Provider performance measurement and management – external environment scan

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Executive Summary

Background: Performance management (PM) is described as a management control process supported by performance measurement. A performance management framework encompasses more than performance measurement, it includes the vision, team work, training, implementation strategies, feedback processes, incentives etc. that surround the performance measurement activity. HSG does not currently have an over-arching clear and transparent Provider Performance Management Framework. Key Performance Indicators have historically been developed at a service-to-service level as part of the contract development process.

Aim: This environmental scan was commissioned to conduct market scanning and literature review to identify and characterise current best practice models in performance management and engagement with providers.

Method: The environmental scan was designed around 3 data collection processes identified by HSG: 1) Interviews with key informants within HSG to provide internal contextual information around the goals of the project and to identify existing models of interest from relevant organisations; 2) Concurrent literature review to identify best practice models including factors which inform the development of the framework and engagement with providers; and 3) Interviews with representatives of relevant organisations, funders and regulators from other jurisdictions.

A total of 18 organisations were identified as relevant to the aims of the project and subsequently contacted to participate in a telephone interview. Fourteen agreed to participate and were interviewed by HSG staff.

A customised review of the English language literature published from 1 January 2000 – December 31 2012 was conducted to identify models of provider performance management in health care. This search yielded a total of 656 records. Following removal of duplicates and screening 83 articles were retained.

Results: Across the literature, a clear distinction between performance measurement and performance management was not evident and the two terms were often used interchangeably. PM was positioned most frequently within conceptualisations of improvement and quality. Typically the PM process is described as a staged process. There is broad consensus across this literature that early consultative engagement with providers is essential and begins with mutual alignment on shared objectives. Indeed, the strongest them to emerge from the literature was the theme of stakeholder collaboration. Collaboration through an all inclusive participatory process and consensus building was seen as crucial throughout the development, implementation and review of a PM initiative: identifying priorities, obtaining endorsement, developing leadership groups and support networks, selecting sensitive indicators and client outcomes, setting standards or targets, meeting the needs of provider subgroups (e.g., rural or low volume providers), contributing to data interpretation as well as collection, advising re public release of data, providing systematic and ongoing feedback and establishing a process for refining indicators.

Of the 14 organisations that agreed to participate, 10 were using or trialling a framework to measure and improve performance of health and disability provider groups and 4 were not using a framework. National and state/territory/province jurisdictions were represented. As was the case in the literature more broadly, the participating organisations had been motivated towards PM in the context of continuous improvement and working with the sector to improve quality of services and client outcomes. Accountability, scheme pressures and financial viability also contributed as motivating factors for the implementation of a PM framework. The move towards PM was only a very recent development across the majority of organisations. Although organisational practice varied, broad themes to guide the development and implementation of a PM scheme emerged from analysis of the interview transcripts. These broad themes also illustrated recommendations contained within the literature.

Conclusion: Given the powerful effect of early collaborative practices in this arena, it is recommended that the next phase of development and implementation of PM utilise co-design methodology with the participatory involvement of all stakeholder groups.

Background

The ability of clients to access high-quality, effective services is a critical factor in improving WorkSafe and TAC client experience and supporting individuals to achieve meaningful life outcomes with an emphasis on Return to Health, Return to Work and Independence. HSG does not currently have an over-arching clear and transparent Provider Performance Management Framework (PMF). Key Performance Indicators (KPIs) have historically been developed at a service-to-service level as part of the contract development process. Having a PMF will allow HSG to increase engagement and influence of their providers.

The broader objective of this HSG project is to develop a Provider Measurement and Performance Framework across all key health and disability provider groups by which Provider performance can be consistently measured and managed. The overall project objective is related to the Transport Accident Commission (TAC) 2015 Strategy and WorkSafe Victoria 2017 Strategy and it aims to improve health outcomes, client experience and projected liability savings through improved provider performance. Relevant strategies noted in the context of this project included the: HSG Provider (Disability) Strategy, Mental Health Strategy, Hospital and Rehabilitation Strategy, and the National Quality Framework and National Health Reform performance framework.

The broader project includes 3 components, an internal environmental scan to determine what HSG currently does, an internal review and proposal of a framework and an external environmental scan which is the focus of this report.

While HSG anticipated that there would be some literature on 'best practice' models, the external environmental scan was expected to focus primarily on conducting interviews with known stakeholders including other personal injury insurers and health authorities in Australasia, and selected organisations, especially in North America.

Delivery of the external environmental scan was expected to be supported by members of the Provider Performance project team within HSG. In particular team members were expected to conduct the interviews with identified external organisations in order to facilitate relationship development between HSG and potential external stakeholders and assist with knowledge transfer at the completion of the scan.

For ISCRR, the project was to be conducted as a part of a broader initiative for the Neurotrauma Research Strategy – the development of a services innovation platform to provide research to support co-design of improvements to health and disability services.

The Research Objectives of the External Environmental Scan Project

The environmental scan was commissioned to conduct market scanning and literature review to identify and characterise current best practice models in performance management and engagement with providers.

The environmental scan was designed around 3 data collection processes identified by HSG, each with defined aim (s):

1. Interviews with key informants within HSG
    - to provide internal contextual information around the goals of the project
    - to identify existing models of interest from relevant organisations, funders and regulators in other jurisdictions which warrant consideration

2. Concurrent literature review
    - to identify best practice models including factors which inform the development of the framework and engagement with providers
3. Interviews with representatives of relevant organisations, funders and regulators from other jurisdictions
    - to explore the implementation, benefits and limitations of the performance management models, how performance management is positioned in the management system, and how the data is used within day-to-day business processes to inform and influence change in provider groups.

Method

Interviews with key informants within HSG

Interviews were conducted with 6 key informants within HSG in order to contextualise the project, identify relevant external organisations to be included in the scan and define the key domains of interest to inform the development of the telephone interview schedule to be used with representatives of external organisations. These interviews were conducted during September 2012.

A preliminary structured interview schedule was developed. The schedule contained two versions: Form A was designed for interviewing an informant from an organisation that currently was using a Performance Framework; Form B was designed for interviewing an informant from an organization that currently was not using a Performance Framework. The forms were designed to use directly while the interview was being conducted with each of the cells expanding to accommodate the information entered.

The content of the structured interview and guidelines for its administration were presented and discussed with HSG staff in a workshop conducted on 23 October 2012. Minor alterations were made and the protocol was piloted in a single interview conducted by HSG staff. Further minor alterations were made to the protocol prior to its subsequent use with external organisations. The final version of the interview schedule used for data collection from external organisations can be found in Appendix 1.

A total of 18 organisations were identified as relevant to the aims of the project and subsequently contacted to participate in a telephone interview. Fourteen agreed to participate in the project, two were unwilling to participate and interview transcripts were not received for the final 2 interviews that had been sought. Interviews were conducted by HSG staff members with representatives of participating organisations from 31 October to 14 December 2012.

Participating organisations currently using a Performance Framework are listed in Table 1; those currently not using a Performance Framework are listed in Table 2. Nominated contact staff members from organisations currently developing/introducing/using a performance management framework have been identified and recorded by HSG staff.

Table 1. Organisations using a Framework to Measure and Improve Performance of Provider Groups

Organisation	Function	Title & Phase of Framework Development
Case 1*: Accident Compensation Corporation (ACC) – New Zealand http://www.acc.co.nz/	Comprehensive, no-fault personal injury cover.	• Supplier Management Framework ○ Development - early Implementation (August 2012)
Case 2: Comcare http://www.comcare.gov.au/	Provides rehabilitation & workers' compensation & OHS arrangements for Australian Government employees and for the employees of organisations which self-insure under the scheme.	• Clinical Framework ○ Development - early Implementation (July 2012)
Case 3: Department of Health (VIC) http://www.health.vic.gov.au/	Planning, policy development, funding & regulation of health service providers & activities which promote and protect Victorians' health.	• National Health Performance Framework ○ Current revision (September 2009)

Case 4: Department of Human Services (VIC) http://www.dhs.vic.gov.au/	Provides information and delivers services in the areas of health, community services, aged care & public housing.	• Department of Human Services Standards
		  ○ Implemented (March 2010)
		  ○ Revised (July 2012)

Case 5: Disability Services Commission – WA http://www.disability.wa.gov.au/	Provides a range of direct services and support and also funds non-government agencies to provide services to people with disability, their families & carers.	• Quality Management Framework (+ output reconciliation process) ○ Implemented (2008)

Case 6: Lifetime Care and Support Authority, NSW http://www.lifetimecare.nsw.gov.au/	Provides treatment, rehabilitation and attendant care services to people severely injured in motor accidents.	• Approved Case Manager Initiative
		  ○ Early implementation (November 2011-June 2012)
		• Tender process for approved Attendant Care Providers (Approved Providers Panel)
		  ○ Implementation (2007)

Table 1 cont. Organisations using a Framework to Measure and Improve Performance of Provider Groups

Organisation	Function	Title & Phase of Framework Development
Case 7: WorkcoverNSW http://www.workcover.nsw.gov.au/	Provides protection to workers and their employers in the event of a work-related injury or disease.	• Workplace Rehabilitation Provider Approval Framework ○ Implementation (2010)
Case 8: WorkCoverSA http://www.workcover.com/	Provides a workers rehabilitation & compensation scheme for the South Australian community.	• Provider Performance and Compliance Framework ○ Early implementation (June 2012)
Case 9: WorkSafe Victoria http://www.worksafe.vic.gov.au/home	Cover for any workers who are injured or become ill because of their work.	• Descriptive only: Star Rating System for Occupational Rehabilitation Providers ○ Early implementation (January 2011)
Case 10: Workers' Compensation Board (WCB) *Alberta* Canada http://www.wcb.ab.ca/	Administer a system of workplace insurance for the workers & employers of the province of Alberta.	• Various models ○ Different contractual arrangements with different providers (e.g. soft tissue continuous care, traumatic, psychological injury models) ○ Introduced (1995)

Note: *Organisations currently using a Performance Framework have been designated a case number for cross-reference with interview data tables provided in Appendix 3.

Table 2. Organisations not using a Framework to Measure and Improve Performance of Provider Groups

Organisation	Function	Performance Related Activities
Australian Centre for Post Traumatic Mental Health (ACPMH) http://www.acpmh.unimelb.edu.au/	Trauma related research, policy advice, service development and education	• Australian PTSD treatment guidelines. • Accreditation services for other organisations (including Department of Veterans Affairs) ○ program evaluation and outcome monitoring • Education for Mental Health providers • Policy development for organisations

Australian Psychological Society (APS) http://www.psychology.org.au/	Professional association for psychologists	• Online self-assessment tool:
		  ○ free resource for APS members
		  ○ anonymous self-assessment on professional practice
		  ○ gives providers a score on performance
		  ○ identifies areas of weakness & identifies appropriate support resources

Hospitals Contribution Fund of Australia (HCF) http://www.hcf.com.au/	Not--for--profit health fund	• Identify & manage improper claiming • Provider profiling: results sent back to individual providers for comparison with other providers ○ Metrics involve number of services not quality of service provided

TIO, Motor Accidents Compensation (Northern Territory) http://www.tiofi.com.au/wps/wcm/connect/tio/website/mac/	No fault motor vehicle accident compensation scheme	• Provider contracts
		  ○ No performance measurement included
		• Treatment providers guide
		  ○ Physiotherapists
		  ○ Psychologists
		• Quarterly provider statistical summaries

Literature review

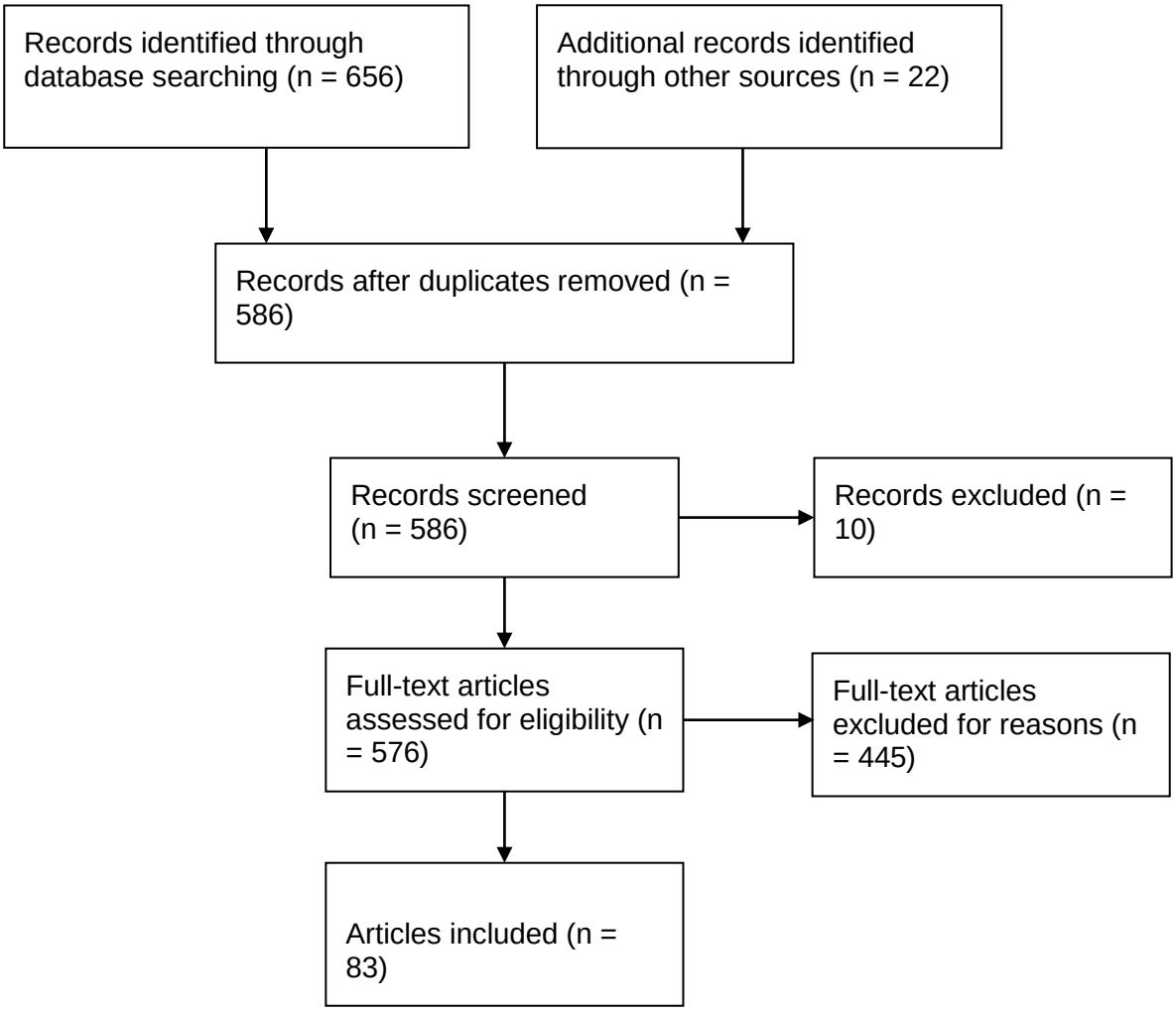
A customised review of the English language literature published from 1 January 2000 – December 31 2012 was conducted to identify models of provider performance management in health care. The concept map to guide the search is shown in Table 3. Both keywords and appropriate subject headings from databases were searched for each concept and OR'd, before ANDing the two concepts. This search was applied to CINAHL, MEDLINE, EMBASE (excluding Medline), PsycINFO, and Informit Health & Business.

Table 3: Systematic literature search: Concept map

CONCEPT 1	CONCEPT 2	CONCEPT 3	CONCEPT 4
Healthcare Health care Subject headings for this concept searched as Explode	Performance management PMF Performance framework* Performance monitor* Performance measure* Performance evaluat* Performance assess* Performance review* Performance compliance* Performance enhancement* Performance improvement* Performance standard* Performance reporting Subject headings for this concept searched as Focus/ Major concept	Quality improvement* Quality management Quality measurement* Subject headings for this concept searched as Focus/ Major concept	Model* Framework* Subject headings for this concept searched as Explode

This search yielded a total of 656 records (CINAHL: 271, MEDLINE: 321, EMBASE (excluded Medline records): 28, PsycINFO: 36, and Informit Health & Business: 0). Following removal of duplicates and screening 83 articles were retained (See Appendix 2). The flow of information through the phases of the systematic search is presented in Figure 1.

Figure 1. Flow Chart



Interviews with representatives of relevant organisations, funders and regulators from other jurisdictions

Interview transcripts were analysed first to identify over-arching themes which could be conceptualised as informing the development and implementation of a performance management framework to maximise provider engagement in the process. The high level themes emerging from the first 7 interviews were presented to HSG staff in a workshop held on 11 December 2012 (see Appendix 3). At the completion of all the interviews, interview data were compiled within the following response categories: 1) Conceptualisation and Planning: Framework, Provider Groups & Nature of Contractual Arrangements, 2) Framework Structure, Motivation to Develop and Initial Implementation, 3) Performance Indicators, Data Use and Reporting (including IT), and 4) Procedures used to facilitate Provider engagement, Outcomes and Limitations of the Framework (See Appendix 4: Tables A4.1- A4.4).

Results: Literature Review

The nature of the literature

It is noted in the literature that there are almost as many conceptualisations of performance in health care as there are health care organisations.[1] In addition, there is marked lack of consensus on concepts and definitions within the performance measurement literature.[2] As noted by several authors,[1,3,4,5,6] this lack of conformity provides a considerable challenge in the context of literature search strategy development. Our relatively inclusive map utilising the first 3 concepts led to high recall but somewhat low precision. We therefore made the decision to include a 4th concept that contained terms for frameworks or models. However, it should be noted that the inclusion of this concept may have resulted in the exclusion of some relevant articles. The final 83 papers included in the review comprised 21 reviews, 15 quantitative evaluations, 5 qualitative evaluations, 1 mixed methods evaluation, 23 case descriptions (including 2 multiple case descriptions) and 18 commentary/opinion articles. Performance measurement and management activities described in the literature were for the most part situated in the USA (42 articles), the UK (18 articles) and less frequently in Canada (6 articles), Australia (6 articles) and New Zealand (1 article).

Defining Terms

The last decade has seen massive growth in the emphasis on quality in healthcare. The Institute of Medicine[7] describes *quality* as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge and defines *quality care* as care which is safe, timely, patient (client) – centred and efficient. Along with the increasing emphasis on quality, there has been a concomitant growth in performance measurement in healthcare. In the context of health service delivery, the term *performance* simply refers to *what is done and how well it is done*[8] and performance measurement is the process of assessing the actual performance of an organisation or provider.[2] *Performance measurement* includes the use of both outcomes and process measures to understand performance and effect positive change to improve care.[9]

Performance measurement is enlisted to serve three purposes: accountability, quality improvement and performance management.[4] *Accountability* captures the obligation to demonstrate and take responsibility for performance in light of agreed expectations usually conferred by a higher authority. Accountability implies more than responsibility, the obligation to act; it implies the obligation to answer for an action.[10] Performance measurement in the context of accountability infers that performance measures are compared with either standards or with other services.[4] In the case of provider performance, accountability refers to the obligation of the provider to measure and report how the provider's performance has resulted in change of the agreed outcomes for a particular client or type of client. In the context of accountability, performance is compared across providers or services and can be published, enabling external audit and providing a means of informing client choice. League tables are an example of performance measurement for accountability purposes.

Quality improvement is defined as a systematic and data-based activity designed to bring about performance improvements in organisational processes and/or products.[6] It is often seen as reactive response to deficiencies in quality. In the present context, this refers to improvements in the services delivered to WorkSafe and TAC clients. Specifically, in the case of provider performance, development of evidence-based practice standards and measuring for improvement in adherence to these clinical guidelines is an example of performance measurement within a quality improvement context. The principal difference between performance measurement for quality improvement and accountability lies in the purpose of the measurement; quality measurement is to facilitate improvement activities and accountability measurement is for comparison purposes. [4]

Performance management is described as a management control process[11] supported by performance measurement. A performance management framework encompasses more than

performance measurement, it includes the vision, team work, training, implementation strategies, feedback processes, incentives etc. that surround the performance measurement activity.[12] While performance management was originally seen as the application of information arising from performance measurement, Adair et al. [2] concluded its contemporary conceptualisation includes "both the set of management activities that set the initial strategy for the improvement efforts leading up to the performance measurement task, as well as the "actioning" of information which, ideally, follows the task" ([2] p.11). In other words, performance measurement in a management framework provides information on which to base future planning decisions. In the case of provider performance, a performance management framework enables the organisation to proactively focus on capacity to reach objectives based on data collected in the past. The performance management framework can be used to connect organisational aims with performance measurement and improvement[13] and to balance performance indicators against each other to prevent over-emphasis on a single indicator (e.g., financial cost).

Positioning and Describing the Performance Measurement & Management Process

Across the literature, a clear distinction between performance measurement and performance management was not always evident and the two terms were often used interchangeably. This tendency has also been noted previously[2,12] and the abbreviation PM will be used to denote performance measurement and management throughout the remainder of this report.

PM was positioned most frequently within conceptualisations of improvement and quality.[14-26] Descriptions were frequently developed around combined quality and performance improvement concepts with some emphasising continuous improvement,[16] solution development (e.g., *innovative solutions to address quality concerns*[17]), practice and services outcomes[20, 22] and quality management.[21]

Typically the PM process is described as a staged process. [2,18,23-29] Although there are differences across the literature in the number of stages identified, the following activities are generally included: conceptualisation and planning, variable/indicator selection and measurement, data collection and analysis/processing, reporting and using results.

Several authors describe general recommendations to consider at the stage of conceptualisation and planning.[2,30,31] These include:

- identification of strategic steering group;
- careful consideration of the issues to be addressed;
- development of criteria for selection of the priority issues to be addressed (e.g., strategic policy direction, high risk client groups, high volume problems, high volume interventions, high volume provider groups);
- conceptualisation of the links between processes and desired outcomes;
- clear identification and characterisation of the stakeholders/intended users, their different perspectives, and how they will use the system;
- development of a strategic engagement process/campaign.

One of the major challenges of introducing performance measurement and management involves the engagement of provider services. Several factors that support the implementation of large scale improvement initiatives by healthcare providers emerged from the literature.[2,14-17,19, 20, 22,28,32-44,

Provider Engagement, Development and Implementation

There is broad consensus across this literature that early consultative engagement with providers is essential and begins with mutual alignment on shared objectives. Indeed, the strongest theme to emerge from the literature was the broad theme of stakeholder collaboration.[2, 14-17, 20, 22, 32-36, 38, 40, 41, 44] Collaboration through an all inclusive participatory process and consensus building was seen as crucial throughout the development, implementation and review of a PM initiative: identifying priorities,[2] obtaining endorsement,[20, 32] developing leadership groups and support networks,[20,33,36] selecting sensitive indicators and client outcomes,[2,15] setting standards or targets,[15] meeting the needs of provider subgroups[33] (e.g., rural or low volume providers), contributing to data interpretation as well as collection,[32] advising re public release of data,[35] providing systematic and ongoing feedback[14] and establishing a process for refining indicators.[44]

The involvement of peak bodies, professional groups, certifying boards and specialty societies featured as an important strategy to facilitate success.[20] The theme of education also appeared throughout the literature. Education was highlighted as a continuous need and a critical component of a structured advanced communication/organisation plan. [28] Education strategies exemplified in the literature included: tool kits specific to groups and environments,[33] practical training sessions,[28] practice-based coaching,[20] simple guidelines,[41] development of PM vignettes[42] and introduction of PM into clinical training curricula.[19]

Transparent information systems,[36, 37] accessible and responsive technical assistance, [33, 17] regular feedback and communication,[14,20] inclusion of interpretation of indicators within performance reports[44] and incentives to promote provider accountability[17,19,20,35] were highlighted as facilitators. Barriers included poorly defined measures,[19] a culture of blame,[22] and lack of supporting evidence.[19]

Indicator Selection, Measurement and Reporting

There are thousands of performance indicators available and in use in healthcare today. Indeed, Alessandrini et al.[45] found 405 potential performance measures in the limited context of paediatric emergency care. Along with the growth in the number of potential measures, there have also been increasing concerns about the validity of these measures and the consequences of using misleading or invalid measures. Our literature review reflected both the quantity and the quality issues in this area with many articles dealing either directly or indirectly with the topic.[4, 5, 14, 27,32, 36, 37, 3945-59]

In the context of PM frameworks, one of the most influential approaches was developed by Donabedian.[60] Donabedian classifies healthcare delivery and its measurement in terms of structure, process and outcomes.[2,4,60] Structure refers to the setting of care delivery; process to the activities between the provider and patient; and outcomes are the end results of care for the patient reflecting effectiveness and efficiency. [4,60] While many continue to focus on indicators/measures across these three domains,[4,61,62] Porter[63] has championed the concept of value in the outcome domain as providing a unifying platform for driving much needed performance improvement in health care. Porter[63] defines value around the customer/client as the health outcomes achieved per dollar cost and states that “achieving high value for patients must become the over-arching goal of health care delivery” and “creation of value for patients should determine the rewards for all other actors in the system” ([63]p. 2477). In this context, value depends on client outcomes and cost refers to the total cost of care for the patient’s condition not individual services.

Porter’s notion that measuring, reporting and comparing outcomes is essential for outcome improvement and decision making about cost reduction is becoming a guiding principle of effective PM in health care, particularly in the US.[64] Comans et al. [49] focused on allied health disciplines to identify indicators currently being used. They noted that the performance measures being used often reflected organisational need and not patient outcome. In line with Porter’s emphasis on

outcome, they concluded that more importance needs to be placed on patient outcomes as a measure of the quality of allied health interventions. Applied to the occupational health care context, Pransky et al. [57] stated that performance measures should address frequently occurring work related health conditions associated with high costs and poor outcomes. They emphasised the importance of stakeholder priorities and a focus on situations where improvement can be achieved through defined approaches.

There is strong consensus in the literature that measures must be robust and evidence-based[2,27,32] and that research should focus on the development of indicators as well as their use.[39] Several authors identified criteria for selecting performance measures in health. For example, Hoelzer et al. [65] identified the traditional measurement parameters of reliability and validity along with feasibility of data collection**,** clinical relevance, transparency, and understandable output for target groups, well-documented standards for data quality and the use of plausibility checks. Kates et al.[66] additionally identified the importance of the explanatory power of the performance measure and the burden associated with collecting data using the measure (cost, time, new data collection efforts, new resource requirements). In addition to quantitative measures, there is a growing acknowledgement of the value of more qualitative approaches to PM.[14,52,54] PM that supports organisations to meet consumer expectations were considered critical. [54]

Multiple reporting strategies are described across the literature including scorecards at individual and group levels,[46, 47, 58] dashboards, [46] and performance reports. [48] The importance of the regularity of reporting (e.g., quarterly) was stressed[48] and the viability of problem-oriented reporting to complement standard reporting was noted.[51] Licensing authorities were identified as a potential partner in the reporting process for professional disciplines [36] and tools to support self-assessment were recommended.[37]

The Nature and Role of Incentives

There is broad discussion of the role of incentives in the context of PM. [3,6,33,35,42,53,67-77] Incentivised management systems can provide financial incentives (e.g., pay-for- performance schemes) and reputational incentives (e.g., public reporting of performance) and there continues to be much debate about their effectiveness. In 2008, Hamblin[53] reviewed the literature to evaluate whether pay-for-performance schemes worked. The review yielded several key findings. The first was that publication of information that enables performance and quality to be compared is a powerful lever for improvement. The second acknowledged the likelihood that schemes that are successful will attract gaming and thus, are better paired with regulatory powers. Finally, Hamblin concluded that regulatory models, which focus on the provision of information with appropriate inspection and enforcement, are appealing in financial terms and in terms of their capacity to stimulate improvement.

In the same year, Maisey et al.[75] published findings form a qualitative inquiry to understand the effects of a 'payment for performance' scheme on professional roles and the delivery of primary care. This work indicated that the organisation, consistency and recording of care improved substantially for incentivised conditions, but not for non-incentivised conditions. Although nurses experienced increased workload, they described more autonomy and job satisfaction. Doctors were uncomfortable with the 'box-ticking' approach but acknowledged improved disease management and teamwork. Participants were less inclined to achieve performance indicators if they did not agree with the evidence on which indicators were based and also felt inundated by the flow of new policy initiatives. Manipulation of data to maximise payments was also described.

PM Literature Summary

- There is marked lack of consensus on concepts and definitions within the PM literature.
- PM is positioned most frequently within conceptualisations of improvement and quality.
- PM is typically described as a staged process.
- One of the strongest themes to emerge from the literature was that of stakeholder collaboration through an inclusive participatory process.
- There is broad consensus that early consultative engagement with providers is essential.
- There are thousands of performance indicators available and increasing concerns about validity.
- It is crucial that client outcomes are a primary indicator in PM.
- Regular, transparent reporting is critical.
- There is continuing debate on the role of incentives in PM.
- Publication of information that enables performance and quality to be compared is a lever for improvement.

Results: Organisational Perspectives

Of the 14 organisations that agreed to participate, 10 were using or trialling a framework to measure and improve performance of health and disability provider groups and 4 were not using a framework. National and state/territory/province jurisdictions were represented, 5 organisations operated within national jurisdictions (4 Australian, 1 New Zealand) and 9 within state/territory/province jurisdictions (8 Australian, 1 Canadian). Brief descriptive information concerning participating organisitions is shown in Tables 1 and 2. Appendix 4 (Tables A 4.1- 4.4) provides the interview data within a categorised format response categories reflecting important aspects of PM development and implementation: 1) Conceptualisation and Planning: Framework, Provider Groups & Nature of Contractual Arrangements, 2) Framework Structure, Motivation to Develop and Initial Implementation, 3) Performance Indicators, Data Use and Reporting (including IT), and 4) Procedures used to facilitate Provider engagement, Outcomes and Limitations of the Framework.

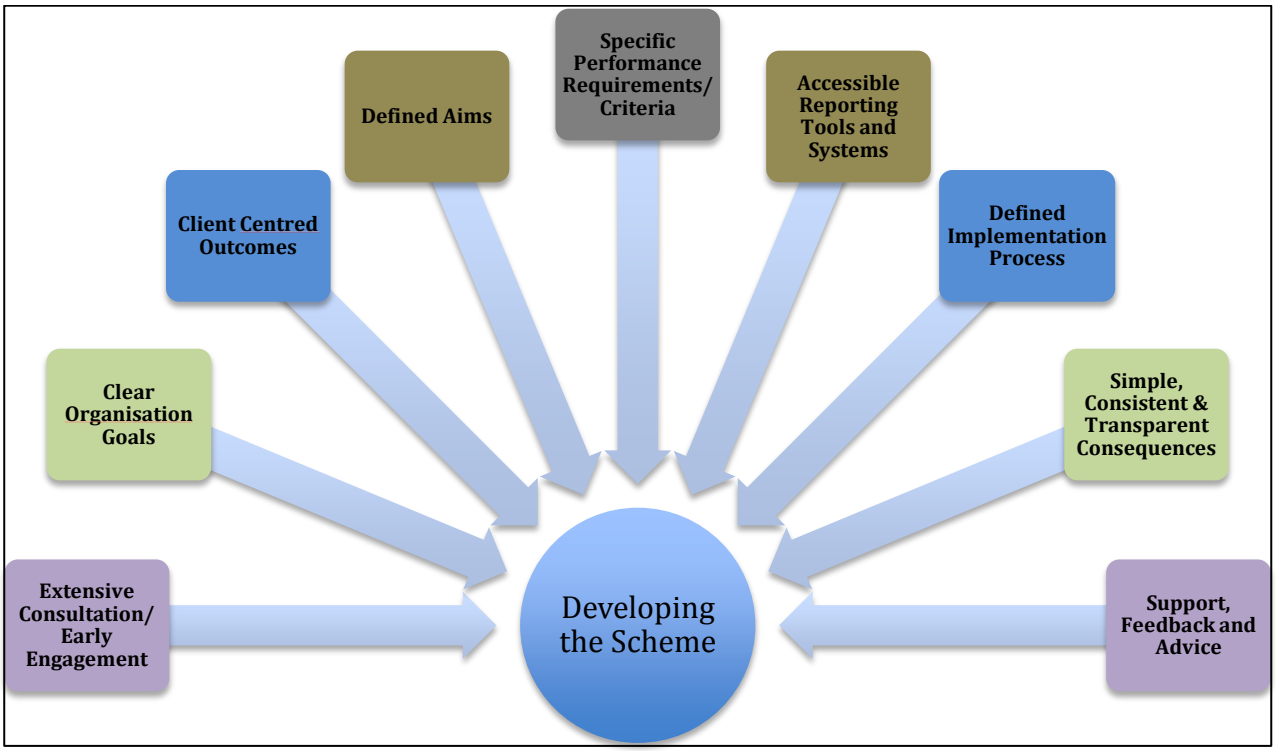
As noted in the literature, there are numerous conceptualisations of performance in health care. This variability was evident across the organisations scanned and was reflected to some degree across the titles applied to their frameworks (e.g., Case Manager Approval Framework, Supplier Management Framework, Provider Performance and Compliance Framework, Quality Management/Improvement Framework, Individual Services Framework). Despite this acknowledged diversity in the literature and the field, there is broad agreement that improving performance and accountability in health care requires clearly articulated inclusive goals that unite all stakeholders. Indeed lack of clarity about goals has been identified as making a substantial causal contribution to lack of progress in performance improvement. As was the case in the literature more broadly, the participating organisations had been motivated towards PM in the context of continuous improvement and working with the sector to improve quality of services and client outcomes. Accountability, scheme pressures and financial viability also contributed as motivating factors for the implementation of a PM framework (Table A 4.1).

The notion that measuring outcomes is essential for improvement and decision making about cost reduction was evident across the organisations scanned in the project. However, it was also clear that a move towards performance management was only a recent development across the majority of organisations. In fact, time since introduction of a framework in those organisations using performance management processes ranged from as short as 2 months to to 2 years, with an average of 12.2 months. Over the time since introduction, 3 organisations had already introduced

some but minimal modification to the framework being used. In this context of recent development, 5/10 organisations indicated information about the framework was available in the public domain, 6/10 reported that performance requirements were stipulated, 3/10 identified performance incentives, and none benchmarked with other organisations. All reported using an IT system to manage the process (Table A 4.3). Although organisational practice varied and implementation was a relatively recent phenomenon, broad themes to guide the development and implementation of a PM scheme emerged from analysis of the interview transcripts (see figure 2). These broad themes also illustrated recommendations contained within the literature.

Themes

Figure 2. Developing the scheme: Broad themes emerging from the interviews



Extensive Consultation / Early Engagement

Extensive consultation with all internal and external stakeholders is a clear requirement for success throughout the development and implementation cycle of PM. Specific reference was made to early and ongoing involvement with providers and professional bodies including the appointment of a steering / reference group with broad representation across stakeholders.

While much of the interview data in Table A 4.2 reveals the use of inclusive consultation strategies, there was a tendency for these practices to appear somewhat unidirectional. In other words they appeared to be education, training or information based rather than opportunities for collaboration. The consultative strategies identified by the participants included seminars, road shows, mail outs, e-communication, and tool kits. This theme and the strategies identified within it clearly mirror the necessity of early engagement identified by many authors in the PM literature. However, collaboration through inclusive participatory processes that build consensus across stakeholders is seen crucial for the ongoing success of PM. Indeed, the literature indicates that the best methodology to apply in this situation is a co-design methodology whereby the stakeholders directly contribute to the design process.[78]

Clear Organisation Goals

A transparent interface between specified organisation goals (e.g., improve client-centred outcomes – degree of functional recovery, support clients to make decisions about care providers, improve quality of services, address unexplained growing costs and levels of service provision) and provider performance criteria is necessary for the success of the PM. Goals tended to be cast in the context of provider management/accountability, cost and client outcomes. There was evidence in the interviews that goals and performance criteria should be articulated in the context of client-centred outcomes, however resource management certainly played a motivating role in the development of a PM framework. As documented in the literature, it is essential that organisational goals do not dictate the nature of the goals ultimately set for clients. The experience of participating organisations also exemplified how reporting tools, measures and systems can act as mechanisms for ensuring functional links between goals, outcomes and provider performance criteria (Table A 4.3).

Client-centred Outcomes

Outcomes in the context of healthcare delivery capture both effectiveness and efficiency and reflect the end results of intervention for the client. The link to client outcomes is important at all levels of PM. Participating organisations were aware of the importance of linking client outcomes in specific domains (e.g., vocational, social, emotional, pain) to cost and service provision performance criteria and for this link to be evident within the reporting tools and measures. However, there was little evidence that this link was conveyed to or perceived by providers (Table A 4.2-4).

Aims Defined for Stakeholder Groups

The aims of the framework require customised definition across stakeholder groups including the client, internal organisation staff, and provider groups and professional disciplines. This requirement was recognised by participating organisations and supported by provider-based activities in some (Table A 4.2).

Specific Performance Requirements / Criteria

Compliance within a PM framework is to a large degree dependent on 3 factors: i) how readily applicable performance indicators are to practice / service provision; ii) how consistent performance criteria are across all the clients seen by the provider; and iii) how easy it is for providers to measure / monitor their own performance.

Given there are thousands of performance indicators available and in use in healthcare today, selection of performance measures is not a straightforward task. As indicated in the interview responses, both the number of indicators and the nature of the measures need to be considered in detail form the perspective of the multiple users. The literature tells us that measures need to be evidence based, clinically relevant and feasible. Providers are often more concerned with the burden associated with gathering and reporting the data and organisations are frequently concerned with the resources required to analyze the data. Clearly, quality improvement requires a collaborative effort.

Accessible Reporting Tools and Systems

Several principles associated with reporting tools were seen as maximising the uptake and use of a performance framework: i) reporting tools should be easily accessible online; ii) reporting tools are best situated within software systems that are familiar to providers (e.g., Excel) and easy to use; and iii) reporting tools should include online training packages and access to helpdesk support. All of these strategies were evident in the interview transcripts, despite the fact that IT development was identified as needing improvement in the majority of the organisations scanned (Table A 4.3).

Defined Implementation Process

Staged implementation with stepwise evaluation throughout the process is recommended. Trial runs with specific provider groups and dedicated feedback forums are broadly endorsed in the literature and also appeared in the interview data. Implementation in several organisations was facilitated through the ongoing engagement of a steering / reference group with broad representation across all stakeholders (Table A 4.1 & 4.2).

Simple, Consistent and Transparent Consequences

Provider performance consequences are predominantly situated directly or indirectly within the financial domain. Direct financial consequences include pay for performance schemes where payment is linked to outcomes. Indirect financial consequences result from changing referral patterns (e.g., fewer referrals to low performing providers). Consequences of poor performance must be clearly defined and consistent from the outset. Risk indicators (e.g., level of performance on percentile charts comparing individual with peer providers as a group, star rating performance) need to be coupled with timely warning alerts and corrective processes (Table A 4.3). Incentives are also used to shape performance and influence outcomes. Incentives can include financial consequences (e.g., bonus payments, sliding fee scales linked to high performance) and recognition of preferred provider status (e.g., mentor designation, awards).

Support, Feedback and Advice

Well-developed ongoing support processes are essential for effective performance management. Feedback systems need to be built directly into the framework and mechanisms for provider initiated self-monitoring are recommended. Self-assessment tools were only referred to by two participating organisations and the lack of use of such tools may well be a lost opportunity for provider engagement and education. Advice needs to be readily available and coupled with specific corrective strategies for improvement. Individualised outlier programs can be developed to target specific providers or provider groups and were used by organisations in the current sample.

PM Interview Summary

- PM was positioned primarily in the context of quality/performance improvement.
- Stakeholder consultation had occurred but the tendency was for consultation to play an educative or training role rather than a collaborative role.
- PM goals were cast in the context of provider accountability, cost and client outcomes.
- For most organisations, PM was in a relatively early stage of development or implementation.
- Evidence of the effectiveness of the PM initiatives was at best preliminary.
- IT was identified as an area requiring ongoing development.
- Incentives were primarily situated in accountability via comparison of individual provider data with group data.
- PM initiatives are an excellent context for application of co-design methodology.

Conclusion

Performance improvement initiatives have become a focus of healthcare providers throughout the developed world. The literature addressing PM has grown exponentially over the last decade. While the number of published research studies is increasing, the literature continues to comprise a large number of commentary or opinion pieces. Across this literature and regardless of the level of evidence, there is one factor that emerges repeatedly as crucial to the success of PM initiatives. This factor captures the critical role played by inclusive collaboration across stakeholders in the outcomes achieved through PM. Given the powerful effect of early collaborative practices in this arena, it is recommended that the next phase of development and implementation of PM utilise co-design methodology with the participatory involvement of all stakeholder groups. Co-design methodology will effectively inform decisions at all levels of a PM framework.

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Appendices

1. Interview Schedule
2. Interview Data Spreadsheet
3. High Level Theme Presentation (11 December 2012)
4. Interview Transcript Summary