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From the Editor

In our last newsletter we shared the results of a literature review of pay-for-performance (P4P) programs and discussed the possibilities of using patient-reported outcomes as the outcomes of interest in P4P. In this issue, we follow up on this discussion by summarizing the results of an evaluation of a P4P program in British Columbia emergency departments and exploring the P4P model being used by the National Health Service in England. We also highlight the upcoming UBC Centre for Health Services and Policy Research health policy conference, which is focused on performance measurement and includes a session on measuring patient experiences.

Please feel free to contact us (editor@healthcarefunding.ca) with any comments or suggestions.

COMMENTARY

Evaluating Pay-for-Performance in British Columbia Emergency Departments

Starting in 2007-2008, BC introduced an emergency department (ED) pay-for-performance (ED P4P) program in order to improve wait times in hospitals' EDs. The ED P4P program continued under the auspices of the Health Services Purchasing Organization (HSPO) from 2010 to 2013. A number of hospitals in the Vancouver Coastal Health (VCH) and Fraser Health (FH) regions of BC joined the program in 2007 and 2008, respectively. The participating hospitals can allocate the ED P4P performance-based funding as they see fit.

Health authorities selected hospitals that had the highest volume of ED visits and longest ED wait times in urban areas to participate in the ED P4P. The financial incentives are based on each patient with an ED LOS less than the targeted wait time, and whose wait times are stratified according to Canadian Triage Acuity Scale. In 2011-2012, the HSPO paid approximately $13 million to FH and VCH for hospitals' performance in this program.

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COMMENTARY

Provider Payment Based on Patient Experience and Outcome Measures in England

When it comes to healthcare improvement, some countries have started to incorporate patient experience measures into their funding models. In our last newsletter we discussed the US's Centers for Medicare and Medicaid value-based purchasing scheme, which started to do so in 2012. In this newsletter, we take a look across the pond to England where hospitals funded by the National Health Service (NHS) are incorporating patient experience and patient outcome measures into their funding models through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Under the NHS model, healthcare services are planned and purchased from providers by commissioning groups to meet the needs of the local population. The NHS CQUIN payment framework allows commissioners and providers to work together to set quality improvement goals that reflect local priorities as well as those set by the NHS Operating Framework. Through CQUIN, commissioners can reward providers who deliver high quality care on these local quality improvement goals in addition to national quality improvement goals set by the NHS (NHS, 2010a).

Although the NHS provides sample goals and indicators for implementation, providers are only encouraged to adopt them in their CQUIN scheme if they are relevant to their needs. It is up to the commissioner and the provider to negotiate the percentage of CQUIN funding linked to both local and national CQUIN goals and the level of achievement required for payment (NHS, 2010a). One example of a national goal set by the NHS is to improve responsiveness to the personal needs of patients, using patient experience as an indicator. Patient experience is measured through a composite of five survey questions that touch upon service issues that are applicable to all or most patients, such as involvement in decisions about treatment (NHS, 2013).

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Amy Cheng and Jason Sutherland published a paper (Cheng & Sutherland, 2013) in the November edition of Health Policy that examines BC's ED P4P program and the association between the financial incentives and shorter ED length of stay (LOS). The paper also makes recommendations to address the limitations of the ED P4P program.

The evaluation of the effects of the ED P4P program are mixed. VCH hospitals that participated in the ED P4P program maintained or even improved their rate of patients meeting the targeted ED LOS. This improvement is in spite of increasing numbers of ED visits. In contrast, FH's participating hospitals experienced decreases in their percentage of patients meeting the ED LOS thresholds; their patients tended to experience longer waits.

Due to the mixed findings of this study, the authors recommend that the government should consider whether or not the ED P4P program improves access to care, whether the amount of the incentives were sufficient to change hospitals' focus to improving wait times, or whether the program served simply to transfer additional unrestricted funding to hospitals.

Cheng AH, Sutherland JM. (2013). British Columbia's pay-for-performance experiment: part of the solution to reduce emergency department crowding? Health Policy; 113(1-2):86-92.

Continued from Provider Payment...

To further address quality improvements in patient experience, acute care providers in England can incorporate patient reported outcomes measures (PROMs) into their CQUIN scheme (with the goal to improve patient reported outcomes) (NHS, 2010a). PROMs aim to capture patient perspectives on the effectiveness of their care, and since 2009 their collection has been mandatory in England for surgeries related to hernias, varicose veins and hip and knee replacements (Department of Health, 2009). The NHS suggests incorporating PROMS into CQUIN schemes by using the data to measure the changes in patient-reported health pre- to post-operatively over the payment period, and to adjust payment by comparing the changes measured to those in the previous year. Commissioners and providers work together to define the thresholds required for payment, but examples of good performance on this indicator would be an increase in change in PROMs score from one year to the next , or an average change that is higher than the national average for the procedure (NHS, 2010b). An example of this goal would be to compare the health gain in one year for patients who received hernia surgeries to the health gain measured in the previous year using pre- and post-operative PROMs scores, rewarding the provider if there was an improvement from the previous year in the changes measured.

Using patient reported outcomes and experience measures in incentivized funding schemes can result in unintended consequences. For example, clinicians may focus disproportionally on reported health gains with less consideration of other clinical indicators that may suggest benefits of surgery. Research in this area is limited, so if England continues moving forward in their use of patient reported measures in quality improvement schemes, other countries interested in doing so will be able to learn from their experience.

Department of Health. (2009). Guidance on the routine collection of Patient Reported Outcome Measures (PROMs) (pp. 1–28). London. Retrieved January 14, 2014.

NHS. (2010a). Using the Commissioning for Quality and Innovation (CQUIN) payment framework. Retrieved January 14, 2014.

NHS. (2010b). An illustrative example of a CQUIN scheme for acute services in 2010/11. Retrieved January 14, 2014.

NHS. (2013). Commissioning for Quality and Innovation (CQUIN) payment framework. Retrieved January 14, 2014.

UPCOMING CONFERENCE

Performance Anxiety: Can Performance Measurement and Reporting Help to Improve Canadian Healthcare?

The UBC Centre for Health Services and Policy Research annual health policy conference will take place in Vancouver, BC on February 24-25, 2014.

Drawing from international experiences, speakers will shed light on the use of performance measurement in Canada and internationally, as well as successes, failures and policy implications for Canada.

Topics include:

- Accountability and indicators across different sectors
- Attribution of performance
- Scientific rigour and reporting
- Reporting performance to patients

Featured speakers include:

- John Abbott, Health Council of Canada
- Irfan Dhalla, Health Quality Ontario
- Sholom Glouberman, Patients Canada
- Kira Leeb, Canadian Institute for Health Information
- Jean-Frederic Levesque, Bureau of Health Information, New South Wales, Australia
- Stephen Peckham, London School of Hygiene and Tropical Medicine
- Robyn Tamblyn, CIHR Institute for Health Services and Policy Research
- Jack Tu, Institute for Clinical Evaluative Sciences
- Diane Watson, National Health Performance Authority, Australia

Registration and more information is at www.chspr.ubc.ca/hpc/overview.

Upcoming Events

Performance Anxiety: Can Performance Measurement and Reporting Help to Improve Canadian Healthcare?
UBC Centre for Health Services and Policy Research
Vancouver, BC | February 24-25, 2014

Quality Forum 2014
BC Patient Safety and Quality Council
Vancouver, BC | February 26-28, 2014

2014 CADTH Symposium
Canadian Agency for Drugs and Technologies in Health
Gatineau, QC | April 6-8, 2014

CAHSPR Annual Conference
Canadian Association for Health Services and Policy Research
Toronto, ON | May 13-15, 2014

Public Health 2014
Canadian Public Health Association
Toronto, ON | May 26-29, 2014

This newsletter was produced by the editorial team of www.healthcarefunding.ca, a reliable and impartial resource for literature, news, and discussion regarding health care funding policies in Canada and internationally.

Chief Editor: Jason Sutherland
Editorial Team: Nadya Repin, Trafford Crump, Dawn Mooney, Elizabeth Yue, Scally Chu
Contact us: editor@healthcarefunding.ca