167: ENHANCING COMPLIANCE FOR INTERNATIONAL BENCHMARKING OF EYE HOSPITALS: MODEL FOR SELECTING INDICATORS BASED ON PERCEIVED SUITABILITY

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Objectives:
Enhancing compliance for benchmarking of an international partnership of eye hospitals by integrating preferences and opinions of the participants, in the selection process of benchmark indicators.

Methods:
Assigned by the European Association of Eye Hospitals (EAEH), we developed, during January and August 2001, a model for selecting suitable benchmark indicators for eye hospitals in an international context. The structure of the EAEH influenced the assignment. Because of the absence of a hierarchic initiator, it was not possible just to impose a quality model in the search for suitable indicators, nor could compliance be enforced. For this reason the emphasis was put on equal influence of EAEH-members in the selection process. In this way we hoped that the members would identify themselves with the selection procedure, accept the selected indicators and comply with measuring these indicators for benchmarking.

The selection was done in of three steps. First, more than two hundred indicators have been collected during brainstorm sessions with experts in ophthalmology. Secondly, the research group extracted seventy unique indicators using a strategic analytic model of input (15 indicators), process (30) and output (25). Thirdly, the selection was made based on interviews carried out at Moorfields Eye Hospital in London, United Kingdom, and The Rotterdam Eye Hospital in Rotterdam, The Netherlands. The interviews provided the input for the suitability-criteria ‘relevancy’, ‘measurability’ and ‘comparability’. To determine relevancy, all indicators were scored on a Likert scale.

Respondents were 64 ophthalmologists, nurses, managers and administration staff from both hospitals. An overall ranking based on non-weighted averages of Rotterdam and London was drawn up. Measurability has been translated in ‘presence of the indicator’ (yes/no) and ‘time needed for annual measurement’ (<8 hours, 8–40 hours, >40 hours). Local experts, concerned with measuring indicators, scored all indicators on these two sub-criteria. Finally, comparability has been investigated by comparing the definition and way of measurement of the indicators in both hospitals. For each indicator, these two should be similar in the two hospitals in order to be comparable. The final decision rule used was: an indicator is suitable if it belongs to the first twenty-five in the relevancy-ranking and both measurability and comparability are considered ‘good’.

Results:
Thirteen out of seventy indicators turned out to be most suitable for benchmarking. The relevancy rankings of both The Rotterdam Eye Hospital and Moorfields Eye Hospital were quite similar. Only a few indicators were judged differently, reflecting actual problem-issues. The output indicators outweighed in the group of relevant indicators. The most occurring reasons for bad measurability were limitations of measurement systems, disagreement about the way of measurement and high investments of time or money. In general, bad measurable indicators are bad comparable as well. Reasons for good measurable but bad comparable indicators were different ways of measurement, broad definitions or different interpretations.

Conclusions:
The involvement, participation and influence of organisation members during the selection process yielded an agreed relevancy ranking. This increases the feasibility and acceptance of the actual benchmark research, which will follow this suitability research of indicators. The results have been presented during the 2001 EAEH Annual Board Meeting. As hoped, the members appreciated the selection procedure, accepted the selected indicators and started collecting them. Our conclusion is that the replacement of a strong theoretical directive selection procedure, by a preference-driven selection procedure, increased willingness to comply with benchmarking.