Provider payment currencies : the US, UK, German & Australian paths to higher quality and efficiency via “P4Systemness”

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Overview

- Paths to quality improvement in hospitals in four nations
- “Systemness”, transparency and the chronic disease burden as P4P targets: provider payment currency reforms in four nations and some costs of non-systemness in Australia
- Two principles shaping a DVA “P4Systemness” provider payment currency

1. Paths to quality improvement in hospitals in four nations

Paths to quality improvement:Germany

Core belief 1990s	Contrary proposition	Performance improvement initiatives		
		Doctors	Hospitals	Care coordination
Best system in world BUT separation of ambulatory and hospital care, and between medical, nursing and social care	2000: World Health Report : #25 in efficiency 2003: Commonwealth Fund : QOC low for chronically ill 2004: limits of 'eminence-based medicine" and non-transparency	1990s: attempt by regional funds to introduce DMP based on old GDR and US experience 2002-2008: DMP: Measures for 5 CIs; CPGs for quality 2009: New risk-adjusted compensation with morbidity as one indicator	2001: Federal Office for Quality Assurance (BQS) 2006: proposals by third largest SHI fund (TK) to obtain data on hospital quality submitted to BQS, but augment with TK data on readmission rates, sick leave following hospital stay, & drug consumption post discharge-> risk-adjusted ratings on internet to guide patients=transparency	2004: Integrated SHI contracts funded by 1% of SHEs 2009: new models of population-based integrated care, having regard to comorbidity

Paths to quality improvement: UK

Core belief 1990s[1]	Contrary propositions	Performance improvement initiatives		
		Doctors	Hospitals	Care coordination
"NHS cheap, spartan, poor patient experience, long wait times,but apart from cancers and stroke we have good clinical outcomes"	2000: Waiting lists can be fixed by raising NHS budget to the EU average share of GDP (11% CAGR 02-07) 2001: Kennedy report on pediatric deaths at Bristol hospital 2006: Populus survey: 47% say extra investment did not improve QOC August 2007: ipsos-Mori survey expect ☐NHS to get worse in next few years: 43%	2004: Quality Outcomes Framework: 146 indicators	2001:Star Ratings, 62 indicators, 9 key targets 2005: scrapped 2006: annual health check on two sets of measures: QOC and use of financial resources, and four-point rating scale 2009: Basic standards of care: safety, clinical quality, patient experience, health inequalities, child health	Commissioning by GP trusts 2005: PbR

Paths to quality improvement:USA

Core belief 1990s	Contrary propositions	Performance improvement initiatives		
		Doctors	Hospitals	Care coordination
Health system is most costly in the world, unsustainable at annual growth rates, many patches of clinical brilliance,	1999: IOM report "To err is human" 2001: IOM report quality chasm can be fixed 2003: McGlynn NEJM gaps in care = 56% 2002-07: Cwealth Fund reports :US low ranking in 6 nations	1999: NQF following PAC on consumer protection and quality in healthcare industry 2000: AMA Physician Consortium for Performance Improvement 2004: AQA (AAFP, ACP,AHIP,AHRQ) 2006: CMS Physician Voluntary Reporting Program: 36-> 16 measures	1998: VA-NSQIP for measuring surgical quality 2002: P4P with multiple criteria, multiple dashboards 2003:CMS Hospital Quality Incentive Program: 10 core quality measures 2003: Premier HQID: 34 quality measures for 5 clinical conditions 2007: No P4 "never events" 2008: 538 -> 745 Medicare Severity-adjusted DRGs[1]	Minimal outside HMOs, so…. P4 Medical Home (BTE 2008)[2] P4 Coordination (CMS) P4 E-B case rate (Prometheus) P4 Guaranteed episode of care (Geisinger) P4 Transitional Care (ICU) P4 Value-based care

Paths to quality improvement:Australia

Core belief 1990s	Contrary propositions	Performance improvement initiatives		
		Doctors	Hospitals	Care coordination
Best care in the world Universal public hospital and medical insurance (Medicare)	1995: 16% hospital errors 2002-2006: Fall in Commonwealth fund rankings for care coordination 2004-2007: series of gaps in patient safety and clinical quality in public hospital deaths 2007: low hospital efficiency ranking by OECD	1998: Practice Incentives Program for public health targets, fee-for-service (FFS) 1999: Enhanced Primary Care program promoting coordn with AHPs, FFS 2005: New GP fee-for-service payments for Chronic Disease Management (CDM) plans and multidisciplinary team care, no adjustment for multiple risk factors, severity or multiple comorbidity 2006: New payments for mental health care	2008: Public hospital waiting list measures and new funding 2008: Private hospitals contracting with DVA offered voluntary P4P	2007: New private health insurance benefits for care outside the hospital

2. “Systemness”, transparency and the chronic disease burden as P4P targets: provider payment currency reforms in four nations

What “systemness” causes these differences in US efficiency? E Fisher

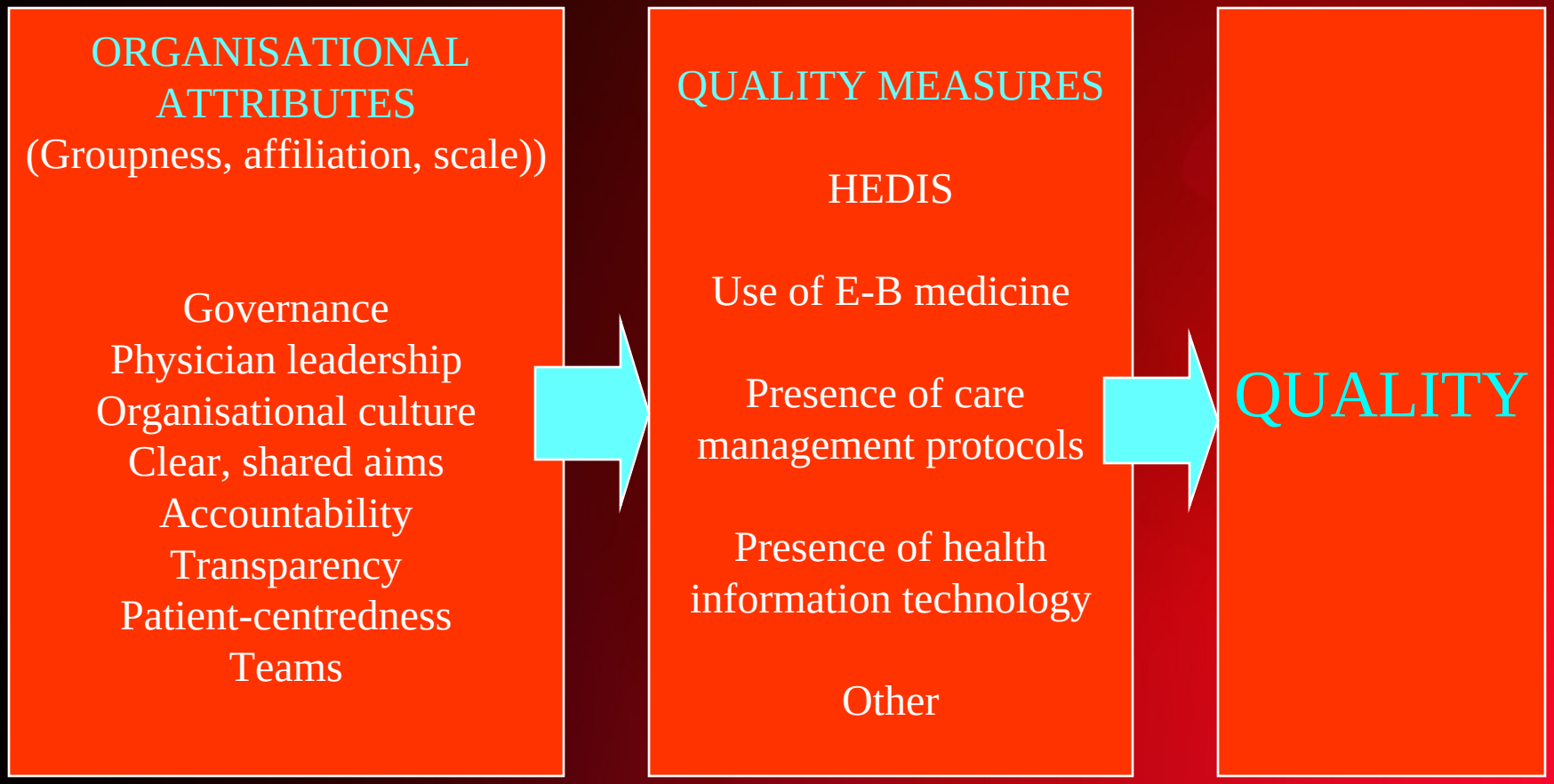
Variations in spending per Medicare beneficiary with severe chronic disease, last 2 years of life 2000-2003

- High: US$ 72K, 50 MD FTEs
- Low: US$ 36K, 24 MD FTEs

Physician supply/100K

- Kaiser Permanente:36% lower than US supply
- Health Partners: 25% lower

“Systemness”, transparency and quality: Kaiser Permanente route



Source: Kaiser Permanente Institute for Health Policy *In focus* November 2007

P4P and its outcomes : the missing policy intervention

Germany : Systemness via care transformation & currency

Goal	Care transform-ation	Incentives to patients	Incentives to providers	Incentives to health insurers	IT support	Quality measures
1. More appropriate care 2. Reduced hospitalis-ation 3. Control drug use	1. Polyclinics integrating pharmacies/ OT/PT 2. DM (integrated care) pilot contracts to 2008, 6 chronic conditions, (*Management Gesellschaften*) 3.Contracts for acute and LT care with insurers	Reduced cost-sharing Reduced quarterly contribution Increased patient education	Payment for extra admin costs of CMP	1. Payment for DMP enrolled ↓ All enrollees valuable 2. 1% of hospital and doctor payments (E280 million)	Minimal data analysis	Federal government plus clinical specialists ↓
4. Budget transform-ation	Integrated health and social care plans	→	Care manage-ment within integrated care -> competition between providers	↓ Risk adjusted payments to SHI adjusted for comorbidity		CPGs

UKNHS: Systemness via care transformation & budgeting

Goal	Care transformation	Incentives to patients	Incentives to providers	IT support	Quality measures
1. Reduce hospital admissions of target group (200K) by 5% by 2008 2. Better IT to improve quality of care	1. PCTs linked to community matrons (case managers) 2. Disease management of single and multiple conditions requiring multiple specialist visits	Expert Patient Programme = self care education, counselling & compliance with drug therapy + support for informal carers	PCT indicative commissioning budgets ↓ Reduce unnecessary referrals 25-33% ↓	Heavy invest-ment	QOF based on 2004 standards ↓
3. Budget transform-ation	Shift 5% of NHS budget for same day care to PHC in next 10 years		Retain 20% of savings from reduced admissions ↓ Create new community services for diabetes, orthopedics, chronic disease management	PCT and regional dash-boards	E-B standards in 2006

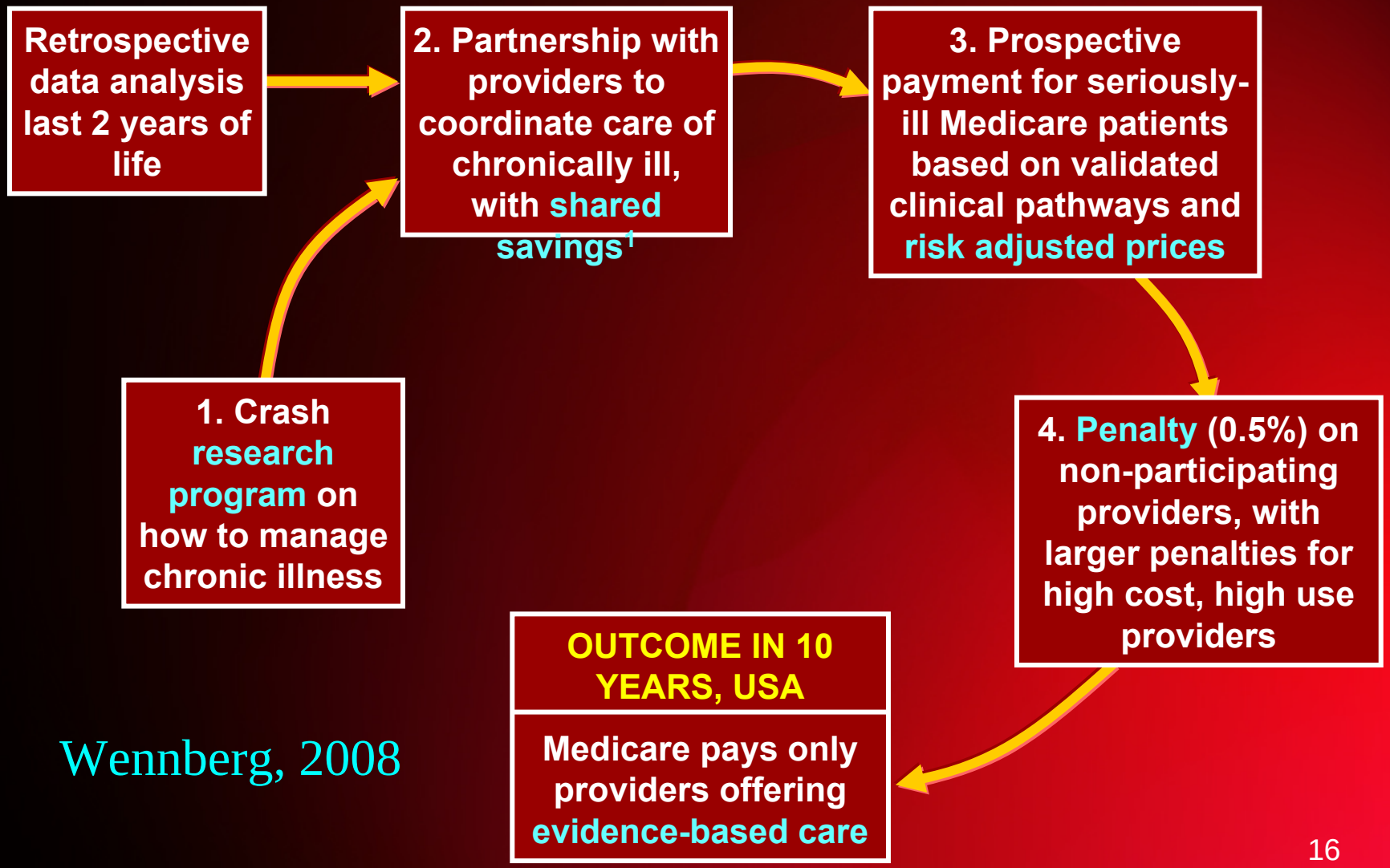
USA: Systemness via P4P incentives & fewer quality measures

Goals	Primary care role	Disease management	Incentives for providers	IT support	Quality measures
1. CMS PGP Demo: shared savings	Central		P4P		Yes
2. CMS MMP pilot in small-medium groups IT use –> QOC	Central		P4P	Incentives for exceeding standards AND for electronic reporting	Yes
3. CMS Physician Hosp. Collaboration-> LT followup care –> QOC and preventable hospitalisations	Central		P4P		Yes
4. CMS Premier Hospital Quality Incentive (PHQI) demo: EB quality measures		5 CIs	P4P		Yes
5. CMS Medicare Home Health P4P demo: incentives to HHAs for improved QOC that reduces additional services			P4P		Yes
6. Tax Relief and Health Care Act (TRHCA) signed in December 2006, creating the Physician Quality Reporting Initiative	All physicians		Bonus payments up to 1.5% of Medicare allowed charges for reporting 1-3 measures July-Dec 07		74 measures, many specialties
7. Next stage??					P4P quality reporting via specialty medical registries, P4 Structural & Outcomes measures

Converging paths to 2012?

NATION	Intermediate focus 2008	2012
Germany	Readmissions, return to work and drug costs	Population-based integrated health and social care, funding tied to comorbidity
UK	Reduced admissions, unnecessary referrals & reduced same-day Px -> savings into new community care	Population-based integrated health and social care, funding tied to E-B guidelines
USA	Bonus payments for reporting a few quality measures, risk-adjusted prices	Medicare Severity adjusted DRGs, shared savings, funding tied to quality
Australia	Preventable admits, adverse events and the risk-adjusted costs of chronically ill veterans	DVA integrated care, funding tied to safety, comorbidity, quality

Reforming chronic care management: US Medicare



Wennberg, 2008

Next stage: P4 measured quality, systemness and culture change

2008

P4 something approximating quality, cost-efficiency and care integration

2012

P4 Opaque superior quality(Maine)

P4 Accountable care (E Fisher)

P4 Physician Quality Agenda (IHI)

P4 Reduction of access disparities

P4 Population-based health

P4 Culture change

Transparency in Australia: six gaps

POLICY GAP	Missing elements
1. DMP gaps in health literacy, frailty & social isolation	Outreach care, health IT
2. Inefficiency gaps (adverse events, prev admits)	P4P in fed/state hospital agreements, DVA contracts
3. Value-based technology acquisition	Systematic HCTA of drugs, devices, procedures
4. Encouragement of healthier lifestyles	Incentives/info for self-care in Medicare,health insurance
5. New risk factors (obesity++)	National health promotion strategy similar to Germany
6. Population health management tools	Linked data sets for clinicians

Five “systemness” gaps, Australia

INDICATOR	INEFFICIENCY LOSS
1. Preventable admissions: vaccine,chronic,acute	9.4% of admissions (chronic = two-thirds)
2. Adverse events in hospitals	10% of admissions
3. Elderly in acute beds	45% aged over 55 years 55% access block,98% occupancy common
4. Over 80s acute beddays	8 times rate of non-elderly (5.5 v 0.7 pa)
5. Potential efficiency gains in acute hospitals[1]	40%

"If something is unavoidable, let's at least pretend we organised it"

Alain Coulomb, paraphrasing Jean Cocteau

Buying quality: provider payment currencies

Change the price , volume, site & quality of care, using economic incentives

1. Traditional casemix and FFS models ANY QUALITY leads to REVENUE	2.Performance-based models PERFORMANCE leads to REVENUE	3.Volume based supply models PERFORMANCE leads to MORE VOLUME leads to REVENUE	4.Care substitute models PERFORMANCE AND COST-EFFIC leads to BETTER HEALTH OUTCOMES and MORE REVENUE
• Per diems,FFS • Casemix • Pooled casemix and per diems • Risk-severity adjusted methods • Rx, device pricing • Marginal cost • Yield management	• Pay--for-performance models (P4P) • Doctor bonuses • Conditional reimbursement tied to patient ability to use devices	• Payments that create higher volume units that achieve better health outcomes	• Payment redesign for chronic conditions with wide variation in ALOS, admit rates • Payments for CPG's, case management that move site of care

Leapfrog quality has three components

Reality

1. **IT investment minimal in Australia**
2. **Crude measures of QOC are accessible in existing datasets**
3. **Only DVA has linked data on use of hospital, medical, drug and community care, plus Adverse Events.**
4. **Relevant price and quality data not available to patients/households.**

Transparency for patients means information available on

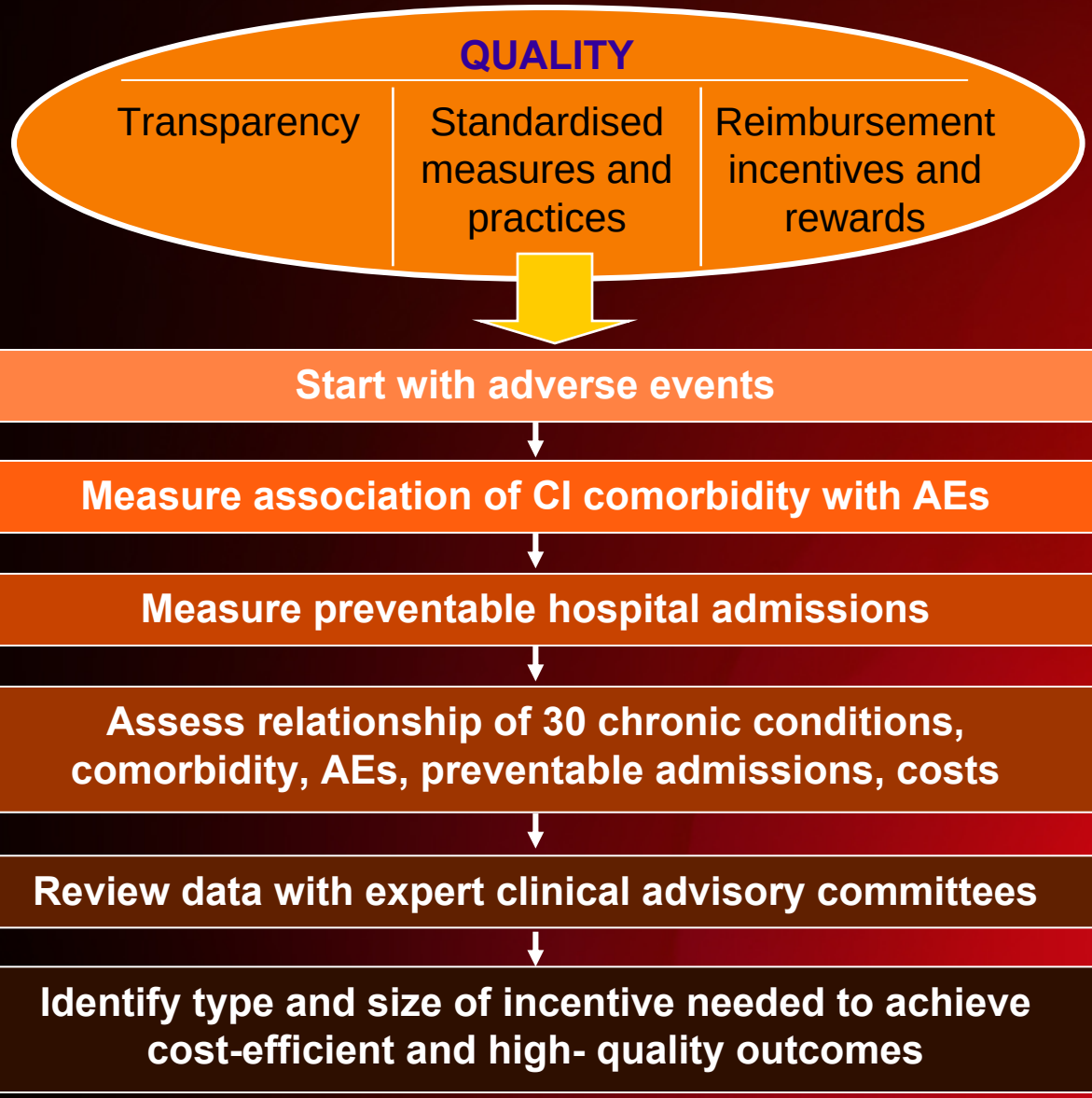
1. **Alternative course of Tx**
2. **Likely outcomes of Tx**
3. **Monetary and other costs of Tx**
4. **Costs of all providers**
5. **Quality of care**
6. **Financing options for care**
7. **Comparing PHI plans**
8. **Self care support information, education, communication**

Transparency for patients means information available on

1. **Health and functional outcomes of care**
2. **Relevant measures of cost-efficiency of providers**
3. **Defensible measures of quality of care**
4. **Patient perceptions of value, quality and outcomes**

AND in Australia, this transparency will need IT investments of A$ 5-10 billion

Quality via standardised measures:DVA decision



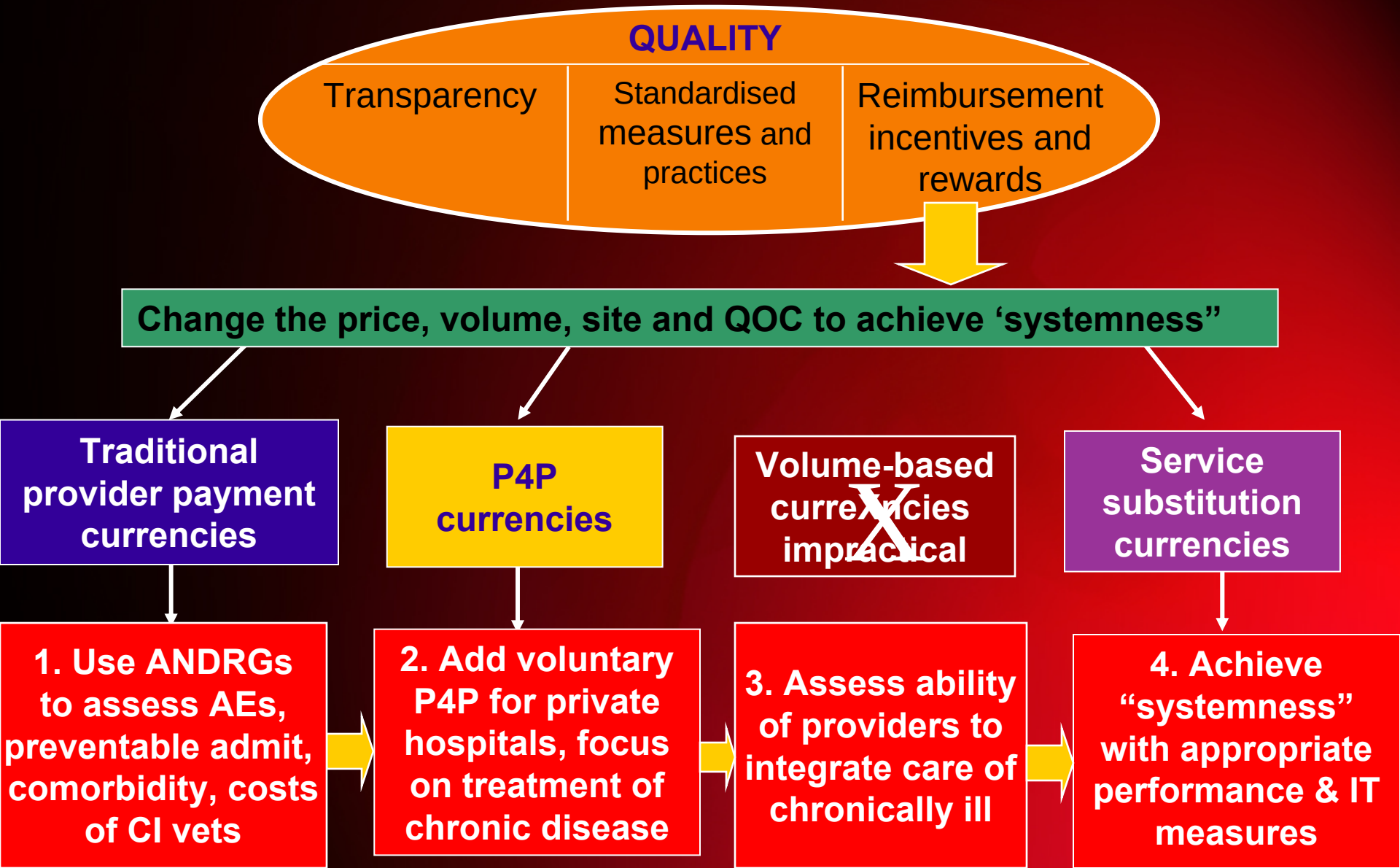
Assumptions

DVA admin data can only measure crude indicators of quality

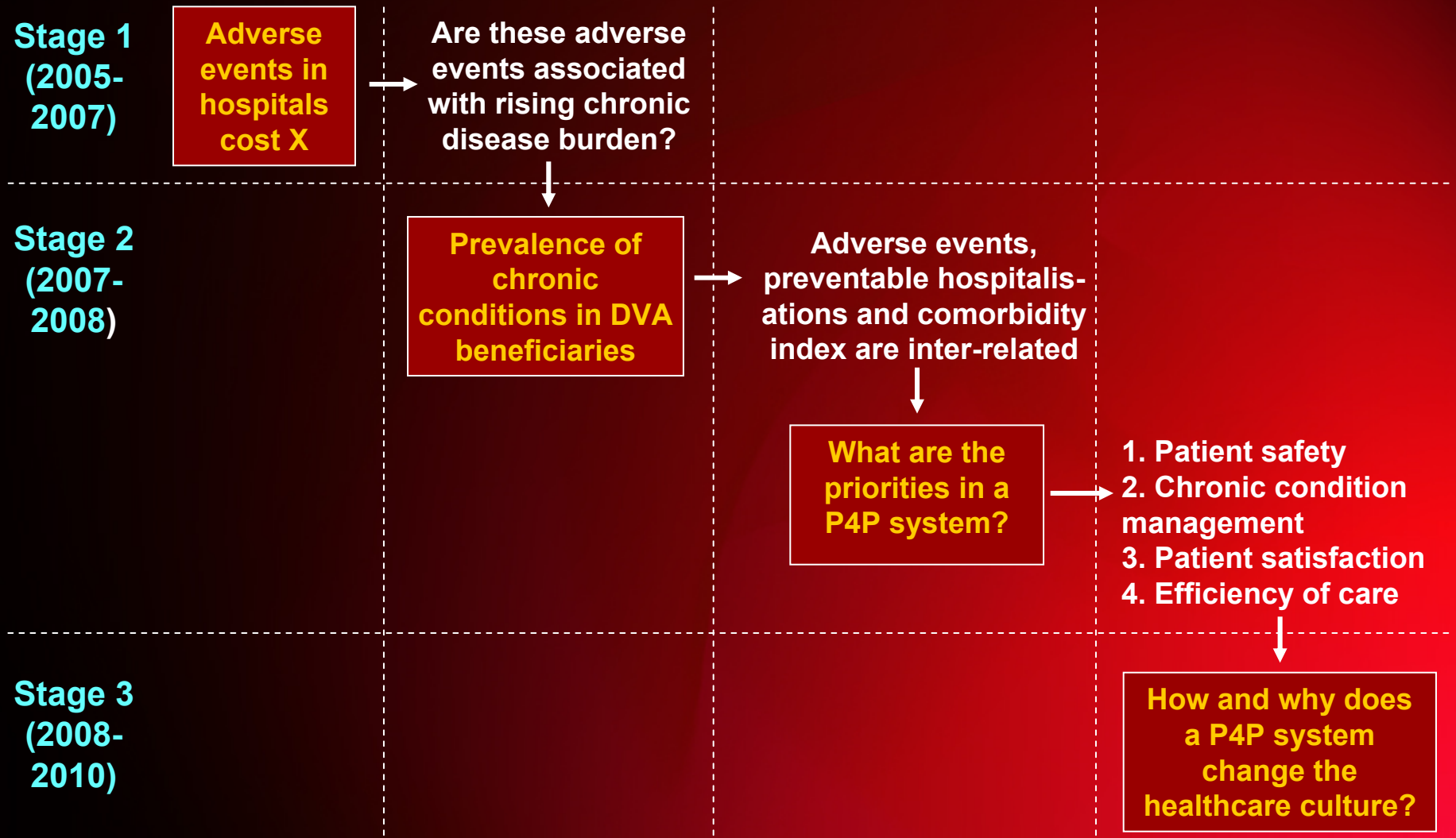
Better measures are needed to reduce waste and improve the health of veterans

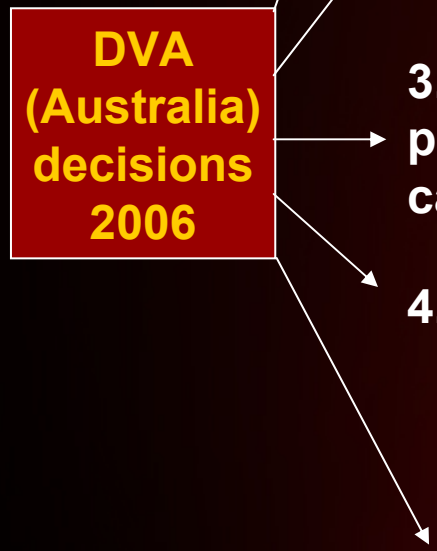
Costs of "non-systemness" in chronic disease management are discoverable

Quality via incentives: DVA decision 2006



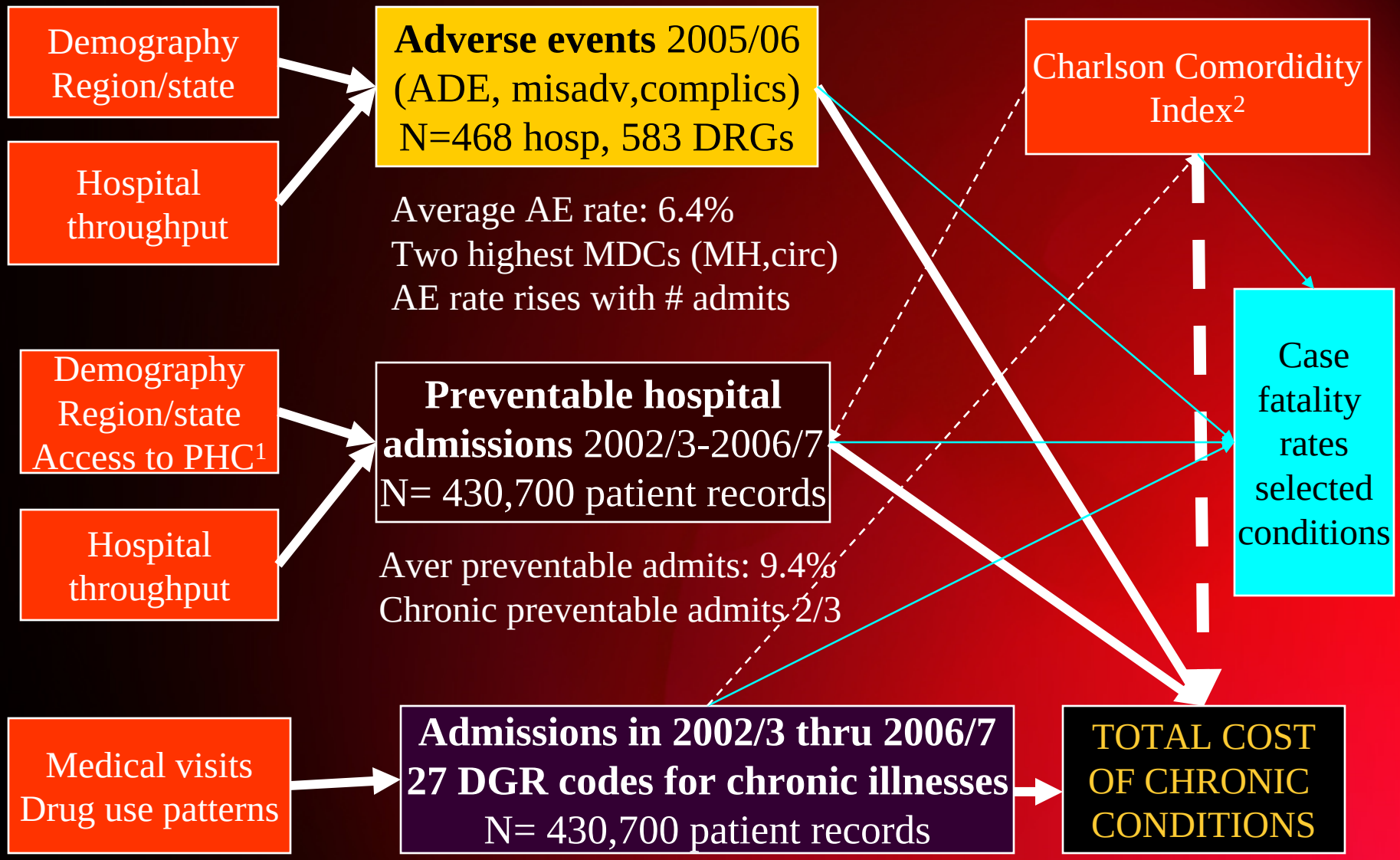
The Australian DVA road to P4P: slow and purposeful beats speed every time



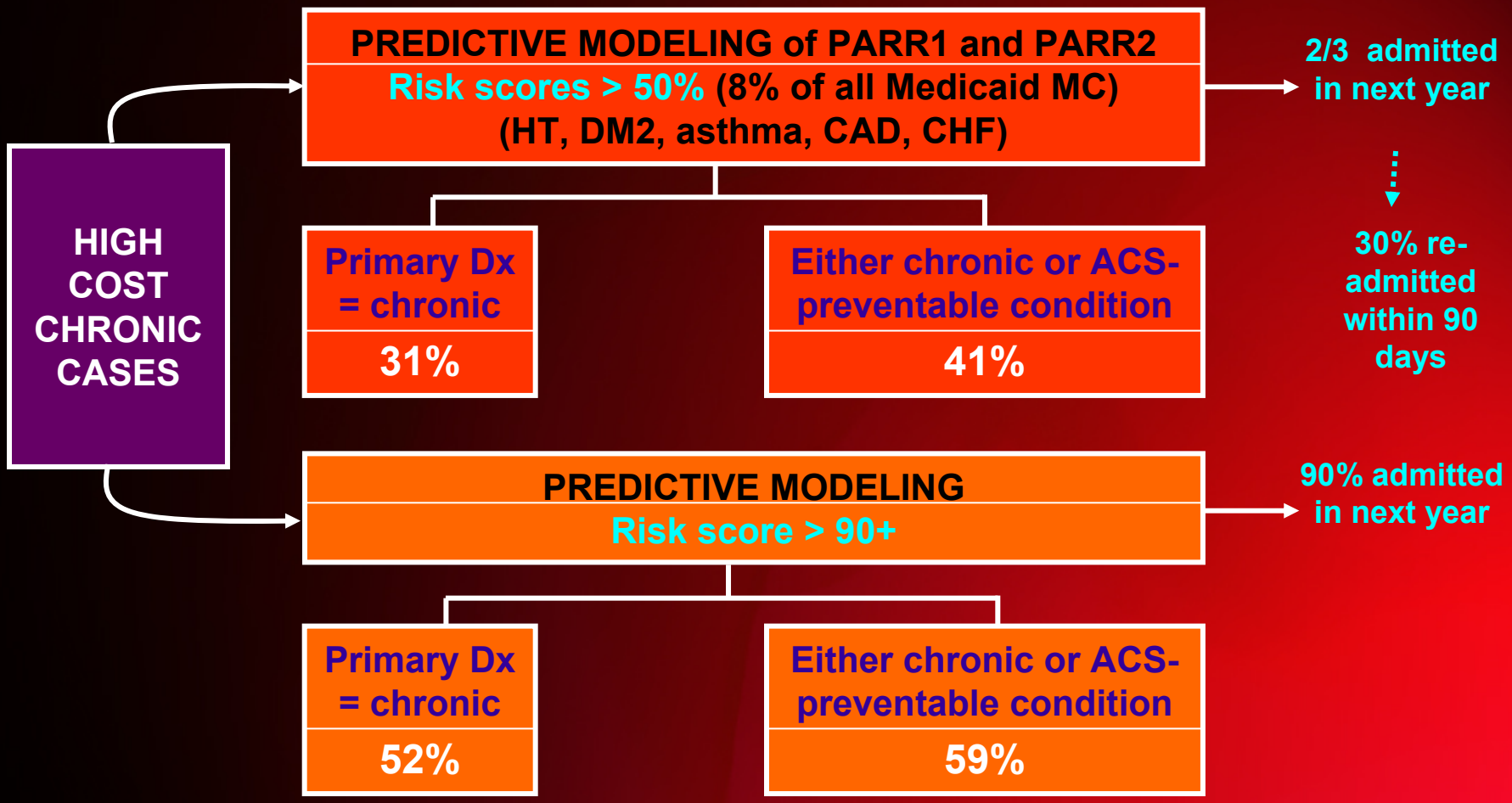


FOCUS	DECISIONS
1. Private hospitals	Small number of performance measures ► report confidentially in contract negotiations ► pay ► public reporting of high quality units
2. Public hospitals	Defer until private hospitals engaged , & new public hospital agreement signed
3. General practice (primary care)	Rely on current practice incentives and expanded payments for care plans of chronically ill veterans
4. Specialists	Defer until measure impact of hospital P4P, and treatment patterns of chronically-ill veterans
5. Community and chronic care	Defer until assess prevalence, costs and claims-based clinical treatment patterns of chronically ill veterans, including use of modern medicines

Some system links now more obvious



High cost chronic cases: predictive modeling US Medicaid: Billings et al 2007



Message: Discharge planning + social service interventions + coordinated care may reduce readmissions

Chronic conditions as total cost determinants 2006/07

TOTAL COSTS = 2,603+ 14,930*Chronic Dx code +

8,329*VacPA + 3,931* ChrPA + 4,359* AcutePA +

14,976*ADE + 17,129*Misadvent + 22,843*Compl

R^2 = 0.477, all coefficients <0.0001

3. Two resulting principles shaping a voluntary P4P provider payment currency, Australia

Two principles shaping an Australian P4P

Issue	Current philosophy
Choice of "performance" measure	1. No single index of performance measures will achieve system-wide change. Quality should be measured explicitly. 2. A balanced scorecard of a few performance measures, unbiased by political imperatives and chosen in collaboration with clinical experts, is optimal. 3. Priority measures in Stage 1: patient safety, coordination of care of chronic conditions, patient satisfaction. 4. Initial reliance on claims-based hospital data but augment with patient satisfaction data. 5. Insistence on evidence-based chronic care processes should facilitate rather than coerce quality improvement.
Adjustment of performance outcomes to reflect patient severity	Stage 1: measure the prevalence of severity and comorbidity in major chronic conditions, then feasibility of episode-based payments that might improve coordination Stage 2: review feasibility of risk-adjusted episode-based case rates, review of Prometheus-like ECRs (but without withholds and contingency funds), seek clinician inputs ,then P4Systemness

The Noah Principle applied to value-based purchasing

"No more prizes for predicting rain; only for building arks".

Louis V. Gerstner, Jr., 1988