

Hospital Report Project: Regional Hospital Sessions 2003 Report

Précis

A series of regional consultations and teleconferences with hospital executives and quality managers have provided substantial guidance for the further development of the *Hospital Reports*. These sessions were attended by directors and senior executives from almost 90% of participating hospitals and more than 50% of non-participating hospitals. Key feedback from the sessions includes the importance of communicating performance information to the public more clearly, improve the timeliness of the reporting process, and increase the scope of reporting to include issues around access to care and community resources available for care and a closer link between hospitals' corporate strategies and the choice of performance indicators.

Background

The *Hospital Report* is based on a four quadrant balanced scorecard model, adapted by Baker and Pink, for use in Canadian Hospitals.[#] It includes indicators of hospitals' efforts to improve management, integration, and innovation (system integration and change), clinical efficiency and outcomes (clinical utilization and outcomes), patient perceptions of care (patient satisfaction), and productivity, sustainability, efficiency, and liquidity (financial performance and condition).

Since 1998, the *Hospital Report* project has grown from a region and peer group-level report on inpatient acute care performance to include hospital-level reports on inpatient acute care, emergency department care, and complex continuing care; region and peer-group level reports on rehabilitation care, women's health, and nursing care; and a province-level report on mental health care. Full execution of the five-year work plan for the *Report* will include hospital-level reporting across all of these sectors, special reports on issues of interest to hospitals and the sponsors (Ontario Hospital Association and the Ontario Ministry of Health and Long-term Care), and focused studies on hospitals' quality improvement efforts.

Over the development of the *Report*, hospitals and other stakeholders such as District Health Councils, the media, and the public (through focus group testing) have articulated a number of challenges to the use and usefulness of the *Report*. There are three common themes across these challenges:

- *Reporting hospital results using a five-star rating system* Currently, hospital level results are reported using a five-star system where one star reflects performance that is statistically worse than average, three star performance is statistically no different from average, and five star performance is statistically better than average. Each quadrant also makes adjustments to try and ensure that differences between the median level of performance for each star rating are substantial enough to support quality improvement efforts (i.e., they are clinically or managerially significant differences). A number of hospitals feel that the star rating system is misleading because, among other problems, it may suggest greater variation across hospitals' performance than truly exists, because readers associate average performance (three star) with acceptable performance, and because it provides little guidance for hospitals' seeking to identify best-in-class performers (benchmarks) to support quality improvement efforts.
- *Reporting results that are a year or more out-of-date* As the *Report* project has moved to ensure that results for each quadrant reflect the same time period, limits on the timeliness of different data sources have meant that results in the *Report* can reflect hospital performance one or even two years in the past. A number of stakeholders have reported

[#] Baker GR and Pink GH, "A Balanced Scorecard for Canadian Hospitals", *Healthcare Management Forum*, 8(4):7-13, 1995, <http://www.hospitalreport.ca/>

that this information is difficult to use in quality improvement efforts, strategic planning, and other decision-making exercises. Hospitals have also argued that use of such old data can be demoralizing and that the data released in any one report may actually predate the hospitals' efforts to improve based on the preceding report.

- *Reporting results that do not provide a complete picture of hospitals' activities or the context within which they operate* The *Report* maintains a rigid focus on care provided in certain types of beds. This means that important aspects of care, such as rehabilitation outside of designated rehabilitation beds or outpatient care, are absent from the *Report*. It also means that many of the strategic priorities of hospitals and the different challenges they face, such as teaching hospitals' educational and research missions and the different types of challenges to the vertical integration of care across hospital peer groups and regions, are absent from the *Report*. Finally, it also means that important determinants of performance such as the resources available to hospitals are absent from the *Report*.

Three key principles have helped guide the development and expansion of the *Report*. These are: voluntary participation in the *Report* by hospitals; strong guidance from the clinicians, managers, and executives working in hospitals on the selection and interpretation of indicators; and the release of all methods and innovations developed by the *Report* into the public domain. Therefore it is not surprising as challenges arose for the *Report*, that the researchers and sponsors agreed that a series of regional sessions should be held to gather hospitals' opinions - provided by CEO, senior executives, and quality managers - on potential responses to these challenges. These regional sessions included 10 face-to-face consultations and four teleconference and web-based (Webex©) sessions on the following dates (locations in parentheses):

- 17 July (Ottawa); 18 July and 21 August (Toronto); 23 July (Thunder Bay); 29 July (Hamilton); 30 July (London); 31 July (Windsor); 7 August (Kingston); 12 August (Sudbury); 13 August (Timmins); and
- 22 July, 6 August, 11 August, and 22 August (Teleconference and web-based)

Participation

Overall participation at these sessions included at least one representative of 87% of the hospitals that participate in any sector of the *Report* and 53% of hospitals that do not participate. These sessions were led by the principal investigator for the *Hospital Report* research collaborative (Adalsteinn Brown). Other researchers as well as a representative of the Ontario Hospital Association (OHA) attended most other sessions. Because of their interest, the executive directors and senior planners from some District Health Councils (DHC) and a policy director from the Ontario Medical Association also attended sessions.

Objectives

The objective of the regional sessions was to obtain hospitals' perspectives on potential solutions to the challenges described above. As the sessions progressed, a number of new potential solutions were also identified by hospitals. These new solutions are also included below and are identified with an asterisk.

- Potential solutions to challenges associated with *Reporting hospital results using a five-star system* included: reporting numeric results, reporting results using a combination of symbols and numbers for each indicator, reporting additional information such as hospitals that achieved an exceptional level of performance or hospitals that have substantially improved or declined in performance, development of other venues for reporting such as editorials,* further focus group evaluation of the reports that include the media,* and retaining the star system.*

- Potential solutions to challenges associated with *Reporting results that are a year or more out-of-date* included: shifting hospital reporting towards an on-line system to reduce the publication and design time (4 months) associated with the production of the *Report*, development of a dummies guide that would allow hospitals to produce their own reports before data cleaning by the Ministry of Health and Long-Term Care and the Canadian Institute for Health Information, use of data for study prior to cleaning, a one time delay of several months to allow the use of more timely patient satisfaction data in the 2003 series of reports,* and the reporting of the most timely data available for each quadrant instead of data for the same time period across all quadrants.*
- Potential solutions to challenges associated with *Reporting results that do not provide a complete picture of hospitals' activities or the context within which they operate* included: expansion of the *Report* to include other types of care such as outpatient care, continued development of the resource inventory, implementation of 360 degree surveying, development of focused quality improvement initiatives, development of a set of indicators that are specific to different hospitals' sets of strategic priorities, and development of reports on the sustainability (resources) of the system.*

Because the sessions were two hours in length, they also provided an opportunity to review the principles and development of the reports, to discuss other issues raised by participants, and to determine the perceived usefulness of the sessions. Other critical important issues included the accuracy and time required to complete the system integration and change survey and continuing concerns over data quality. All participants stated that the sessions were useful and there was unanimous support for conducting the regional sessions on a yearly basis.

Action Item 1: Conduct yearly regional sessions to discuss development of the *Report* and to obtain hospital perspectives on challenges to the *Report*.

Findings

Overall the sessions were very useful. Hospitals provided substantial constructive suggestions for improvements to the reports, indicated that the reports are valuable, and are used by boards, senior executives, and teams within hospitals. Most suggestions for improvement reflected the desire for more timely and more useful information for quality improvement and accountability functions internal to the hospital, such as quality improvement programs and templates for presentations to the board. Participants found updates on research in progress and recent work on the relationships among different indicators and the accuracy of the indicators particularly useful. There were no challenges or suggestions for changes to the principles guiding the development of the *Report* (i.e. voluntary participation, provider driven, independent development, and public domain for all work) nor to the objectives of the *Report* (i.e. enhanced accountability, support for quality improvement, improved data quality, and development of research into hospital performance). There were no challenges to the principles for selecting indicators (scientifically sound, feasible, and relevant), but there was strong consensus around shifting the definition of relevant so that indicators would reflect the diversity of activities and strategies across hospitals rather than reflecting the same set of activities at each hospital.

The remaining findings from the sessions are organized according to the major challenges identified prior to the sessions and are organized within each challenge in order of descending consensus. This means that findings supported by unanimous or near unanimous consensus are listed first. The principal investigator tried to determine consensus through straw polls in which participants raised their hands or nodded in support of a potential solution (face-to-face sessions) or stated their support (teleconference).

Reporting hospital results using a five-star rating system

Discussions about the use of the five-star rating system identified or confirmed a number of issues and concerns around the way that results are reported in the public (newspaper insert)

report, in the managerial (blue book) report, and the private (confidential numeric) report. Although, the issues and concerns tend to be specific to each type of report, there are two broad themes – hospitals’ ability to use the reports and the public’s ability to understand the reports– that underlie most issues and concerns.

Although hospitals believed that their ability to use the *Report* was limited by a number of factors, a major issue related to reporting results using a five-star system, was their ability to compare themselves to other hospitals. Currently, hospitals only receive their own numeric results in their private report and they must use star ratings in the public or managerial reports to figure out how to interpret their own scores and to compare their own results to those of other hospitals. They are unable to answer important questions such as the size of the differences in performance among comparable hospitals. Hospitals unanimously supported including all hospitals’ results in the private reports received by each hospital. Although, the principal investigator pointed out that this sort of reporting creates the risk where numeric values can be leaked to the media, hospitals accepted this risk and felt that having comparative numeric performance information is more important.

Action Item 2: Include numeric values for all participating hospitals for each sector in the private reports received by hospitals.

Another major issue limiting hospitals’ ability to use the reports was the ability to identify best practices and explore the data more thoroughly. Implicit in the current managerial reports is some information on hospitals that consistently score well (according to the star system) and the degree to which differences across hospitals are statistically significant. Hospitals felt that this information could be made more explicit. There was strong support for including more information on the statistical significance of results in the private and managerial reports and for including some method of identifying exceptional performance.

However, hospitals also felt strongly that exceptional performance should not be calculated on an indicator-by-indicator basis. Several participants noted that the balanced scorecard model underlying the *Report* meant that benchmark performance should be calculated on the basis of several indicators and that a hospital could not do very poorly on one area and still receive a “benchmark” rating for another area. There was general support for the notion that benchmark performance on unidirectional indicators – those indicators for which higher or lower scores were always better – could be based on a statistical adaptation of the Achievable Benchmarks of Care (ABC)[#](ref) method and that benchmark performance on other indicators – where both high and low values could signal problems – could be based on consensus panel adjudication or theory. One participant expressed concern that these distinctions should not be based on statistics and instead should reflect some level of clinical or managerial significance. There was, however, strong support for some form of review of the benchmark levels, regardless of their method of calculation, by hospitals, following their release in a private or managerial report and before their release in a public report. There was also strong support for follow-up case studies that would identify some of the determinants of benchmark performance. Work on benchmarking should also include testing of more advanced techniques such as DEA.

Action Item 3: Compare different methods of identifying benchmark hospitals that perform well on sets of indicators.

Action Item 4: Study matched pairs of hospitals – benchmark performance and a comparator hospital without benchmark performance – to identify potential determinants of good performance. Report on case studies in private and managerial reports.

[#] Weissman NW, Allison JJ, Kiefe CI, Farmer RM, Weaver MT, Williams OD, Child IG, Pemberton JH, Brown KC, Baker CS, “Achievable benchmarks of care: the ABCs of benchmarking”, *Journal of Evaluation in Clinical Practice*, 5(3):269-81, 1999 August.

Hospitals also expressed substantial concern over the ability of both their internal audiences (boards, clinical departments) and their external audiences to understand the reports. A number of participants noted that the process of educating internal audiences about the report was very time consuming and that the managerial reports could not be distributed on their own. A number of participants also felt that their own resources were inadequate for the education required around the *Report*. There was strong support for the provision of additional educational materials around the *Report* to support internal communications.

Action Item 5: Develop and distribute templates for PowerPoint presentations that hospitals can use to present their own results to internal audiences. Redevelop educational sessions to support greater understanding of the *Report* (see below).[#]

There was less consistent support for shifts to numeric reporting and the introduction of benchmarks as a solution to problems around communicating the reports to external audiences (i.e. public, media, other stakeholders), although there were some consistencies in the distribution of support for different potential solutions by hospital peer group and by participants' positions within their hospitals. Hospitals were less confident that the public could understand numeric values better than the current star system, although some participants pointed out that the problem with the star-system was the fact that it was used to represent different levels of performance historically by different industries (e.g. hotels and restaurants) so it was misleading to the public. Teaching hospitals and participants at the Ottawa, the first Toronto, and the first two teleconference sessions were the strongest supporters of public reporting of numeric values. Community and small hospitals and participants at later sessions were less confident about the public's and the media's ability to interpret numeric scores. All sessions accepted the need to report some indicator results using numeric ranges, particularly for the System Integration and Change quadrant, because of limitations on the underlying data. However, there was strong support at all sessions for some method of reporting performance that identified which hospitals' performances were not statistically significantly different from the peer-group or regional average.

Overall, there was cautious support for changes to the way that results are reported publicly, particularly if they combined some sort of symbol that would be easily understood by the public and numeric values that allowed interested readers to delve deeper into the results and to allow hospitals to respond to ratings based on the underlying distribution of scores. One option that received relatively strong support at a number of sessions included reporting numeric values or numeric ranges against a coloured (gray-scale) background that indicated whether hospitals' performance was better than average (dark background), average (medium background), or worse than average (light background). All sessions strongly supported the caveat that there was a strong need for substantial educational efforts around any rating system (e.g. it is not a hotel guide) and for more attention in the public reports to system and regional-level performance.

At virtually all the sessions, participants disagreed over how much of any rating system could be accurately interpreted by the public, given the complexity of the underlying indicator methodology. At several sessions, participants asked whether the researchers had made any attempt to meet with the media and determine their interests and ability to interpret different presentations of results. Several participants noted that there should be more interaction between the media and the groups producing the reports. At all sessions there was also support for further focus group testing of the public reports with hospital representatives (e.g. public relations personnel) and with the media and the public before their release.

[#] This sort of presentation has already been developed and distributed with the *Hospital Report – Women's Health Excerpt* released on 27 August 2003. Similar education activities such as the "Responding to the Hospital Report" educational day at the University of Toronto have already been created. This session included more than 150 hospital staff and clinicians who attended the free one-day session at the University. This session will provide a model for regular sessions and for identify key themes for presentation at other venues.

There were varying levels of consensus around other aspects of public reporting of hospital performance. There was very strong support for the notion of reporting changes in hospital performance. The simplest presentation of this information – lists of hospitals that had improved substantially or declined substantially over time for each indicator – received the greatest support from participants. More complicated presentations, such as arrows associated with each indicator value, would make the report too visually confusing even for expert users in hospitals. Hospitals agreed that this sort of information was the most important piece for demonstrating accountability. As before, there was some concern that these differences over time not be based solely on statistical calculations and that these changes should be reviewed for clinical or managerial significance. A number of participants also felt that reporting provincial, regional, and peer-group trends over time was also important as it showed changes in system sustainability over time and provided some context for interpreting hospitals' changes over time.

At each session, hospitals' seemed comfortable with changes in the reporting process as long as they were based on the input from across the Province and were preceded by a new consent process.

Action Item 6: Change reporting of hospital level results in public and managerial reports in staged process with the eventual goal of user-friendly numeric reporting. First-year reporting to combine graphic representation, such as numeric values (or ranges) against symbols or coloured backgrounds indicating statistically significantly higher performance than average, performance that is not statistically different from average, or statistically significantly lower performance than average. Second year reporting will be based on evaluation of first year reporting and may include lists of hospitals whose performance has declined over time and benchmark hospitals. All changes in reporting will be based on consent from hospitals.

Action Item 7: Change public insert to include more information on trends in performance over time and regional and peer-group results.

Action Item 8: Sponsors to conduct focus groups with the media, the public, and with hospital public relations personnel to review new report formats prior to release.

Finally, there were a number of suggestions about how to communicate effectively with hospitals, the media, and other stakeholders about the results of the reports. These suggestions included: a regular newsletter for hospitals that described the status of the reports, anticipated release dates, new findings, and trends in performance; newspaper editorials and other public documents and reports that describe system level changes in performance and the use and mis-use of the *Report*.

Action Item 9: Develop a new communications plan for the Research Collaborative that includes more direct communication with hospitals and the media. Link this plan to media educational sessions prior to the release of the *Report*.

Reporting results that are a year or more out of date

There was clear support at all sessions and from all hospital participants that the timeliness of the results included in the *Report* was a major limiting factor on the use and usefulness of the *Report*. Each session included a review of the timelines for the collection, analysis, and reporting of the data underlying the indicators in the clinical utilization and outcomes and financial performance and condition quadrants. Based on this review, hospitals did not believe that any further improvements in submitting their data sets or their corrections to CIHI or the MOHLTC were possible. Hospitals were supportive of a number of other options for improving the timeliness of the data.

The production of the managerial reports requires approximately four months for design and publication and an additional one to two months of actual writing. Participants unanimously

supported the development of an on-line decision support system where they could log on, see the numeric values for the entire *Report* and then begin to create custom tables and charts based on the indicators they wanted to study, compare groups of hospitals, and compare different indicators and contextual variables such as the presence or absence of certain resources and volumes of care. This on-line decision support tool could be based on a prototype system developed by members of the *Hospital Report* Research Collaborative with the support of the Canadian Health Services Research Foundation. Hospitals agreed that this database could also be updated as new data became available, but updates would need to be consistent with a strategy for the release of the public reports so that there was a clear and strong message about hospitals' accountability to the public sent every year.

Hospital support for replacing the managerial report with this on-line decision support tool was more mixed but support for this sort of replacement increased with the addition of special reports on system-wide trends in performance and the relationships between indicators, a clear technical report, a "Dummies' Guide" style explanation of the methods (see below), and support for internal education as described above.

Action Item 10: Use the prototype decision support system already developed to create a user-friendly multi-dimensional decision support system for hospitals to improve the timeliness of data.

Action Item 11: Identify a clear communications plan for provincial, regional, and peer-group results and the results of ongoing research (including the articulation of research topics) that is linked to Action Items 2,3,6,9, and 10 to allow gradual elimination of the managerial (blue book) reports and the potential expansion of the public report to reflect more system level issues.

Another potential solution for improving the timeliness of the data underlying the reports was the development of a "Dummies Guide" style explanation of the methods underlying the *Report*. This guide would provide algorithmic representations of how hospitals can calculate their own indicator values based on their own internal surveys or their quarterly data submissions to CIHI and the MOHLTC. This guide would be accompanied by a disk that includes user-friendly programs that hospitals could use to calculate their own values based on these surveys or quarterly data submissions. Although this solution would not lead to more timely public or managerial reports, it would allow hospitals to track their own performance in a more timely way.

Hospitals expressed nearly universal support for this guide with the following caveats: (i) consider a range of underlying analytic engines for the disk, all hospitals can use Excel®, many hospitals can use SAS®, and some hospitals use other programs such as Crystal ReportWriter ©; (ii) regardless of the underlying engine ensure that the programs are user-friendly and do not require programming knowledge; (iii) make sure the guide and software can be downloaded easily off the web; and (iv) ensure that the programs can be run off of a desktop computer.

Action Item 12: Develop and pilot test a user-friendly guide and set of programs for the Report to allow hospitals to calculate their own results.

There were a number of other options for increasing the timeliness of data underlying the *Report*. One suggestion was to allow the researchers earlier access to the financial data since the data for all but one indicator would be available in an earlier data set. There was no resistance to this suggestion. Virtually all sessions included requests by participants to shorten the length of the System Integration and Change surveys. A number of participants commented on the importance of sending the message that data collection was an undervalued activity in the hospital system and specific support is necessary to improve the timeliness and accuracy of routinely collected financial and clinical data. A few participants noted the substantial amount of data collection carried out by the OHA and asked whether these data could be used as part of the *Hospital Report* and thereby reduce data collection specific to the *Report*. Another participant made the

valuable suggestion to lay out all data collection processes, including those mandated by the MOHLTC and conducted by the OHA, to identify potential bottlenecks in the data collection process and schedule *Hospital Report* data collection and verification processes in line with these processes. All of these issues will be examined and incorporated where possible into the ongoing redevelopment of the *Report*.

At the second Toronto session, participants also raised and unanimously supported a one-time delay in the release of the next round of reports so that the most recent patient satisfaction data (based on the NRC-Picker surveys) could be incorporated. Hospitals felt that this would be important because the current patient satisfaction data was too old to be used in quality improvement, that it would not be used regardless since the nature of the surveying process had shifted dramatically, that patients had already filled out different surveys and would not find congruence between the questions they had answered and the indicators described in the *Report*, and because such a delay would set the foundations for trending of patient satisfaction results in future reports (otherwise trending may have to wait until the 2005 reports). This shift would have three major implications beyond the substantial delay in reporting. First, this shift would leave hospitals without a report on their last round of patient satisfaction data based on the Parkside © questionnaires. Second, this would mean that the data underlying each quadrant will not describe the same time period despite the fact that this is the first year that this would be possible. Third, this would require that the NRC-Picker surveying cycle and the Hospital Report cycle would have to be aligned. The principal investigator raised the issue of this delay at the next (and last) teleconference session; there was unanimous support for the delay in this session as well. This would mean that release of the Emergency Department and Acute Care Reports would be delayed until April/May 2004. It should also be noted that this may inappropriately de-emphasize results in other quadrants.

Action Item 13: Consider a delay in the release of the 2003 Acute Care and Emergency Department reports to allow incorporation of the NRC-Picker survey results and the release a special interim report on the last round of the Press-Ganey Patient Satisfaction results and provide hospitals with comparative numeric data on the other quadrants.

Reporting results that do not provide a complete picture of hospitals' activities or the context within which they operate

A number of participants believed that the reports failed to give a complete picture of the context and constraints faced by hospitals and the range of services and functions provided by hospitals. This is an issue that has already been raised (like many others covered in the regional sessions) by the SAC. There are some simple issues around scope that can probably be handled relatively quickly such as ending the restriction on studying only rehabilitation care delivered in designated rehabilitation beds and studying the feasibility of including rehabilitation care provided in non-designated beds. There was strong support for expansions in scope, where possible, that would provide a more complete picture of the care provided by hospitals within one sector. There was somewhat less support for expanding the scope of reports to include day-patient or outpatient care. Although virtually all participants felt that it was a critical area for future work, they felt it had to start at the feasibility study level (congruent with the development of other reports), that it had to not increase the burden on hospitals through cost of patient satisfaction surveying or the length of the SIC survey, and that it would be much more difficult to do so and not compromise current efforts for the sectors already surveyed. Finally, virtually all hospitals supported the development of a set of indicators that were core to the reports and then a set of standardized indicators that would allow hospitals to identify strategic priorities and then be evaluated according to those strategic priorities for the remainder of the report. The development of these indicators would be based on a survey of strategic priorities and the hospital peer group specific panels (community panels not yet organized; recruiting of chairs has begun).

Action item 14: Complete and distribute strategic priority survey and begin development of indicators for strategic priorities through review with existing investigator groups and hospital peer-group panels. Identify core indicators in each quadrant and sector through same process.

Action item 15: Increase scope of rehabilitation report to include care provided in non-designated beds. Use this increase as a template for handling same issues for Mental Health Report.

Action item 16: Develop table of contents and proposal for feasibility study of outpatient care in hospitals that relies heavily on routinely collected data.

Support for 360 degree surveying, particularly around the system integration and change quadrant indicators was more cautious but generally strong. Most participants felt that 360 degree surveying would provide important validation of the system integration and change indicators that dealt with community partnerships and would provide important information about the context within which hospitals operate.

Action item 17: Develop and pilot test 360 degree survey based on SIC and resource inventory questions.

Other issues raised during the regional consultations

A large volume of comments centred on the System Integration and Change survey and ways to reduce survey burden, improve the validity of the results, and increase the usefulness of the indicators. A number of these comments focused on the length and nature of the questions on the surveys that prompt a number of hospitals to spend a great deal of time interpreting the questions. A common suggestion was to provide more thorough guidelines on how to complete the survey. There was substantial concern expressed that the current survey does not capture much of what hospitals are doing and does not provide a clear reflection of innovation that is within the reach of many hospitals. Hospitals were particularly interested in the development of new indicators to reflect underlying measures of efficiency such as occupancy, hospital workplace problems such as absenteeism, and a clearer link between performance in SIC and good performance in other quadrants. Other comments included:

- i. ensure that indicators do not assume the existence of a problem, e.g. why have strategies to deal with ALC days if ALC days are not a problem
- ii. focus the reports more on human resources and development issues
- iii. include more on resources available to hospitals and include more indicators relevant to small and rural hospitals
- iv. reduce survey burden from both OHA and the *Hospital Reports*.

Action item 18: Redevelop system integration and change survey tool this year with goal of improving specificity and shortening length, explore possibilities of using routinely collected data to capture issues and of using the routinely collected data definitions (such as MIS capital definitions) to improve data collection. Re-attempt to integrate OHA and Research Collaborative surveys on similar issues

Participants also had some important concerns about how well we are addressing public concerns about the system. It was suggested that the public reports should build on questions that have been identified through focus groups and other techniques as important. These suggestions are congruent with the results of focus groups conducted by the Research Collaborative over the last few years. Special reports on these subjects would include trending of results but would also focus on other important issues such as waiting times and access issues and the relationships among indicators and sectors.

Action item 19: Develop proposals for additional reports to focus on issues of interest to the public (waiting times) and hospitals (e.g. patient safety) identified through prior focus groups.

Other issues raised at the regional sessions included:

- the need to provide more clear instructions on how to respond to the verification reports sent out to individual hospitals to verify accuracy of indicator data.
- the importance of continuing to try and improve the coordination of communication about Hospital Reports. As well, there were concerns expressed about the burden of surveying in general, and a desire for the OHA to coordinate their surveying efforts with Hospital Reports.
- concerns over the cost of patient satisfaction surveying despite recent efforts to reduce costs. Some hospitals expressed a desire to understand what a reasonable volume should be for surveying their patients.
- continued concern over the quality of routinely collected clinical data. One participant made the suggestion to provide health records departments with coding standards specific to the clinical indicators in Hospital Reports to increase the quality of the data underlying the clinical quadrant.

All of these issues will be studied and a set of guidelines will be developed, where possible, and released to hospitals or communicated to the MOHTLC or OHA as appropriate.

Finally, a number of participants made suggestions for indicators that would be the focus of province-wide quality improvement activities. There was unanimous support for quality improvement exercises based on indicators in the *Report*; suggested indicators included: overall patient satisfaction, guideline use, or a combination of length of stay and readmissions (indicators strongly related to hospitals' own performance); and readmissions, access to angiography, waiting times in emergency departments (indicators related to both hospitals' own performance and health care system resources). These quality improvement processes would allow hospitals to drill down into their own data and understand and more usefully compare their performance. Participants also made novel suggestions around reproducing the "data blitz" used by the MOHLTC as a format for incorporating hospitals in the process of understanding outlier indicator values.

Action item 20: Develop proposal for select group of indicators for CQI process that reflect both hospital-level and system-level concerns.

Next Steps

This report includes 20 important action items for improving the *Hospital Report*. The next step on all of these action items is to obtain input from the Strategic Advisory Committee for the *Hospital Report*, develop and mail out the consent form to participating hospitals, and attach time lines and deliverables to the action items. Following review of this draft report by the Strategic Advisory Committee and the *Hospital Report* Research Collaborative, it will be made public through the *Hospital Report* website (www.hospitalreport.ca).

The following appendix includes a sample of the presentation given at the regional sessions.

Update on the *Hospital Report*: Issues in using and reporting hospital performance data in Ontario

Webex Session
22nd August 2003



Canadian Institute for Health Information
Institut canadien d'information sur la santé



A joint initiative of the Ontario Hospital Association
and the Government of Ontario

Summary

- The *Hospital Reports* publicly release data on 4 dimensions of hospital performance across 5 sectors
 - Public releases use a star (★) system for hospital results
 - Private releases limited to numeric data for receiving hospital
 - All data are at least a year old
- Hospitals would like more timely/useful data
 - Public may not understand star system
 - Current consents do not allow sharing of data across hospitals
 - Some indicators (e.g. access to angiography) reflect health care system performance
- Reporting of numeric results, improving access to data, and focusing support for CQI activities will reduce challenges

Hospital leaders are audience for reports

Project Principles

**Public domain
Provider-driven
Independence
Voluntary**

Indicator Principles

**Scientifically sound
Feasible
Relevant**

Objectives

**Quality Improvement
Accountability
Data quality
Original research**

Reporting by sector different each year

2003

Hospital Reports

Acute Inpatient
Emergency Dept
Complex Cont Care

Regional Reports

Rehabilitation
Women's Health

2004

Hospital Reports

Acute Inpatient
Emergency Dept
Women's Health

Regional Reports

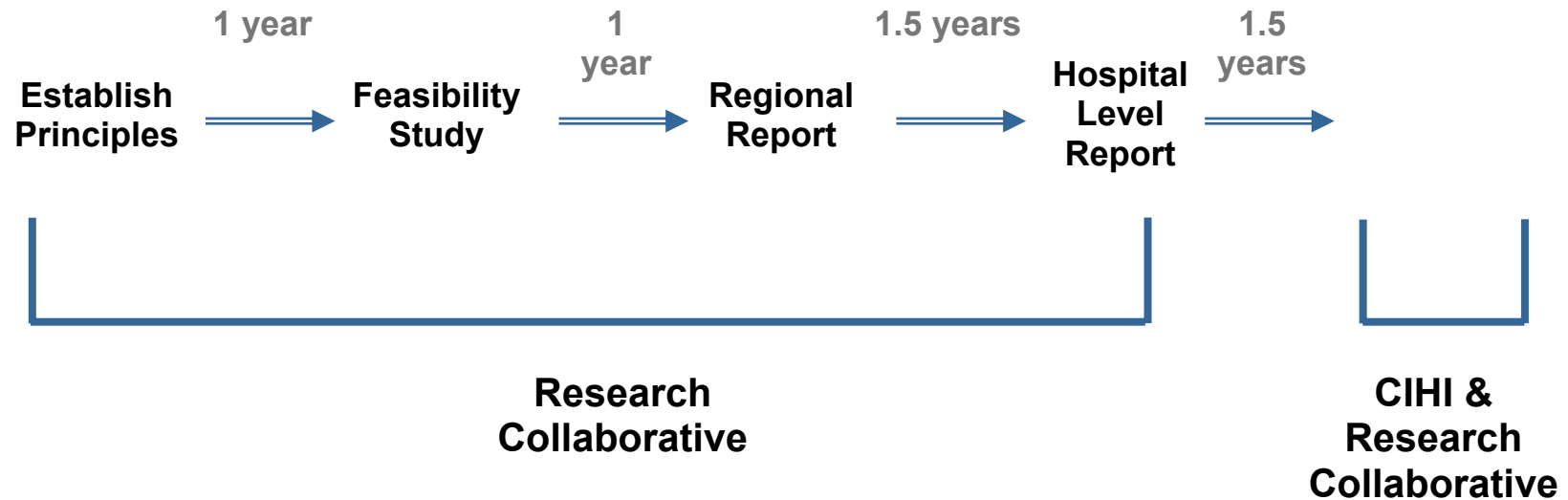
Mental Health

2005

Hospital Reports

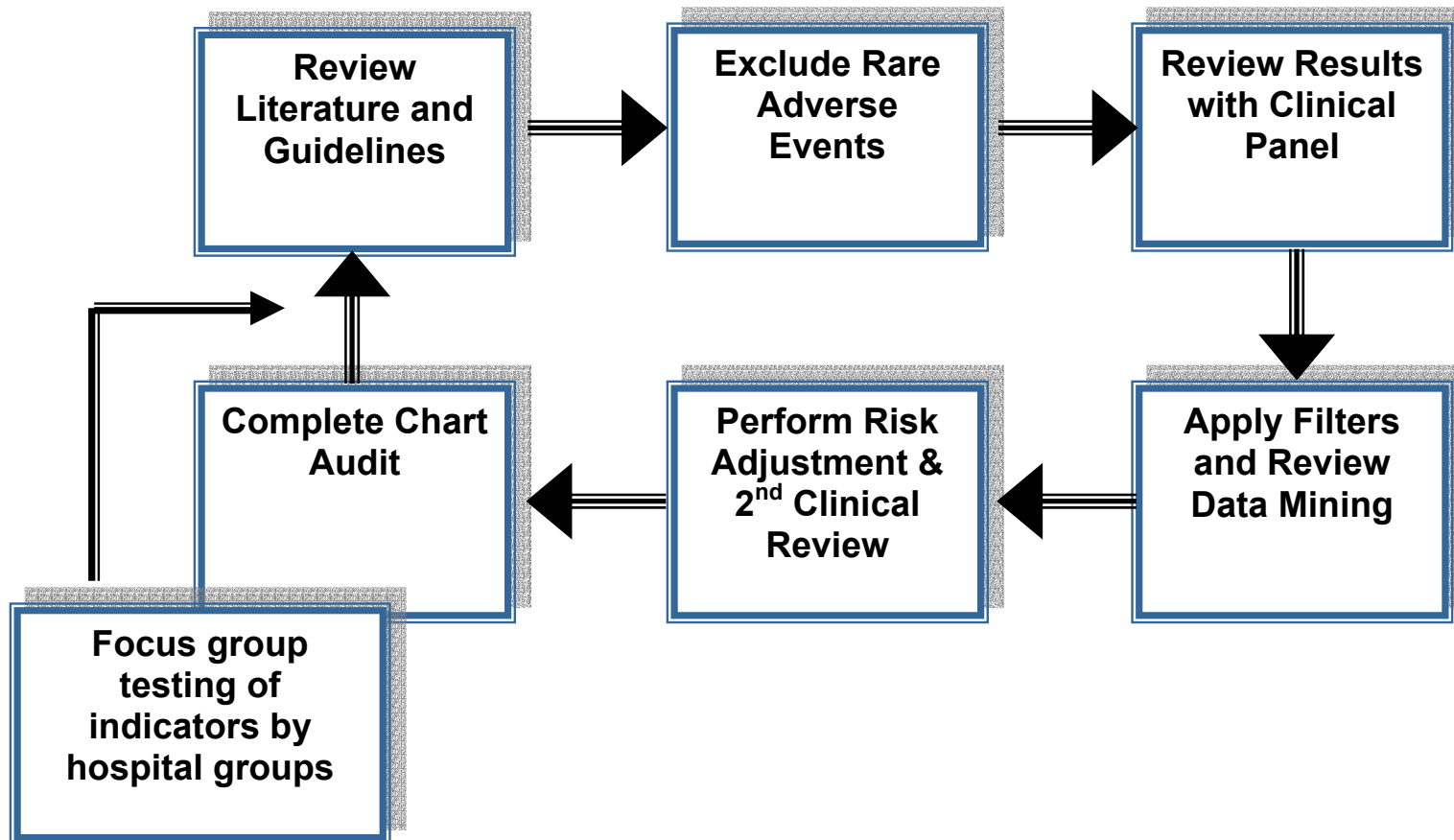
Acute Inpatient
Complex Cont Care
Rehabilitation
Women's Health

Development process is consistent



Indicator selection is also consistent

Example: Clinical utilization and outcomes



New indicators, formats, and findings

- **Increase to 5 star (★) system in 2001 up from original 3 star**
- **Creation of women's health and nursing excerpts in 2002**
- **Development of resource data base in 2003**
- **Balance between new indicators, new methods, and trending in acute care report**
- **Improvement in patient satisfaction scores, protocol use**
- **Links between indicators (e.g. cost per case with patient satisfaction)**

Three key challenges to reports

- Star system hard to interpret
 - “It’s like a hotel guide”
 - “Bad for morale”
 - “Average isn’t necessarily good”
- Quality of data and support for QI
 - “Data is too old to use or motivate”
 - “Our data are different”
 - “What now, how can we compare ourselves to others?”
- Incomplete scope
 - “Readmissions are a primary care failure”
 - “A lot of rehab outside of designated beds”

Star System: Pros and cons

- **Pros**

- CEOs recommend ('99)
- Less ranking
- Does not over-represent data quality
- Less gaming
- Easy for public to understand

- **Cons**

- Misinterpreted by public
- Average values may be unsustainable
- No benchmarking
- Sometimes small differences between stars
- Most reports now use numeric data

Example of the problem: *Patient Satisfaction*

- Variation in mean scores across rankings in global patient satisfaction indicator from *Hospital Report 2001*
 - *Acute Care*
 - 8 hospitals score below average (one star; scores: 79.2 - 86.8)
 - 46 hospitals score average (three stars; scores: 89.6 - 91.6)
 - 11 hospitals score above average (five stars; scores 90.9 - 99.3)
 - Inter-quartile range (88.8 – 93.0) includes one star & five stars
- “It’s hard to know what an 85 signifies if it doesn’t have any context”. [Greenfogel, 1996]

Trending can be difficult

	Process Quality	Unit-based Care	Satisfaction with Outcome
1999	73.8 (*)	78.3 (***)	78.0 (*)
2001	81.0 (**)	80.8 (*)	82.4 (***)

Options for change

- Shift reporting to numeric results
 - Benefits
 - Transparent representation of performance (e.g. patient satisfaction)
 - Easy to identify and compare year-to-year performance
 - Allows reader to interpret scores
 - Difficulties
 - Transparent representation of performance (e.g. complications)
 - Supports ranking of hospitals
 - Indicator data quality will require the use of ranges of performance in some cases (e.g. guideline use)

Numeric Results – What would it look like?

Teaching Hospitals	Process Quality	Current Ratio	Pneumonia Complications
Hospital A	78.3	0.91	5.1%
Hospital B	87.9	0.95	4.3%
Hospital C	84.9	1.01	3.1%
Hospital D	83.2	1.20	1.2%
Hospital E	89.1	3.01	17.1%
Hospital F	92.0	1.00	4.8%
Mean	83.0	0.99	5.0%

Adding Benchmarks and Average Values

Teaching Hospitals	Process Quality	Current Ratio	Pneumonia Complications
Hospital A	78.3	0.91	5.1% *
Hospital B	87.9	0.95 *	4.3% *
Hospital C	84.9 *	1.01 *	3.1%
Hospital D	83.2 *	1.20	1.2%
Hospital E	89.1	3.01	17.1%
Hospital F	92.0	1.00 *	4.8% *
Mean	83.0	0.99	5.0%

* Not significantly different from the mean

Adding changes in scores?

Teaching Hospitals	Process Quality	Current Ratio	Pneumonia Complications
Hospital A	78.3	0.91	5.1% *
Hospital B	87.9 ↑	0.95 * ↑	4.3% *
Hospital C	84.9 *	1.01 *	3.1%
Hospital D	83.2 *	1.20	1.2%
Hospital E	89.1	3.01 ↓	17.1%
Hospital F	92.0	1.00 *	4.8% *
Mean	83.0	0.99	5.0%

Adding Benchmarks and Average Values (Option)

Teaching Hospitals	Process Quality	Current Ratio	Pneumonia Complications
Hospital A	78.3	0.91	5.1%
Hospital B	87.9	0.95	4.3%
Hospital C	84.9	1.01	3.1%
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Hospital F	92.0	1.00	4.8%
Mean	83.0	0.99	5.0%

* Not significantly different from the mean

Adding Changes in Scores (Option)

Significant Improvements (2001/02 – 2002/03)

**Hospital B (Process Quality)
Hospital B (Current Ratio)**

Significant Declines (2001/02 – 2002/03)

Hospital F (Current Ratio)

Timeliness of Data: Challenge

- Clinical and financial data are limiting factors

March 31st year end

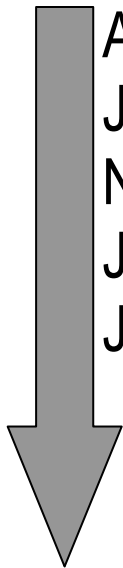
Apr to June hospital resubmissions

Jul to Oct CIHI / MOH data cleaning

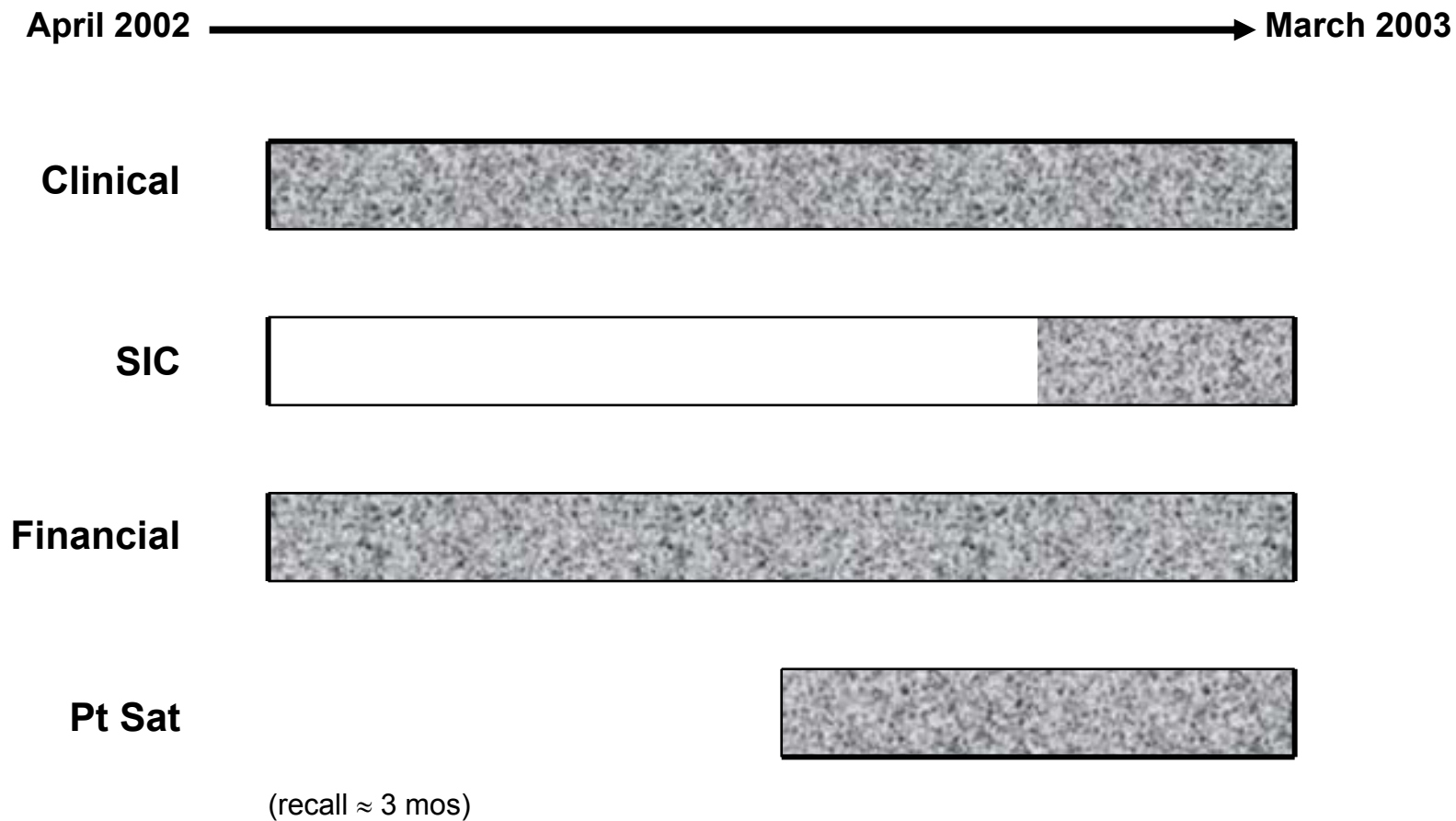
Nov to May report analysis

June verification process

Jul to Oct design, production, release prep



Timeliness of Data: Typical Data Timeframes (June 2004 Reports)



Timeliness of Data: Opportunity for Improvement

- Working group:
 - Reviewing barriers to more timely production
 - Proposing options for improvement
- Under consideration:
 - Timing for hospital corrections
 - Timing for CIHI and MOH to process hospital submissions
 - Producing reporting formats that are less labour-intensive and user-friendly
 - Report most recent data, not data from same time period

Incomplete Scope: Challenges

- Restricted to inpatient care (exception day surgery)
 - Most limiting for rehabilitation and mental health
 - Some areas limited by lack of required data (community-based rehab & mental health)
 - Possible areas for enhancement – ambulatory care, home care, long term care
- Majority of indicators most relevant to community hospitals

Incomplete Scope: Opportunities for Improvement

- Continue discussions with stakeholders about new sectors
- Increase community-based data collection
- Add peer group and regional focus groups and panels to improve range and relevance of indicators

Other Challenges

- Knowledge transfer increase
- Data quality improvement
- Implementation of quality improvement strategies
 - One indicator at system level
 - One indicator at hospital level
 - Set strategic targets
 - Sharing data across hospitals

Immediate Next Steps

- Complete regional CEO sessions across the province
- Decide transition to numeric results
 - Obtain written hospital-specific feedback on transition to numeric results
 - Develop limited set of benchmarks for 2003 reports?
 - If no support continue study of different ways of reporting results that support quality improvement and accountability