lead indicators occur before changes in other indicators. Lag indicators occur after changes in other indicators. A mix of lead and lag indicators is preferable to all lead or all lag.

Question: Are all of the indicators lead or lag? If yes, can we find some alternates to create a better mix?

- 10) Hospital Report may include experimental indicators that are suggested by theory, empirical research or consensus panels, but have no existing evidence. Experimental indicators are clearly labeled and justified.

Question: Is there any evidence in support of this indicator? If no, it is an experimental indicator.

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