Here are some thoughts:

I think most people are going to accept the need for comparison between hospitals of quality measures.

BUT

Data integrity – if data is going to be used to separate “the good” from the “need intervention” data integrity must be of a very high standard. I have been through pseudo-catastrophes with VAED data and coding data that appeared to show problems but when investigated we found data problems, not real problems. Worse, decisions were made in some cases on incorrect assumptions.

Wherever possible, and I know it is hard, measure outcomes! This drives the organisation in the right direction, anything else leads to gaming and unintended consequences.
-Right diagnosis?
-Right treatment for that right diagnosis?
-Was the right treatment given for the right reason in reasonable time?

Avoid the temptation of automatically collecting and relying on automatically collected process measures. Patients do not care if they are in hospital for 3.1 days instead of 2.7 days. They do care if the diagnosis was wrong or the treatment was wrong or they received it too late.

Managers are only really motivated by financial KPIs, and in some cases they have bonus culture personally driving them. Bonus culture has NO PLACE in a public hospital, it creates perverse incentives.

We need KPIs for success of teaching (we are teaching hospitals after all) and quality as well as for economic efficiency. The teaching and quality measures could be given a pseudo dollar amount so they stand next to the real dollars on the annual budget spreadsheet. This is the only way these things will really get proper consideration.

Regards
Paul Johnson

Professor Paul Johnson
Infectious Diseases Department
Austin Health & University of Melbourne
T. +613 9496 6678
F. +613 9496 6677
E. paul.johnson@austin.org.au