



*Analisi comparata dei sistemi di valorizzazione delle
risorse umane nell'ambito sanitario
Pay for Performance (P4P)*

Leonardo Falduto

What Are Pay-for-Performance Programs?



Pay-for-Performance (P4P) programs **link compensation to results** and serve as potentially powerful catalysts for strengthening health systems and achieving health targets. Many developing countries are piloting and scaling-up P4P programs to improve health results and meet health Millennium Development Goals.

Pay for Performance e Performance Contracting

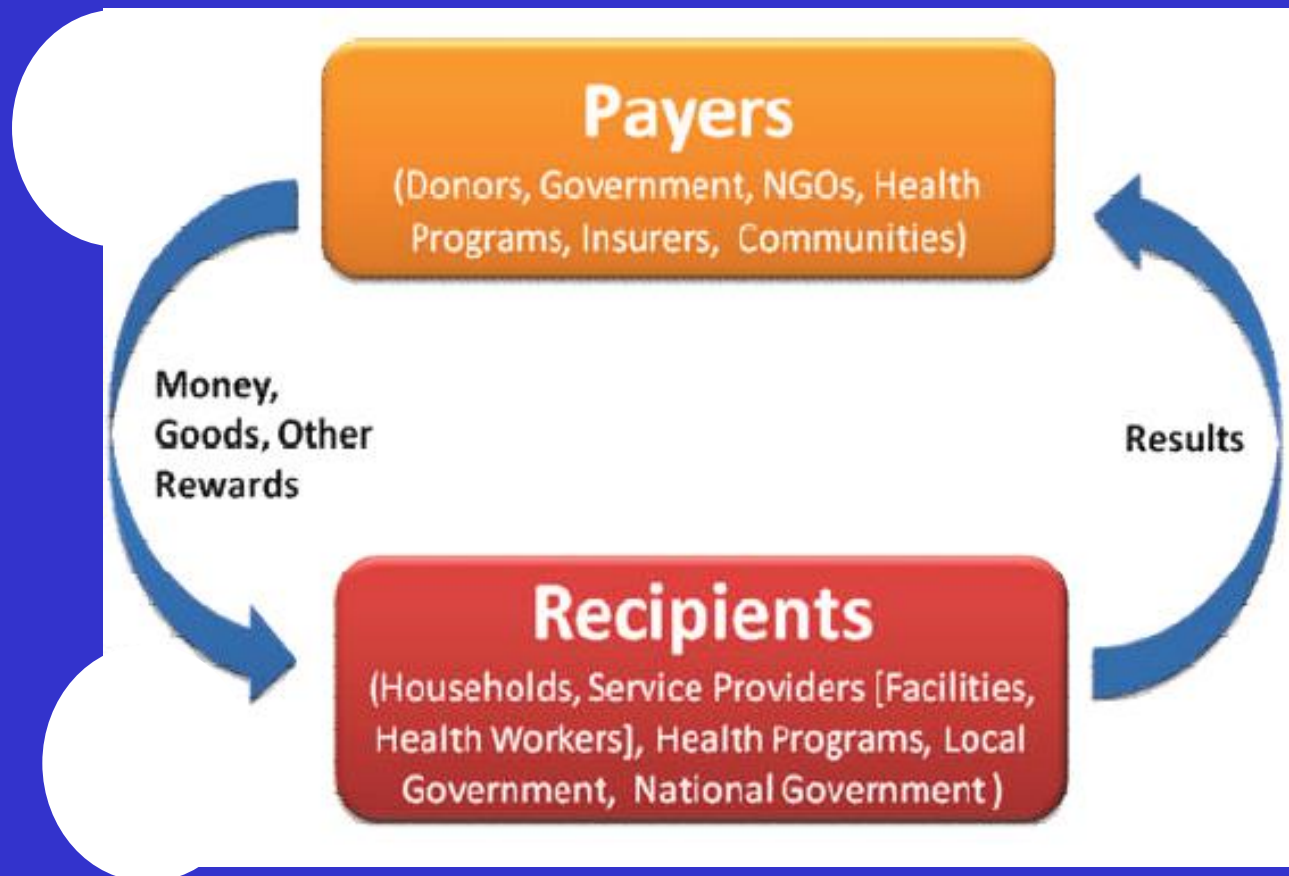
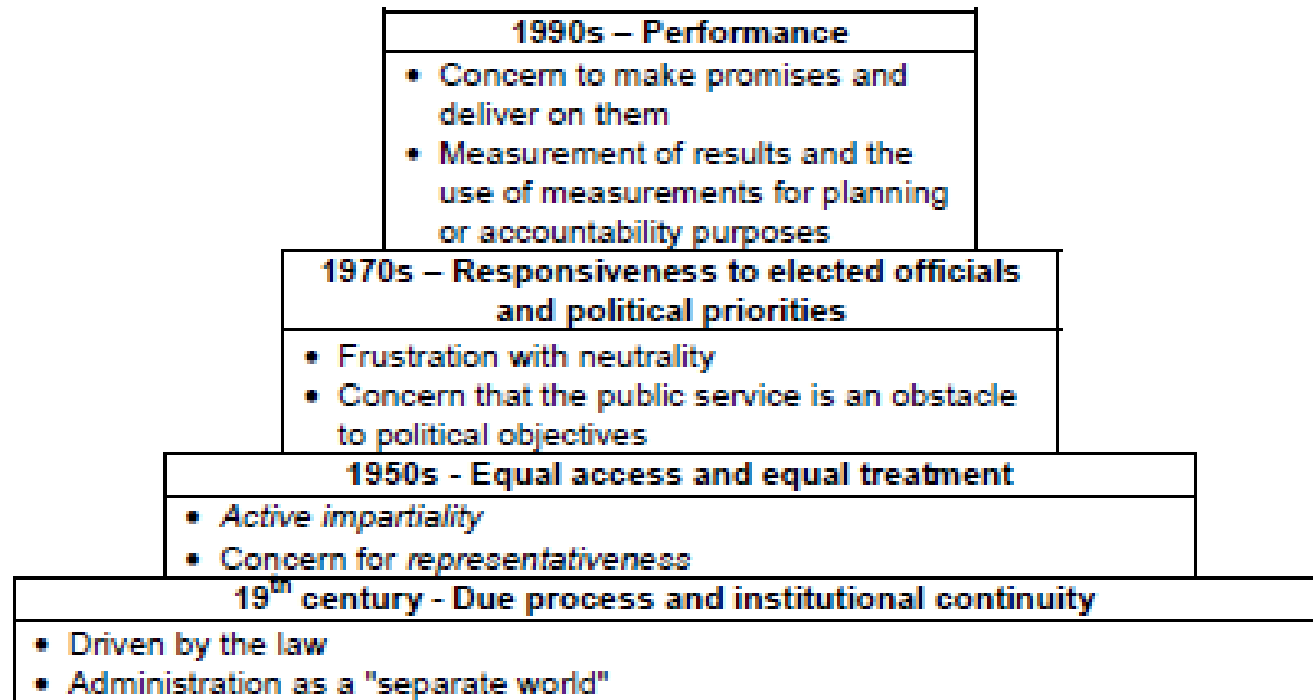


Figure 1. The historical foundations of the performance movement in the OECD



Source: Based on (Blum et al: 2007).

- I Sistemi P4P:
 - da un lato tendono a stimolare le Organizzazioni Sanitarie al raggiungimento di particolari obiettivi (*Performance-based Contracting*) correlando a tali Performance il trasferimento di una quota addizionale di Risorse Finanziarie (provenienti dal finanziatore), definita nel suo valore massimo teorico, rispetto ad un valore base trasferito su base storica o capitaria.

EXAMPLE: Name of recipient	Public health centers	
Amount of payment linked to performance	10% of historical budget to deliver target services (funded by a combination of withholding 5% of historical budget and an additional 5% of historical budget as potential additional funds)	
Amount of payment not exposed to risk	95% of historical budget to deliver target services	
Formula for performance payment	Performance Target	Associated Weight
	e.g., 10% increase in full immunization coverage	0.2
	e.g., 20% increase in # of pregnant women receiving at least 3 prenatal care visits	0.2
	e.g., 5% increase in the number of mothers with full knowledge of oral rehydration therapy	0.1
	e.g., 50% of outreach points with at least 3 modern family planning methods	0.1
	e.g., 25% reduction in the discontinuation of family planning	0.2

	e.g., 50% reduction in waiting times for child patients	0.1
	e.g., well-defined community committees with appropriate coordination with Ministry of Health	0.1
	Total	1.00



- The NHI (national Health Insurance) pays the clinics a monthly member capitation payment; “members” are persons enrolled on a clinic roster. Clinics, therefore, have an incentive to register as many people as they can. Each month, the NHI pays clinics 70% of the member capitation payment upfront. The remaining 30% of the payment depends on how the clinic performs on groups of indicators that lead to scores for:
 - efficiency (70 % of the withheld amount),
 - quality (20 % of the withheld amount), and
 - administrative processes (10 % of the withheld amount).If an indicator is not fully achieved, then the proportional weight is deducted from the clinic’s total potential payment for that month.

- A very low performing clinic could potentially receive only 70 percent of the capitation payment (quota capitaria), though this has not occurred. The total potential payment is a *per capita* allotment multiplied by the number of people registered (nell'esempio $6,3 \$ * 12.000 * 0,7 = 75.600 \$ * 0,7 = 52.920 \$$).

Monthly Indicators	How Measured	Performance Standard	Maximum Amount (US dollars)
Efficiency Indicators: (70%)			\$15,876
1. Productivity per GP team/day	Database exported to NHI by clinic	28-36 pts/shift	\$3,176
2. Rational drug usage (drugs/encounter)	Database exported to NHI by clinic	<2.0	\$3,176
3. Rational imaging usage (tests/encounter)	Database exported to NHI by clinic	<0.5	\$3,176
4. Rational laboratory usage (tests/encounter)	Database exported to NHI by clinic	<1.5	\$3,176
5. Completeness of encounter forms/rostered patients	Survey (bi-annual survey implemented by NHI)	99% forms complete	\$3,176
Quality Indicators: (20%)			\$4,536
6. Patient satisfaction: survey	Survey (bi-annual survey implemented by NHI)	>80 patient satisfaction	\$2,268
7. Medical Records compliance	Random auditing of medical records	99% compliance	\$2,268
Administrative Indicators: (10%)			\$2,268
8. Unreported encounters/activities	Database exported to NHI by clinic	<0.5% margin of error	\$1,134
9. Data entry errors	Database exported to NHI by clinic	<1.0% margin of error	\$1,134

Il bonus massimo teorico è invece pari al 30% del totale capitaro: 30% di 75.600 = 22.680 \$

Totale: \$22.680

- Dall’altro, sfruttano l’effetto motivante del c.d. *goal setting* e dei conseguenti effetti valutativi a beneficio/carico degli operatori sanitari (*supplier*) in termini di *bonus* o penalizzazioni commisurati al livello di *performance* (assoluto o relativo) effettivamente raggiunto .

Uncertainty and Doubt

THE WALL STREET JOURNAL.

- 60% of Americans believe there are fair ways to measure and compare medical care
- 38% would support pay based on quality ratings while 47% are unsure and 15% are opposed

*WSJ/Harris Interactive poll
conducted 2/6 – 2/8*

The San Diego Union-Tribune.

“A review of 10 pay-for-performance programs by PricewaterhouseCoopers found tremendous variation among how health care providers were evaluated and how bonuses were paid, creating an administrative nightmare for providers participating in multiple programs.”

February 24, 2008

P4P incentives are designed to encourage behaviors that both increase:

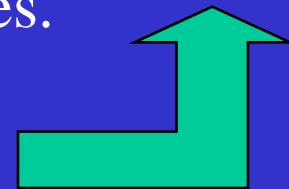
- demand for and use of services and
- improve the quality and availability of those services.

Payments may be issued:

 **Demand Side**

- To households or patients for a specific action (such as delivering at the health facility) as well as
- To service providers, such as physicians, hospitals, and health clinics, for increasing the quantity and improving the quality of their services.

Supply Side



Individuals or groups of public and/or private providers can receive payments that are linked to increases in service utilization or improvements in service quality. Recipients of performance payments can often decide how to use the money empowering them to think creatively about:

- how to reward staff,
- improve facilities,
- reach communities and
- overcome system constraints.

- Choosing the type of P4P approach to use depends in large part on the realities of the health system and health priorities of a country.
 1. In countries with stable government leadership, pilots or a scaled-up national model that pays for results in public facilities can prove to be a valuable option.

2. In a fragile state environment, contracting NGOs and paying them based on achieved results may prove to be a more successful approach. If utilization barriers are primarily on the demand side, payments can be linked to health actions taken by users.
3. { A decentralized system where the national government wants to stimulate improved performance at subnational levels of the country may benefit most from an approach that **links federal to state level transfers to results.**

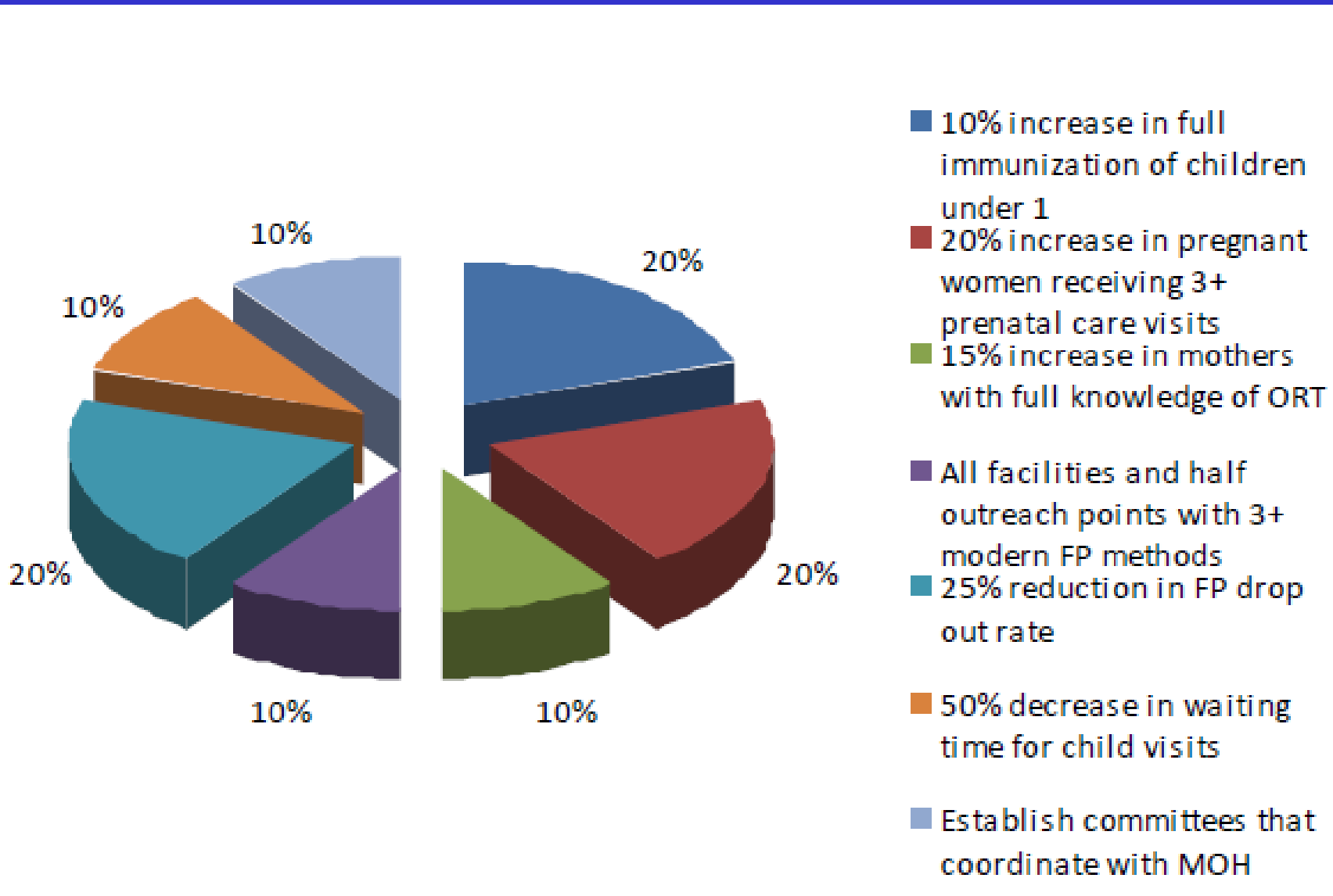
Supply-side P4P interventions reward performance achieved by entities and workers involved in organizing and delivering health care, preventing illness, and promoting health. P4P initiatives can motivate providers to develop innovative strategies to improve outreach that will achieve health goals, as well as improve the volume and quality of services. Examples of rewards include the following:

- **Financial bonuses** to reward good performance and/or penalties for poor performance. This can motivate community outreach, in particular to underserved areas; encourage more convenient clinic hours; improve provider-patient interactions; and stimulate solutions that reduce financial barriers faced by households.
- **Social, community-based, and private insurance** that pays providers based on performance.
- **National-to-local transfers based on results**, which can stimulate local solutions that improve provider performance and reduce financial barriers to access.



Formula dei bonus

- There is no set approach to development of a payment formula. What is clear, however, is the importance of *clearly specifying the terms of payment in a written contract or performance agreement that is signed by both recipient and payer*. Examples of payment formulas are the following:
 - 1. Payment formula: All or nothing population-based targets:
 - Total potential payment received by health facility = 95% of historical budget + performance bonus.
 - Maximum potential performance bonus = 10% of historical budget.



Il Finanziamento del P4P

The team can also advocate for *new funding sources* to cover the award fee amount. This is likely to be the most attractive to recipients. However, if these funds are only available for a short period of time, the long-run viability of the program may be threatened. It is possible, however, that demonstration of strong results from P4P using external funding may provide the evidence policymakers need to increase public spending for health.

- Lobby donor partners for funds – many donors are increasingly adopting a performance-based culture.
- Lobby the Ministry of Finance for additional funds.

Limiti -



The following problems with the implementation of PRP are repeatedly cited across the literature:

- PRP systems are expensive and are administratively burdensome.
- Managers show particularistic tendencies, especially in countries with patronage politics and a politicised bureaucracy.
- Unions often resist the introduction of PRP schemes.
- Performance related bonuses are generally too small to motivate in any significant way.
- It is difficult to objectively quantify and measure performance, especially when people work in teams.

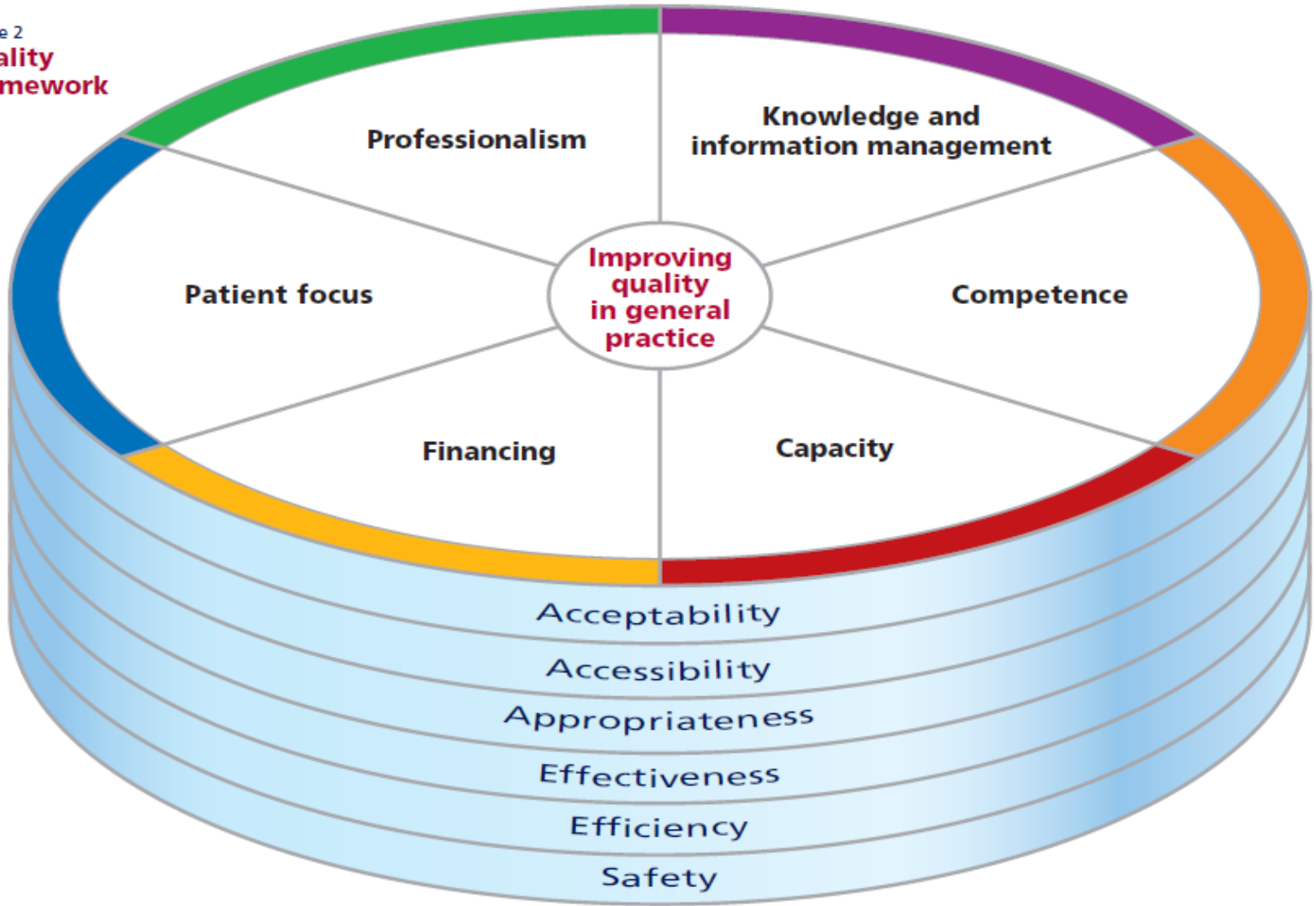
Precondizioni

- A supportive legal framework
- A strong performance assessment system
- Good management and administration capacity
- Adequate monitoring systems
- Good records management.

Fattori abilitanti di contesto

- Other contextual factors that will support the implementation of PRP include:
 - High political commitment and flexible government
 - Supportive trade unions
 - High administrative and managerial capacity
 - Stable economic growth to finance PRP
 - Strong donor / government coordination
 - Good donor harmonisation (to allow for pooled funding arrangements).

Figure 2
**Quality
Framework**



	National framework – Australia	POPULIS – Canada	Performance assessment framework – UK	HEDIS 2000 – USA	PHIS, HIPE, IMRs, PIs – Ireland
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Health improvement/outcomes

Elective preventive interventions		X			
Health outcomes of care			X		X
Health/ill-health		X	X		X

Effectiveness and quality

Effectiveness	X		X	X	X
Quality		X			X
Appropriateness	X		X		X
Safety	X				
Technical proficiency	X				

Patient-oriented services

Acceptability	X				
Patient/carer experience			X	X	
Informed health choices				X	
Health plan descriptives				X	
Continuity	X				

Access

Access	X	X	X	X	X
Service utilisation		X		X	X

Financial/resource management

Cost of care				X	
Health plan stability				X	
Efficiency	X		X		X

Additional indicators

Demographic changes		X			
Socio-economic risk characteristics		X			X

5.2.1 Health improvement/outcomes

The public health information system (PHIS) contains data on three types of population health outcome – fertility, mortality (death) and morbidity (illness). A small amount of data is also kept on outcomes of care – caesarean sections, low birth weight and causes of mortality. It is anticipated that the PHIS and national cancer register will enable progress on longer-term health outcomes to be monitored at national and regional levels in the future and will enable closer examination of inequalities in health across the country.

5.2.2 Effectiveness and quality

A clear distinction can be seen between indicators of appropriateness and effectiveness/quality in the service plan indicators.

- (a) *Appropriateness*: Indicators of appropriateness generally refer to care settings and their appropriateness in terms of what is known about best practice, for example re-attendances in A&E and OPD and rate of transfer of inpatients in mental health services where treatment in the community is more appropriate. HIPE data includes length of stay, discharge destination and number of day cases by diagnosis related group (DRG).
- (b) *Effectiveness/quality*: Three types of indicator relating to effectiveness/quality are seen:
 - (i) Indicators of success in increasing the uptake of services, such as immunisation and breastfeeding rates, the uptake of paediatric surveillance and the number of foster carers recruited.

5.2.3 *Patient-oriented services*

The findings suggest that the dimension of performance identified in other health systems but neglected in the Irish system, at least at national and regional level, is patient orientation/satisfaction. The need for services to be more clearly focused on the patient and the concept of a patient-focused approach to be reflected in performance management is emphasised in Framework 1 of the *Programme for Prosperity and Fairness* (2000). It suggests that a patient-focused approach would include realigning and reconfiguring services in a way that puts patients first; using feedback from users in the service planning/business planning process and reflecting the needs of users in team and high-level objectives; and developing performance standards to monitor the level of quality of service. It proposes a number of 'key elements of a change programme' as possible indicators of success for the next phase of implementation of the health strategy (see Appendix 3). Examples given include extending hours of service to the public, addressing waiting times, auditing patient satisfaction and improving communication.

5.2.4 Access

Access indicators are used in six of the seven programme areas and more extensively in some than in others. Examples are seen of the concept of access in terms of distribution of services and fair access as in the UK system. Perhaps the best examples are seen in services for older people: the proportion of people assessed as requiring services who actually receive them within a certain time-frame (although the time-frame or how it should be derived is not explicit). Indicators of fair access in primary care include the proportion of targeted school children covered by dental screening, and the proportion of practices having a female GP. In services for persons with intellectual disability an objective is set to identify needs for specialised services and to develop appropriate responses. In services for persons with physical disability data are required on access to additional day and residential places, additional home support services and personal assistants, respite care and additional therapists. However, in this area the measures used could be improved, as discussed later in this paper. The HIPE system contains data on referrals in terms of source of referral, area of residence and GMS status.

Indicators of access in terms of individuals obtaining the same quality of services, as identified by Boyce *et al.* (1997) in Australia, are also included. Examples in the acute hospitals area include waiting times for outpatient appointments and for inpatient admissions, and waiting times in the outpatient (OPD) and accident and emergency departments.

5.2.5 Financial/resource management

Resource management

Data on resource management in IMRs includes expenditure, income, employment and variance against agreed budgets.

Efficiency

Efficiency indicators are found only for child/family services, environmental health and food control areas. Examples include:

- numbers of premises re-inspected and average waiting time for inspection
- proportions of intra-country applications for adoption received that are completed and average waiting time
- proportion of tracing requests completed within 12 months, and average waiting time from receipt of application to commencement of tracing.

Efficiency indicators for environmental health relate to the proportion of premises inspected and target numbers for sampling. IMR data relating to efficiency includes data on bed use, day cases and A&E and outpatient attendance patterns.

Area for motivation	Define indicators of performance	Determine targets for improvement	Describe how indicators will be measured and validated
1. Maternal mortality (Neonatal mortality) – Mothers / Health provider	% of skilled supervised deliveries at health facilities	Baseline = 62% Year 1 = -10% Year 2 = -8% Year 3 = -7%	HMIS data, Validated by Community-based data surveys [post natal mothers delivered by skilled personnel]
2. TB (Clients – H/facility + Community volunteers)	% TB cure rates	Baseline = 71% Year 1 = +5% Year 2 = +6% Year 3 = +7%	HMIS data, Lab data [Smear negatives]
3. RTI/Pneumonia [HF / Care takers]	Incidence of RTI/ pneumonia among children <5	Baseline = 71% Year 1 = -15% Year 2 = -9% Year 3 = -6%	HMIS data, Community data [Community mapping of priority diseases among <5 children, KII; incidence of coughing/ fever + fast breathing, dyspnoea]
4. Under-5 mortality [HF / Care takers]	% children under 5 immunized	Baseline = 81% Year 1 = +8% Year 2 = +7% Year 3 = +4%	HMIS data, Community-based data [Immunization scars, sites, client knowledge, <5 cards]
5. Malaria [HF / Care takers of <5 children]	Malaria attendance [HF]/ Fever prevalence [Com] among <5 children; ITN / IRS coverage	Baseline = X% Year 1 = ±18% Year 2 = ±10% Year 3 = ±8%	HMIS data, Community-based data Incidence of fever among children <5 children, Proportion of households with at least 1 ITN or Sprayed

TABLE 2. KEY PERFORMANCE INDICATORS FOR ANNUAL BONUS PAYMENTS FOR BELIZE CITY PRIMARY CARE PROVIDERS, APRIL 1-DECEMBER 31, 2009

Primary Care Providers (PCPs)	Target	Bonus	Means of Verification
At least 90% of the GPs and nurses have received training on protocols in the last year (Chronic Disease Management Protocols)	90%	5%	Report from PCPs on training with list of participants signatures
Percentage of clinical records with incorporated forms and complete information*	80%	15%	Audits by NHI
System for suggestions/complaints in place	Yes	5%	Facility evaluation by NHI (direct observation)
Percentage of complaints resolved within two weeks	80%	5%	Facility evaluation by NHI (direct observation)
At least 85% of PCP patients expressed full satisfaction** with regard to services received from the PCP	85%	15%	Patient Satisfaction Survey by NHI
Percentage of women age 19-64 who had a Pap smear test in the last two years	50%	10%	Reports from PCPs and data analysis by NHI
Percentage of pregnant women with one prenatal care visits during the first trimester	50%	10%	Reports from PCPs and data analysis by NHI
Percentage of high-risk pregnancy cases with at least seven prenatal care visits during their pregnancy period	80%	10%	Reports from PCPs and data analysis by NHI
Percentage of men over 50 yrs of age who had Prostate Specific Antigen (PSA) test a during the past two years	30%***	10%	Reports from PCPs and data analysis by NHI
Compliance with Medical Protocols implementation (diabetes, hypertension, and asthma) ²	75%	15%	Protocol audits by NHI
		100%	

PAYMENT PROCESS

The NHI makes the incentive payments to each clinic. It is up to the clinic administration to distribute the payment; that is, each clinic can choose how much of the payment is used to pay personnel vs. investing in infrastructure or other inputs. In public clinics that receive a bonus, the usual policy is for all staff to get a \$300 bonus.



Performance Measures Waiting Times – Acute Care Procedures

Coronary Artery Bypass Graft (CABG) Wait times: Percentage meeting Target, Median Wait Time and 90th Percentile Wait Time

AHS CABG* Wait Time Performance (April 1 to June 30, 2009)

Urgent Target = 1 week, Semi-Urgent Target = 2 weeks, Non-Urgent Target = 6 weeks

<i>Site</i>	<i>Urgency Rating</i>	<i># Patients</i>	<i>% That Met Target</i>	<i>Number of weeks by which 50% of patients had their surgery</i>	<i>Number of weeks by which 90% of patients had their surgery</i>
Foothills Medical Centre	Urgent	50	100%	0.4	1.0
University of Alberta Hospital	Urgent	74	39%	1.1	2.0
Foothills Medical Centre	Semi-Urgent	27	100%	1.9	2.0
University of Alberta Hospital	Semi-Urgent	4	0%	3.3	7.0
Foothills Medical Centre	Non-Urgent	61	34%	8.0	15.7
University of Alberta Hospital	Non-Urgent	61	13%	9.0	20.1
Total		277	49%	N/A	N/A

* CABG only procedures

Wait times for surgical procedures are an indicator of access to the health care system and a reflection of efficient use of resources. Wait times are for elective procedures.

Performance Measures

Length of Stay - Emergency and Urgent Care

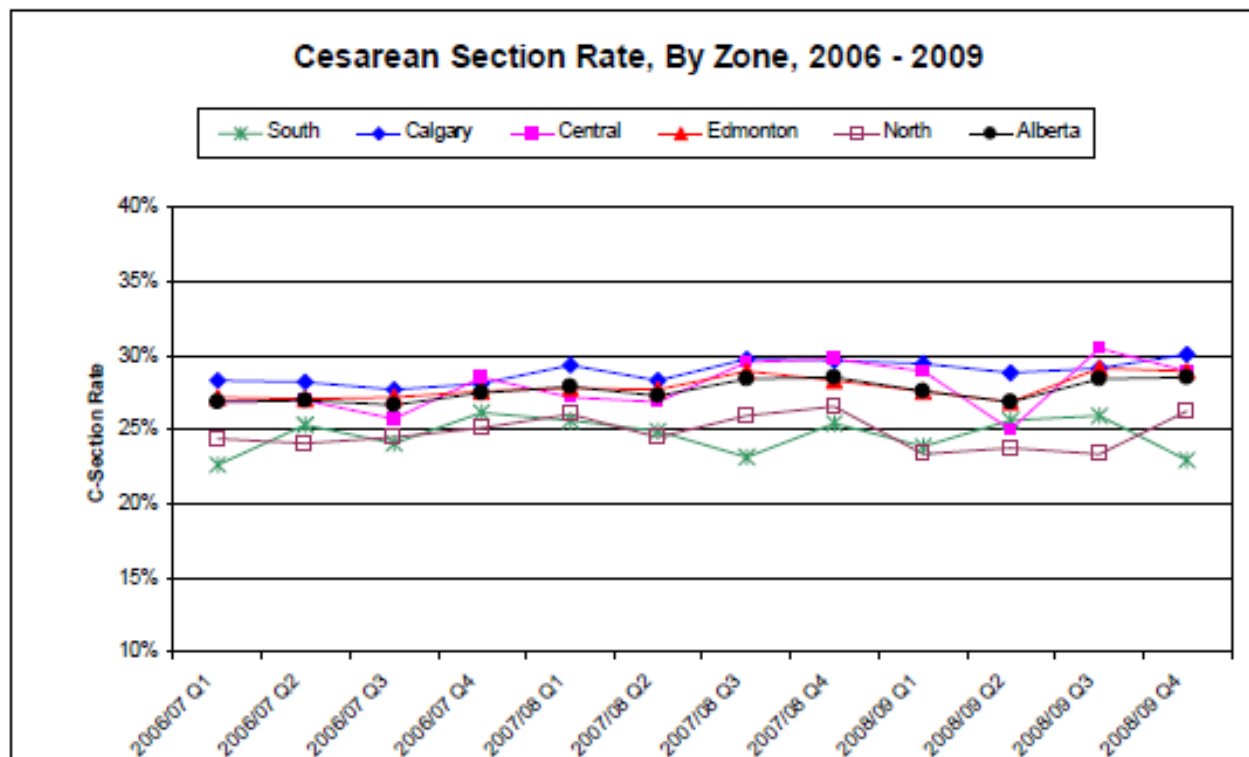
Emergency Department Length of Stay – 14 high volume sites

Quarter 4 2008/09 (Jan. 1 to Mar. 31, 2009)

Peer Group	Site	90th percentile Time In Hours ED LOS for Uncomplicated Cases	Median Time In Hours ED LOS for Uncomplicated Cases	90th percentile Time In Hours ED LOS for Complicated Cases (7 day window)	Median Time In Hours ED LOS for Complicated Cases (7 day window)
Teaching	Alberta Children's Hospital	5.2	2.9	7.4	3.7
	Foothills Medical Centre	7.4	3.1	20.9	6.1
	University of Alberta Hospital	7.9	3.4	20.0	5.3
	Grey Nuns Community Hospital	5.4	2.0	18.4	4.7
Large Urban	Misericordia Community Hospital	4.7	1.7	12.7	3.8
	Peter Lougheed Centre	6.9	3.0	16.4	5.2
	Rockyview General Hospital	5.4	2.0	19.4	5.1
	Royal Alexandra Hospital	11.0	4.9	24.6	7.3
Large Urban Ambulatory	Northeast Community Health Centre	5.8	2.8	7.8	3.6
Regional	Chinook Regional Hospital	4.8	2.3	7.5	3.4
	Northern Lights Regional Health Centre	4.3	1.6	6.3	2.6
	Queen Elizabeth II Hospital	6.0	2.5	9.0	3.7
	Red Deer Regional Hospital Centre	4.2	2.0	16.8	4.4
Suburban/Rural	Sturgeon Community Hospital	5.7	2.7	11.1	4.1
Overall	14 high volume site aggregate	5.9	2.5	15.9	4.6

The Emergency Department (ED) length of stay (LOS) is the time from when a patient is triaged until they are discharged or enter the hospital (leave the emergency department).

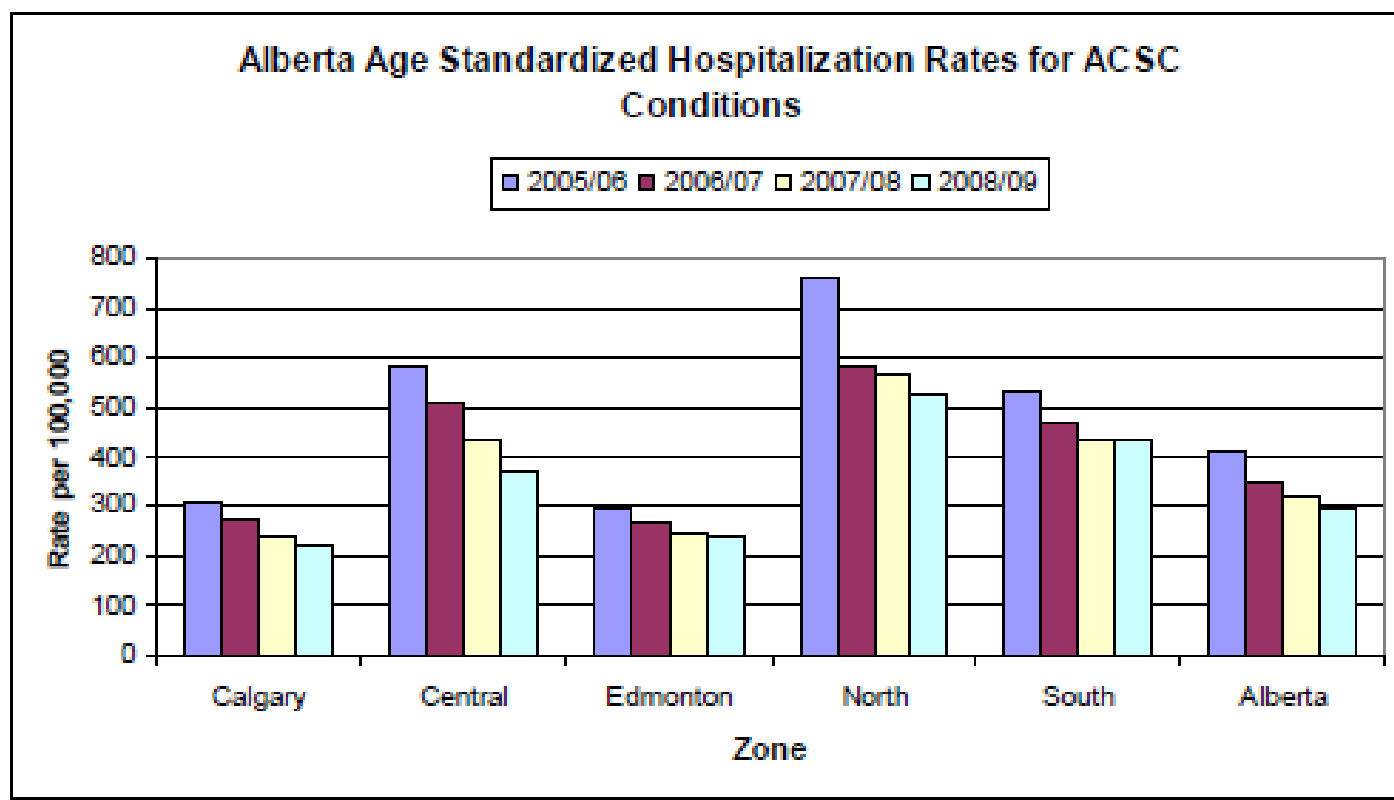
Caesarean Section Rate by Zone and Quarter



Caesarean section rates provide information on the frequency of surgical birth deliveries relative to all modes of birth delivery. Since Caesarean section delivery increases maternal morbidity/mortality and is associated with higher costs, Caesarean section rates are often used to monitor clinical practices with an implicit assumption that lower rates indicate more appropriate and more efficient care. (CIHI Health Indicators Report)

A higher rate of Caesarean section deliveries would be expected in Edmonton and Calgary because referral centres for high risk pregnancies are located within these zones.

Hospitalization Rates for Ambulatory Care Sensitive Conditions (ACSC) measured per 100,000 population younger than 75 years of age by Zone and Year



Ambulatory Care Sensitive Conditions (ACSC) are conditions where appropriate ambulatory care may prevent or reduce the need for hospitalization. These conditions include *Angina, Asthma, COPD, Diabetes, Grand Mal Seizures/Epileptic Convulsions, Heart Failure/Pulmonary Edema and Hypertension*.

While not all admissions for these conditions are avoidable, appropriate ambulatory care in the community could potentially prevent the onset, control an acute episodic illness or condition, or manage these types of chronic conditions. In addition to improving the health of the patient, this could have an impact on health spending for chronic illnesses in Canada.

Hospitalization for an ACSC is considered to be a measure of access to appropriate primary health care. A disproportionately high rate of ACSC is presumed to reflect problems in obtaining access to appropriate primary care (CIHI).

Here the hospitalization rates are age standardized using Alberta Registry Population Data, Provincial Inpatient Discharge (DAD) Abstract Data, 1991 Census Data.

Primary Elective Knee Replacements (April 1 to June 30, 2009)

Benchmark = 26 weeks

Site	# Completed	% That Met Provincial Territorial Benchmark and AHS Target	Number of weeks by which 50% of patients had their surgery	Number of weeks by which 90% of patients had their surgery
Foothills Medical Centre	27	81%	15.9	39.2
Health Resource Centre	113	96%	9.9	22.1
Misericordia Community Hospital	114	41%	30.2	86.7
Peter Lougheed Centre	111	77%	15.7	37.9
Royal Alexandra Hospital	245	58%	24.3	54.7
Red Deer Regional Hospital	62	89%	15.9	27.0
Rockyview General Hospital	146	80%	15.7	32.1
University of Alberta Hospital	46	89%	12.7	26.3
Total	864	72%	18.0	48.0

Timeliness of Care in Tertiary Oncology Facilities (Referral to First Consult): Percentage meeting Target, Median Wait Time and 90th Percentile Wait Time

(April 1 to June 30, 2009)

TIME PERIOD 1: REFERRAL TO FIRST CONSULT - The number of days between the date that a referral was received from a physician outside a cancer facility (eg, family physician or surgeon) to the date that the first consult with an oncologist occurred. Target = 4 weeks

Facility	Type of First Consult	Number of patients who had their first consult	% That Met Target	Number of weeks by which 50% of patients had their first consult	Number of weeks by which 90% of patients had their first consult
Cross Cancer Institute	Medical Oncologist ¹	613	70%	3.0	6.1
Cross Cancer Institute	Radiation Oncologist	614	70%	2.7	9.9
Tom Baker Cancer Centre ²	Medical Oncologist	905	82%	2.0	6.1
Tom Baker Cancer Centre	Radiation Oncologist	466	75%	2.9	6.9
<i>Total</i>	<i>Medical Oncologist</i>	<i>1,518</i>	<i>77%</i>	<i>2.2</i>	<i>6.1</i>
<i>Total</i>	<i>Radiation Oncologist</i>	<i>1,080</i>	<i>72%</i>	<i>2.7</i>	<i>9.1</i>

TIME PERIOD 2: READY-TO-TREAT TO FIRST RADIATION THERAPY - The number of days from the date the patient is physically ready to commence treatment to the date the patient receives his/her first radiation therapy.

Facility	Type of First Treatment	Number patients who started radiation therapy	% Meeting Provincial Territorial Benchmark (within 4 weeks)	Number of weeks by which 50% of patients had their first treatment	Number of weeks by which 90% of patients had their first treatment
Cross Cancer Institute	Radiation Therapy	895	70.0%	2.0	5.7
Tom Baker Cancer Centre ²	Radiation Therapy	691	77.0%	2.0	5.0
<i>Total</i>	<i>Radiation Therapy</i>	<i>1586</i>	<i>73%</i>	<i>2.0</i>	<i>5.4</i>

	Basic salary (including seniority premium):	"Guaranteed" supplements/benefits:	Performance-related pay:
Australia ¹⁵	77%	20%	3%
Germany	Currently: 99%; planned 92%	-	Currently: 1%; planned to rise to 8%
Ireland ¹⁶	98%	1%	1%
Italy	Basic pay is the most important part of total remuneration, also if in some administrations the "administration allowance", that is different among ministries, can reach 35% of the basic pay.		
Japan ¹⁷	86.6%	13.4%	0%
Korea	48%	51%	1%
Mexico ¹⁸	20%	80%	0%
Netherlands	90%	7%	3%
Spain	<p>The present pay structure for civil servants is as follows:</p> <ul style="list-style-type: none"> - Basic salary: the same within each administrative group. - Post remuneration: according to the general level of the post. - Specific remuneration: aimed at paying the special difficulty of a determined post. - Performance appraisal system: Nowadays there is only remuneration based on productivity of the employee. In the future, when the Basic Statute of Public Employees is approved, there will be a wider appraisal system. 		
Sweden ¹⁹	99.3%	0.7%	0%
Switzerland ²⁰	94%	0%	increase of 0-6%; on reaching salary class maximum a performance-related bonus of up to 12% may be paid
United Kingdom	Pay systems and settlements are now so diverse that any averages are meaningless or not applicable		
United States ²¹	77%	22%	1%

Source: OECD Strategic Human Resources Management survey – 2006.

Performance Audit Report

Three Public Hospital Districts

Valley Medical Center, Evergreen Healthcare, Stevens Hospital

Report No. 1002324



November 12, 2009

The hospital districts use employee satisfaction surveys effectively

Employee satisfaction surveys provide valuable feedback and team-building opportunities for the hospital. Hospitals ideally should conduct employee satisfaction surveys at least every other year. After conducting the survey, results are presented to the staff and staff are asked to work together to develop organizational/departmental action plans to improve. After a sufficient time has passed, a follow-up survey will be conducted to mark progress and identify new opportunities, and the process repeats.

All three public hospital districts demonstrated leading practices in this area. Although **Evergreen** has not conducted an employee satisfaction survey since 2003, it is currently developing a survey for this year. The reason Evergreen has not conducted a survey since 2003 is leadership did not feel it could respond to any outcomes in a timely manner due to ongoing initiatives.

The hospital districts have employee suggestion programs in place

Employee suggestion programs can be formal or informal because the most important point is to develop a culture of trust with management in which employee ideas are encouraged and the strong ideas are evaluated and used by the hospital. Other ideas are developed by management and staff into strong ideas when possible. It is important employees receive appropriate and timely feedback to encourage new ideas in the future and recognition when their ideas are used.

All three public hospital districts demonstrated leading practices in this area.

The hospital districts have operational compliance hotlines

A compliance hotline is a phone number employees can call anonymously to report activities or practices they believe do not meet the standards for ethics, privacy, etc. Although compliance hotlines are used infrequently across the industry, they are an important aspect of the fourth element in the Office of Inspector General's Compliance Program Guidance for Nursing Facilities. The fourth element deals with developing effective lines of communication. All three districts introduce the compliance hotline during new employee orientation, and each year employees take a mandatory follow-up course. Valley even encourages usage by having its CEO record the greeting on the hotline. Management at all three public hospital districts believes there is a low frequency of usage due to their culture, which allows open, two-way communication between management and staff.

All three public hospital districts demonstrated leading practices in this area.



2009/10 Performance Agreement Targets for President and CEO

Goal	Focus	Performance Measure	Baseline	2009/2010 Target	3 year Target	Weighting	% of Bonus			
							100%	66%	33%	0%
Access	Improving access	Number of alternate level of care patients in acute care	700	550	350	10%	≤ 550	≤ 650	≤ 700	> 700
	Decreasing wait times	Wait time in Emergency Department for uncomplicated cases (90 th percentile)	5.6 hours	5 hours	4 hours	10%	≤ 5 hours	≤ 5.2 hours	≤ 5.3 hours	>5.3 hours
		Wait time in Emergency Department for complex cases (90 th percentile)	16.1 hours	14 hours	8 hours	10%	≤ 14 hours	≤ 15 hours	≤ 16 hours	>16 hours
		Wait time for hip replacement surgery (90 th percentile)	33 weeks	30 weeks	26 weeks	10%	≤ 30 weeks	≤ 31 weeks	≤ 32 weeks	>32 weeks
Quality	Learning and improving	Develop incident reporting system (including common definitions, approaches, etc.)	n/a	Completed by December 31, 2009	n/a	10%	By Dec. 31, 2009	By Jan. 31, 2010	By March 31, 2010	Later than Mar. 31, 2010
	Improving population health	Seniors influenza immunization rates	58%	63%	75%	10%	≥ 63%	≥ 62%	≥ 60%	< 60%
	Responsive to consumers and communities	Establish Health Advisory Councils	n/a	12 HACs by March 31, 2010	n/a	10%	12	-	-	-
Sustainability	Living within our means	Any bonus within the sustainability component is contingent on achieving Board-endorsed budget targets.								
	Fit for the future	Implement organizational structure with associated HR and financial delegations, and budget assignment.	n/a	By September 30, 2009	n/a	10%	By Sept. 30, 2009	By October 31, 2009	By Dec. 31, 2009	Later than Dec. 31, 2009
	Workplace of choice	Develop Board-endorsed human resource management plan.	n/a	By December 31, 2009	n/a	10%	By Dec. 31, 2009	By Jan. 31, 2010	By March 31, 2010	Later than Mar. 31, 2010
		Board-endorsed Strategic Plan	n/a	By June 30, 2009	n/a	10%	By June 30, 2009	By Sept. 30, 2009	By Oct. 31, 2009	Later than Oct. 31, 2009