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HEALTH SERVICES AND POLICY RESEARCH

# Looking Beyond the Hospital: International Perspectives and Directions

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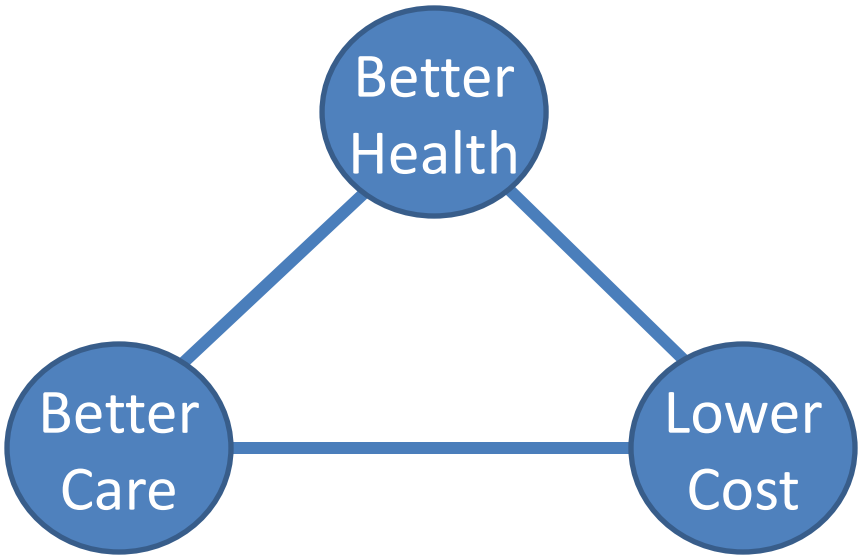
Quality-Based Procedures Symposium, OHA

Toronto, May 14th, 2013

# Objective

- Using funding policy as one lever to support a high-performing healthcare system



# Hospital funding mechanisms:

| Type of Funding | Number of Cases | Spending Control | Transparency | Cost Efficiency | Quality |
|---|---|---|---|---|---|
| **Per Diem / Cost Plus** | Yes | No | No | No | Flat |
| | | | | | |
| **Global Budget** | No | Yes | No | Flat | Flat |

Adapted from: R. Busse, EuroDRG project

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| Type of Funding | Number of Cases | Spending Control | Transparency | Cost Efficiency | Quality |
|---|---|---|---|---|---|
| **Per Diem / Cost Plus** | Yes | No | No | No | Flat |
| **DRG / Case-based** | Yes | No | Yes | Yes | Flat |
| **Global Budget** | No | Yes | No | Flat | Flat |

US Medicare

European Countries

Adapted from: R. Busse, EuroDRG project

# Evidence to Date

- Medicare, Europe and now Asian countries…
  - Activity 
  - Length of Stay 
  - Spending 
  - Cost-Efficiency 
  - Quality 

What else did these countries experience?

- Over-use/mis-use
- Risk selection
- Upcoding

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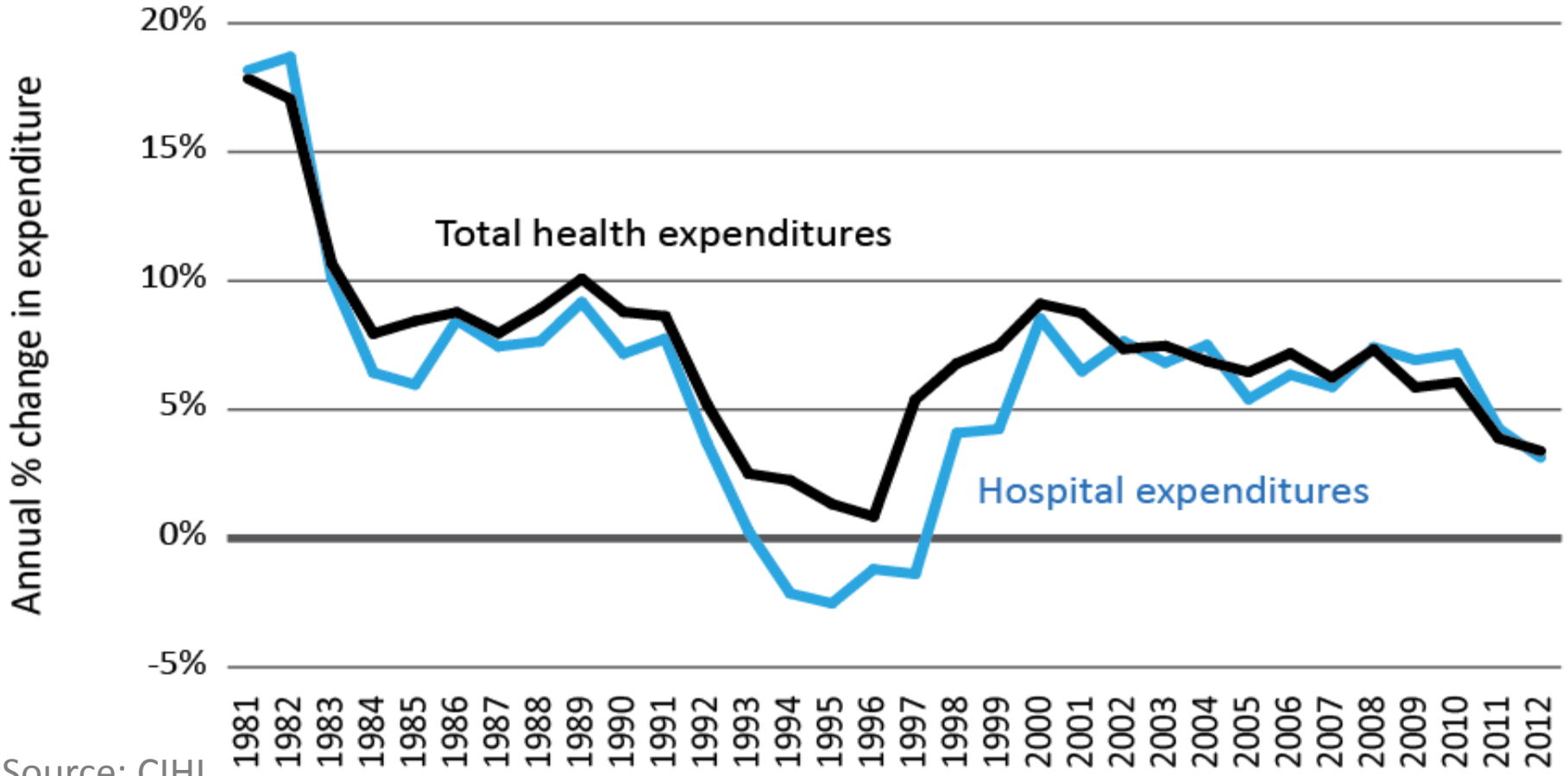
# Perspective: Annual % Change in total health and hospital spending




Source: CIHI

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# Navel-Gazing?

## Wait Times

- Last in access to specialist
- Last in access to elective surgery

| | Australia | Canada | France | Germany | Netherlands | New Zealand | Norway | Sweden | Switzerland | United Kingdom | United States |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Able to get Same/Next Day Appointment When Sick | 65% | 45% | 62% | 66% | 72% | 78% | 45% | 57% | 93% | 70% | 57% |
| Very/Somewhat Difficult Getting Care After-Hours | 59% | 65% | 63% | 57% | 33% | 38% | 45% | 68% | 43% | 38% | 63% |
| Waited Two Months or More for Specialist Appointment[a] | 28% | 41% | 28% | 7% | 16% | 22% | 34% | 31% | 5% | 19% | 9% |
| Waited Four Months or More for Elective Surgery[b] | 18% | 25% | 7% | 0% | 5% | 8% | 21% | 22% | 7% | 21% | 7% |

Spending Control ↓

Cost Efficiency ↔

Quality ↔

Ref: Commonwealth Fund

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# What's Missing?

## Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures Among Medicare Beneficiaries

15 Randomized Trials

**Context** Medicare expenditures of patients with chronic illnesses might be reduced through improvements in care, patient adherence, and communication.

**Objective** To determine whether care coordination programs reduced hospitalizations and Medicare expenditures and improved quality of care for chronically ill Medicare beneficiaries.

**Design, Setting, and Patients** Eligible fee-for-service Medicare patients (primarily with congestive heart failure, coronary artery disease, and diabetes) who volunteered to participate between April 2002 and June 2005 in 15 care coordination pro-

The NEW ENGLAND JOURNAL of MEDICINE

## The Implications of Regional Variations in Medic Health Outcomes and Satisfaction with Care

Elliott S. Fisher, MD, MPH; David E. Wennberg, MD, MPH; Thérèse A. Stukel, PhD; Da and Etoile L. Pinder, MS

Background: The health implications of regional differences in Medicare spending are unknown.

Objective: To determine whether regions with higher Medicare spending achieve better survival, functional status, or satisfaction with care.

Design: Cohort study.

Setting: National study of Medicare beneficiaries.

Patients: Patients hospitalized between 1993 and 1995 for hip fracture ($n$ = 614 503), colorectal cancer ($n$ = 195 429), or acute myocardial infarction ($n$ = 159 393) and a representative sample ($n$ = 18 190) drawn from the Medicare Current Beneficiary Survey (MCBS) (1992–1995).

Exposure Measurement: End-of-life spending reflects the component of regional variation in Medicare spending that is unrelated to regional differences in illness. Each cohort member's exposure to different levels of spending was therefore defined by the level of end-of-life spending in his or her hospital referral region of residence ($n$ = 306).

Outcome Measurements: 5-year mortality rate (all four co- horts), chang (MCBS coho

Results: Co but those i 60% more c ing was ass fracture coh cohort, 1.01 cohort, 1.00 0.99 to 1.03 functional st ences in sat

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See related 347-348, 348

SPECIAL ARTICLE

## Rehospitalizations among Patients in the Medicare Fee-for-Service Program

Stephen F. Jencks, M.D., M.P.H., Mark V. Williams, M.D., and Eric A. Coleman, M.D., M.P.H.

ABSTRACT

BACKGROUND

Reducing rates of rehospitalization has attracted attention from policymakers as a way to improve quality of care and reduce costs. However, we have limited informa-

# What are other countries doing about the missing elements that case-based payment doesn't provide?

| Lever | Quality | Fragmentation | Effectiveness |
|---|---|---|---|
| **Funding Policy** | Value-based Purchasing and Non-Payment | Episodes of Care | Episodes of Care |
| | | Meaningful Use of EHR | Meaningful Use of EHR |
| **Organization and Delivery System** | Accountable Care Organizations | Accountable Care Organizations | Accountable Care Organizations |
| | | Medical Home | Medical Home |
| **System-Level** | Cross Sector Data Standardization<br>Patient Outcomes and Experience | | |

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# Accountability for Quality: Hospitals

| Value Initiatives | Non-Payment for Poor Quality |
|---|---|
| Medicare:<br>• Redistribute percentage of payments to high quality hospitals<br>England:<br>• Percentage reduction in payments for poor quality standards<br>France:<br>• Payments for quality improvement | No additional payments for related admissions in 30 days:<br>• Medicare<br>• England (NHS)<br>• Germany |

| LHIN | All Cause Readm |
|---|---|
| 6 | 9.6% |
| 7 | 9.6% |
| 8 | 9.5% |
| 12 | 12.5% |
| 13 | 12.3% |
| 14 | 13.4% |

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# Accountability for Quality: All

| Episodes of Care | |
|---|---|
| **START: Hospital** | **START: Post-Acute Care** |
| All care during a defined period of time<br><br>• Triggered by a hospitalization<br>• Includes physician payments<br>• Chronic and Acute events<br>• Based on 2 years historical utilization and cost data | All care during a defined period of time<br><br>• Triggered by an admission into post-acute care (nursing home, rehabilitation, or home care) after a hospitalization<br>• Includes physician payments<br>• Based on 2 years historical utilization and cost data |

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# Accountability for Quality: All

"A network of organizations that provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the outcomes and the health status of the population served."


Ref: Shortell, R.R. Gillies, and D.A. Anderson, "The New World of Managed Care: Creating Organized Delivery Systems," *Health Affairs* (Winter 1994): 46–64.

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# Reflections from Ontario

- Hip Fracture Care:

| LHIN of Residence | Index Event | Average 30 day Cost | Average 90 day Cost |
|---|---|---|---|
| Overall | $20,574 | $29,537 | $37,882 |
| 4 | $21,854 | $30,769 | $39,577 |
| 5 | $19,171 | $27,858 | $35,665 |
| 6 | $18,817 | $29,797 | $38,691 |
| 7 | $20,632 | $33,063 | $44,679 |
| 8 | $19,941 | $30,310 | $38,888 |
| 12 | $20,475 | $28,187 | $36,319 |
| 13 | $27,366 | $32,495 | $40,178 |
| 14 | $20,581 | $29,593 | $39,971 |

| | First Discharge Location | | | |
|---|---|---|---|---|
| LHIN of Residence | CCC | LTC | NRS | HOME |
| Overall | 14% | 20% | 32% | 34% |
| 4 | 21% | 20% | 24% | 36% |
| 5 | 20% | 21% | 27% | 31% |
| 6 | 13% | 15% | 45% | 26% |
| 7 | 19% | 14% | 48% | 18% |
| 8 | 11% | 19% | 46% | 25% |
| 12 | 12% | 24% | 21% | 42% |
| 13 | 8% | 29% | 10% | 53% |
| 14 | 22% | 17% | 22% | 38% |

| | 90 Days Following Discharge from Acute Care | | |
|---|---|---|---|
| LHIN of Residence | All Cause Inpatient Readmission | ED Visit | Doctor Visit <7days |
| Overall | 17% | 28% | 90% |
| 4 | 15% | 26% | 90% |
| 5 | 16% | 25% | 90% |
| 6 | 17% | 24% | 91% |
| 7 | 19% | 32% | 94% |
| 8 | 18% | 28% | 94% |
| 12 | 14% | 26% | 90% |
| 13 | 19% | 31% | 78% |
| 14 | 22% | 38% | 82% |

# Accountability for Quality: All

- Ontario has develop sophisticated clinical and administrative data collection
  - Know what services people are accessing
  - Cost and location of services
- Challenges:
  - Meaningful change in accountabilities will require physician participation
  - Some outcome measures, few process measures
  - Long history of silo-based organization, delivery and funding

# Discussion

- QBPs are not far removed from other countries efforts to achieve more for healthcare funding
- Integrating quality into funding policies is trying to address short-comings of other funding policies
  - Canada and Ontario are laggards in reform efforts to achieve better value from healthcare spending
  - Reforms are challenging
    - Research from the UK demonstrates significant mgmt turnover

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- Significant potential
- Current system has many limitations
- Plenty of risks

thestar.com

COMMENTARY

Opinion / Commentary

## Ontario's hospitals: Pitfalls and opportunities for high-quality care

Over the next three years, the Ontario government plans to begin partially funding hospitals based on the number of patients they treat and the quality of care they receive.

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VINCE TALOTTA / TORONTO STAR

Ontario is introducing a new approach to the Canadian hospital funding scene, known as quality-based procedures (QBPs). It's an ambitious plan that could fall flat or set a new global benchmark.

By: Jason Sutherland and Erik Hellsten Published on Thu May 09 2013

For several decades, the amount of funding that Ontario's hospitals receive each year has been based more or less on the funding they received the previous year, regardless of

EXPLORE THIS STORY

1 PHOTO

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