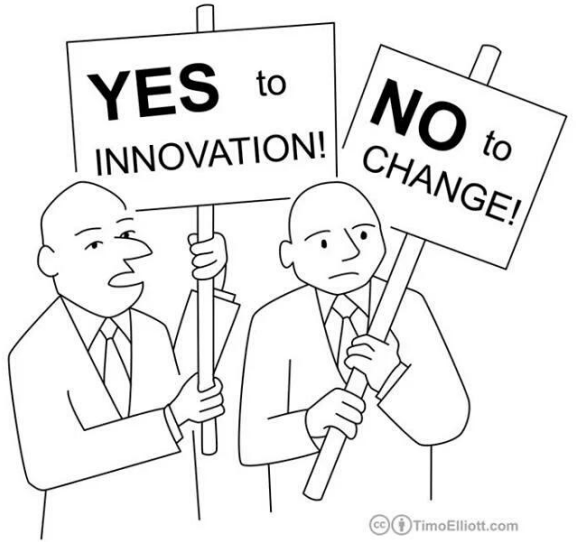
HELIOS Kliniken
Jeder Moment ist Medizin

Interacting with “policy makers”– The view of the hospital administrator

Ralf Kuhlen
Chief Medical Officer, HELIOS Hospital Group

What does Innovation mean for hospitals….

- Who actually is a Hospital?
  - Patients
  - Employees
    - Medical Doctors
      - » Academic?
      - » Career oriented?
    - Nurses
    - Health Care Service Personnel
  - Owner
  - Management



"We only have two demands!
Why don't people just give us what we want?"

Quality: … translated into a Hospitals mission

- Provide quality
  - Best?
  - State of the art?
- Do no harm
  - Prevent risk
  - Do no needless interventions
- Provide Patient Service
- Don’t waste resources
  - Economics

What problems should policy makers actually solve?

1. Take away the economical pressure
   - Provide enough well trained personnel ,time, resources in general?
2. Provide a sufficient structural framework
   - Provide reliable and general access to health care
   - Control and avoid waste?
   - Control and avoid overutilization?
   - Control and avoid artistic freedom when evidence is existing?
3. The reimbursement framework
   - The amounts? The costs?
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     - P4P? NP4NP?

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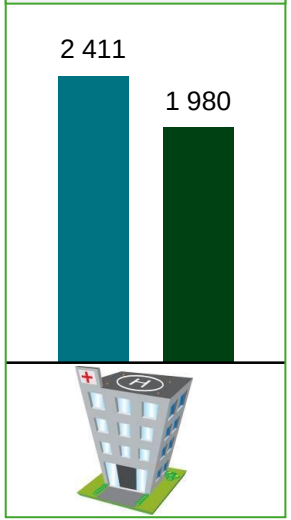
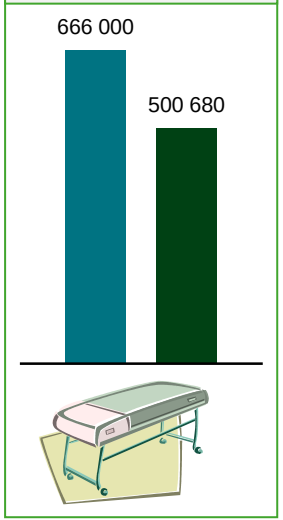
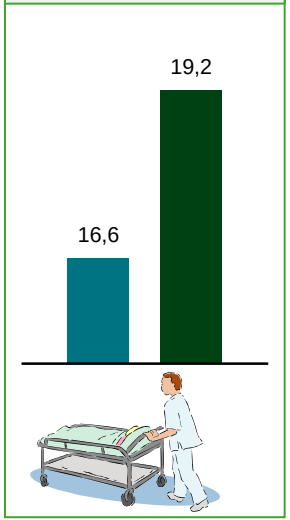
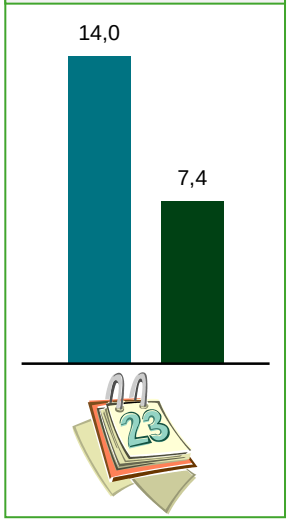
Hospitals market – Major trends

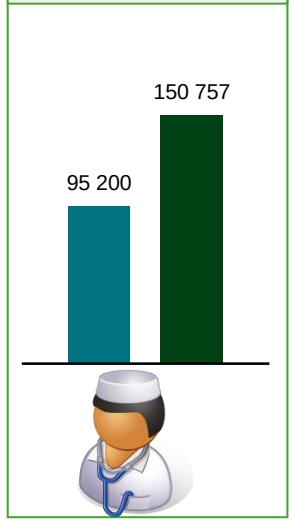
Number of hospitals	Beds	Patients in m	Average length of stay	Physicians[1) 2)]	Non-physician employees[2)]
-18%	-25%	+31%	-6.6 days	+58.3%	-9.2%

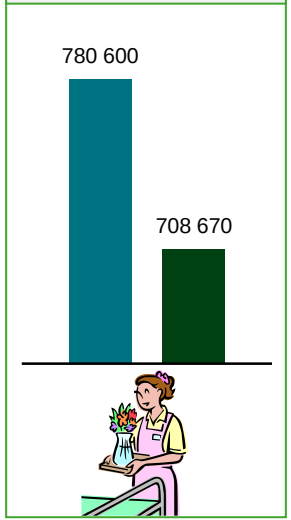












1) full-time physician
2) On a full-time basis converted

Source: Statistisches Bundesamt

1991 2014 Development 1991 to 2014

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How many days p.a. do people in different countries spent as inpatients? Take Germans as an example…..

1,8

1

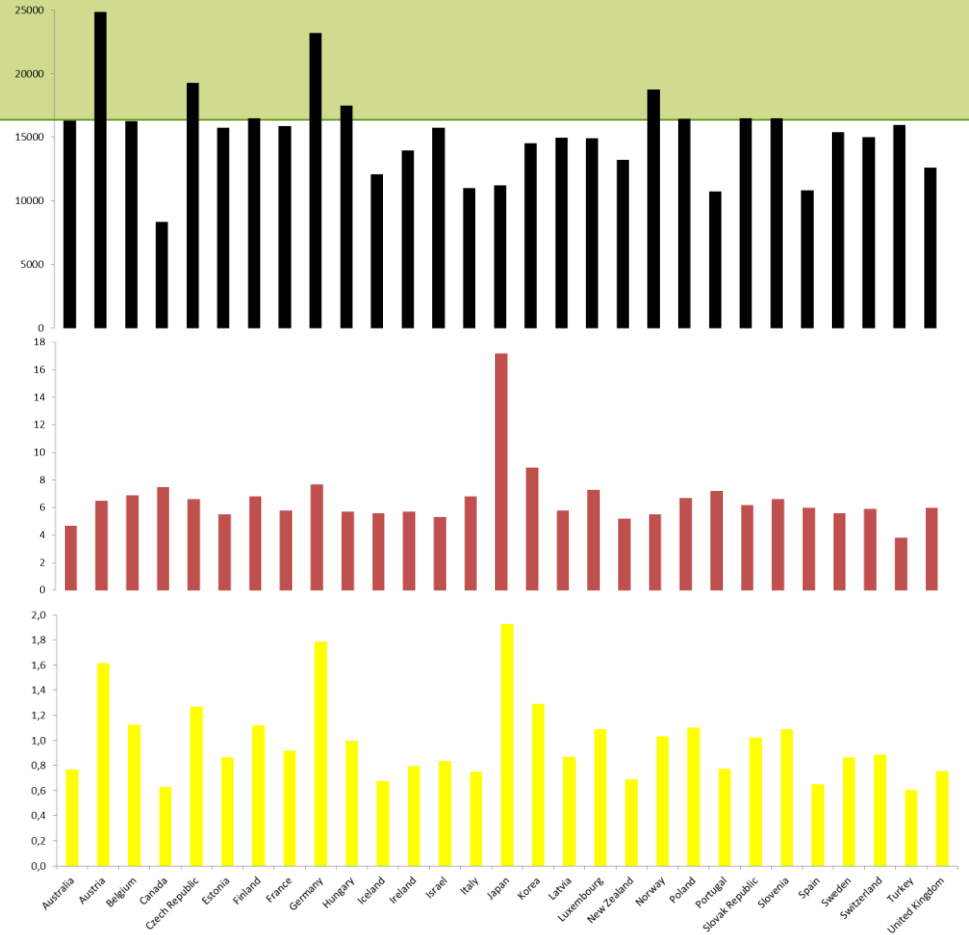
0,7

0,6

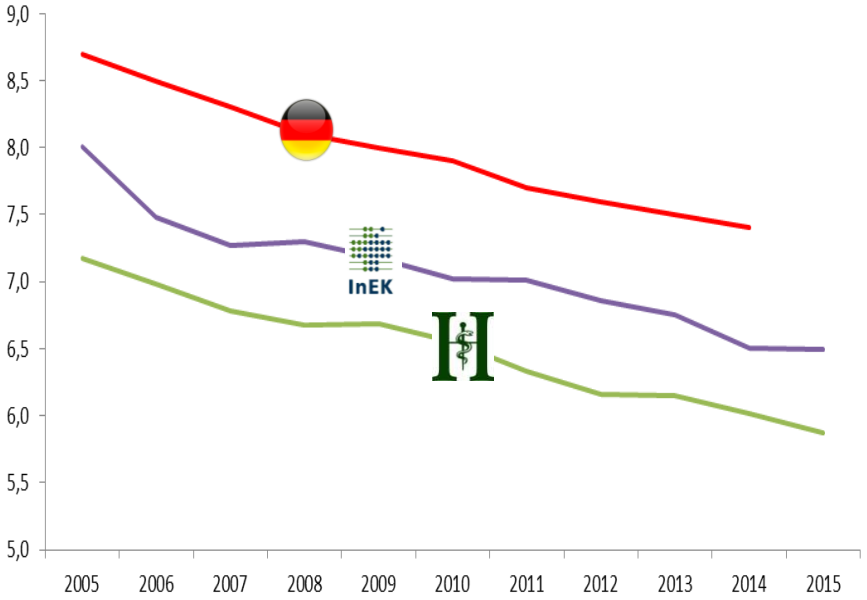
Inpatients /
100000 population

AVLOS (d)

Bed Days per capita



Average length of stay …



Germany – a platform for Modern Medicine

Capio

- Germany late in implementing Modern Medicine
- Performance based remuneration introduced 2005, but administrative restrictions prevent development
- Political reform needed and discussed

The biggest potential in Europe

Source:
AVLOS – Sweden: Socialstyrelsen; Norway: Helsedirektoratet; France: ATIH; Germany: Federal Statistical Office's DRG browser; Finland: Eurostat ; UK: Health and Social Care Information Centre; Spain: Eurostat; Best-practice - knee prosthesis: North Wales knee clinic; Best-practice - AMI: US Healthcare costs and utilization project
Ambulatory surgery – All countries excluding Germany: Eurostat; Germany: German association of ambulatory surgery; Best-practice - Inguinal hernia: NHS; Best-practice - Tonsillectomy: US agency for healthcare research and quality

How many ICU admission per 100 inhabitants do different countries have p.a.? Again, who is Germany?

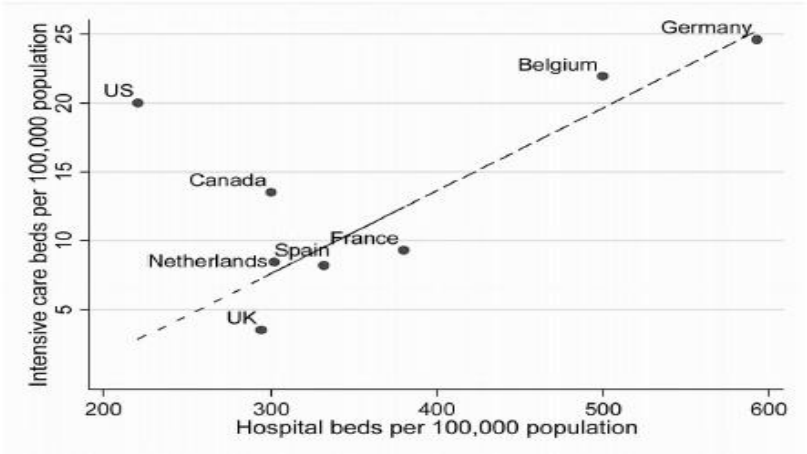
1,9

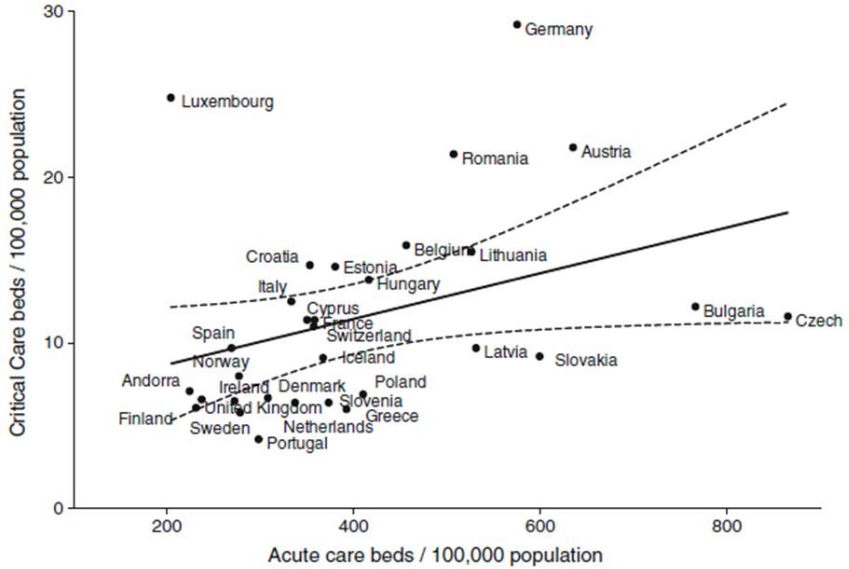
0,2

2,4

Do not want to know

Number of Intensive Care beds in different countries





Comparing is the end of happiness and the start of feeling uncomfortable (Kierkegaard)

Abbildung 2:
Deutschland im Ausgabenvergleich mit den europäischen OECD-Staaten (Anteil der Gesundheitsausgaben am Bruttoinlandsprodukt)

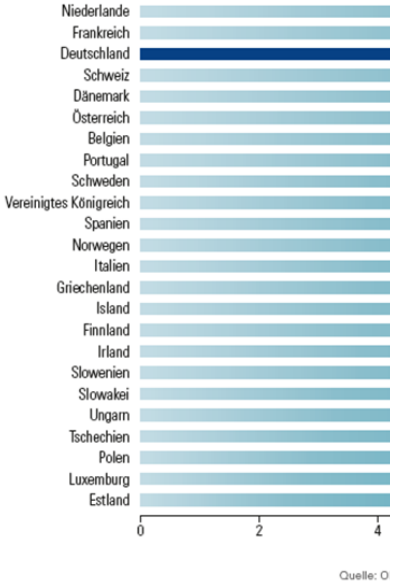


Abbildung 3:
Deutschland im Qualitätsvergleich mit OECD-Staaten (OECD-Ranking)

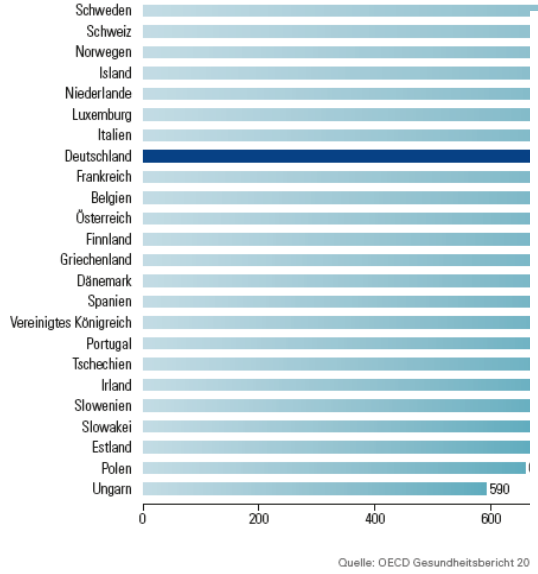
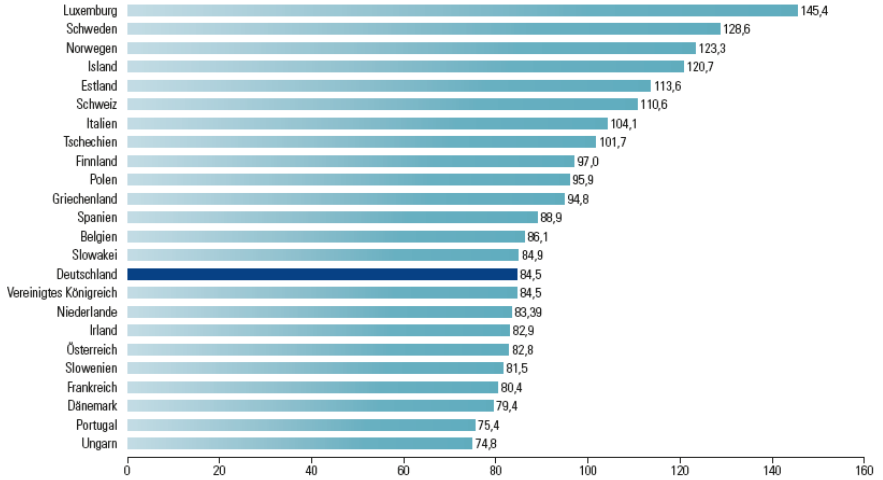
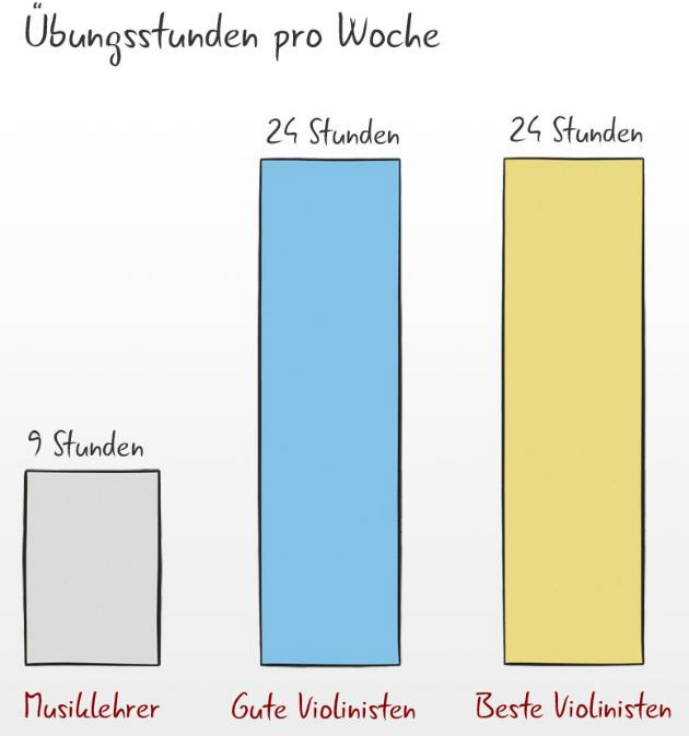


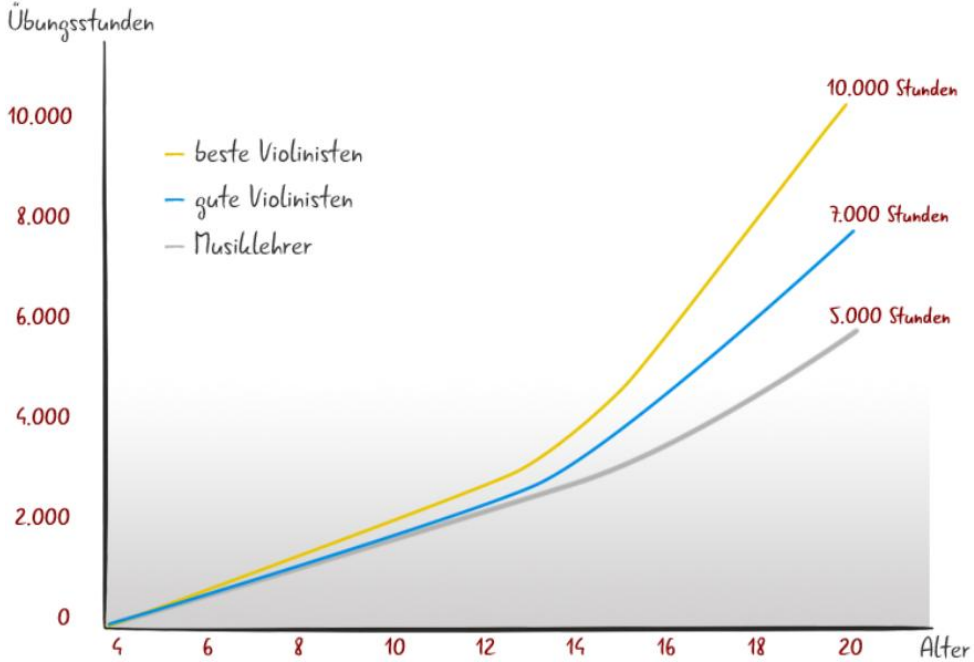
Abbildung 5:
Ausgabeneffizienz der europäischen Gesundheitssysteme (OECD-Staaten)



Quelle: OECD Gesundheitsbericht 2013; Datenauswahl, Berechnungen und Darstellung durch KPMG, Deutschland, 2014

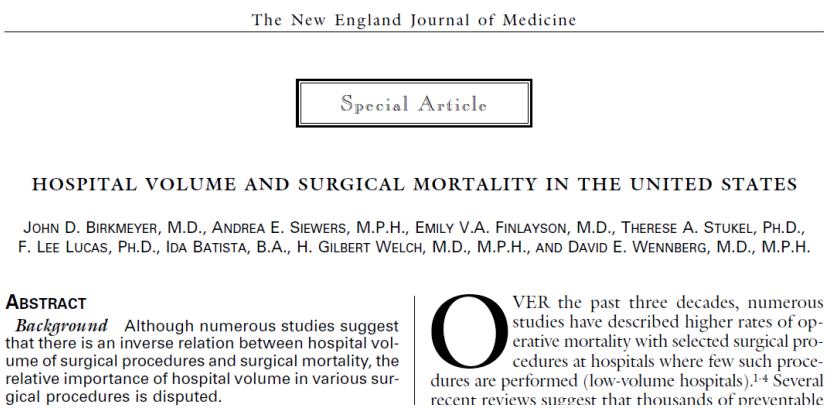
Volume-Outcome relationships - Practice makes perfect…..





- Anders Ericsson, The Role of Deliberate Practice, Psychological Review 1993, 363-406
- Malcolm Gladwell – the10.000 h rule

Evidence supporting volume – outcome relationship



The New England Journal of Medicine

Special Article

HOSPITAL VOLUME AND SURGICAL MORTALITY IN THE UNITED STATES

JOHN D. BIRKMEYER, M.D., ANDREA E. SIEWERS, M.P.H., EMILY V.A. FINLAYSON, M.D., THERESE A. STUKEL, PH.D., F. LEE LUCAS, PH.D., IDA BATISTA, B.A., H. GILBERT WELCH, M.D., M.P.H., AND DAVID E. WENNBERG, M.D., M.P.H.

ABSTRACT

Background Although numerous studies suggest that there is an inverse relation between hospital volume of surgical procedures and surgical mortality, the relative importance of hospital volume in various surgical procedures is disputed.

OVER the past three decades, numerous studies have described higher rates of operative mortality with selected surgical procedures at hospitals where few such procedures are performed (low-volume hospitals).[1-4] Several recent reviews suggest that thousands of preventable

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Hospital Volume and 30-Day Mortality for Three Common Medical Conditions

Joseph S. Ross, M.D., M.H.S., Sharon-Lise T. Normand, Ph.D., Yun Wang, Ph.D., Dennis T. Ko, M.D., Jersey Chen, M.D., Elizabeth E. Drye, M.D., Patricia S. Keenan, Ph.D., Judith H. Lichtman, Ph.D., M.P.H., Héctor Bueno, M.D., Ph.D., Geoffrey C. Schreiner, B.S., and Harlan M. Krumholz, M.D.

… the learning curve. Another aspect of volume-outcome...

Figure 1. Annual Operator Volume of Carotid Stenting Across 2339 Operators During the Study Period

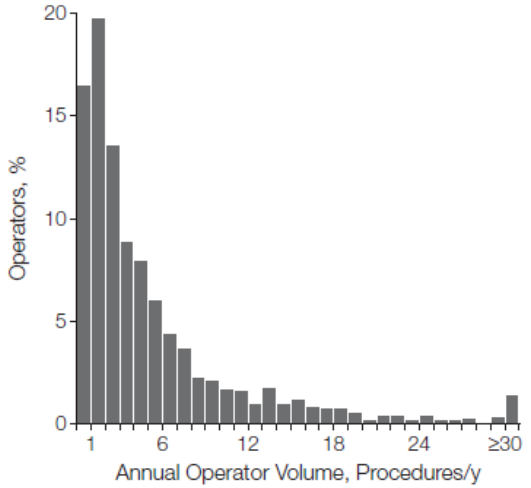
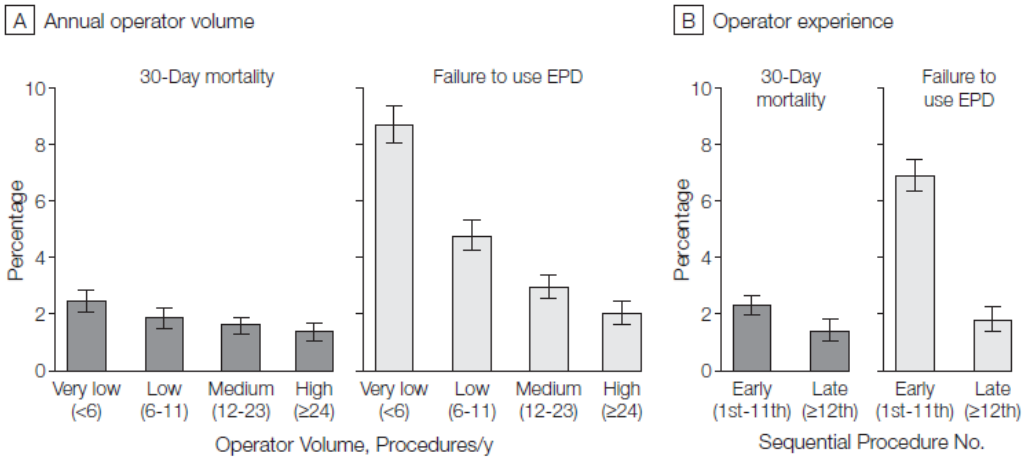


Figure 2. Unadjusted Patient Outcomes by Annual Operator Volume and Operator Experience at the Time of the Procedure



P<.001 for differences across categories for both outcomes. EPD indicates embolic protection device. Error bars indicate 95% CIs.

Nakkamothu et al (2011) JAMA: 306, 1338

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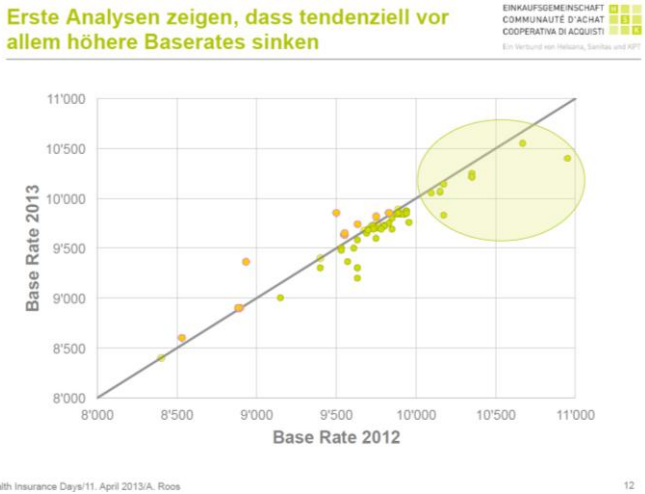
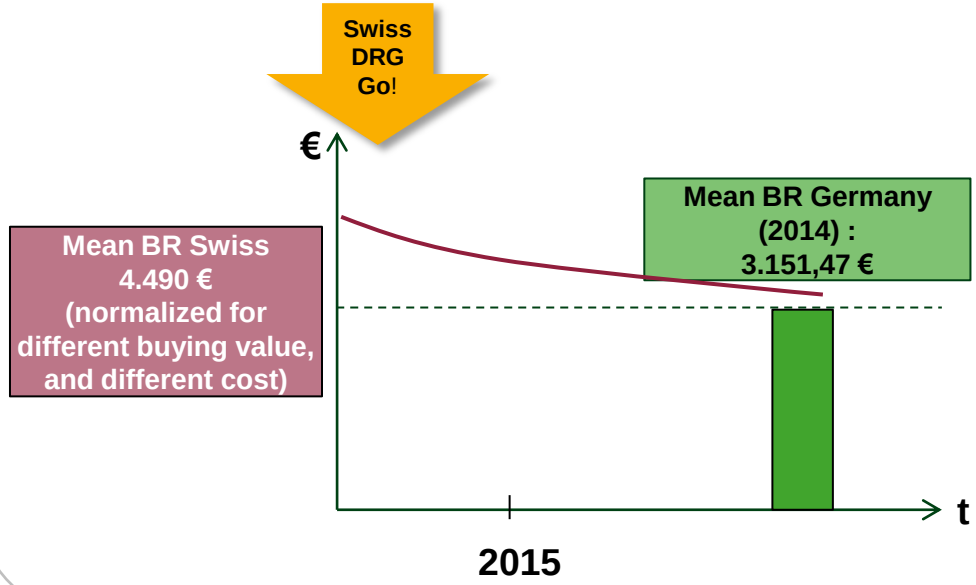
Perspectives on reimbursement

Decreasing base rates in Swiss…..

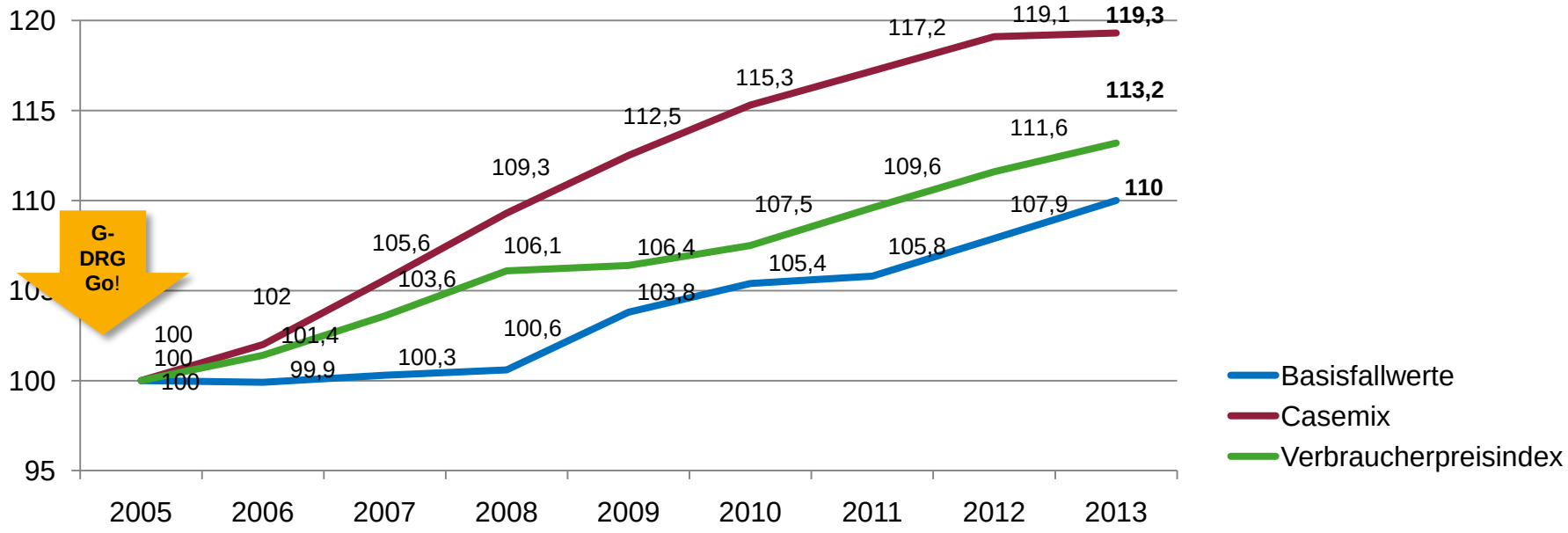


Quelle: Einkaufsgemeinschaft HSK, Health Insurance Days 11. April 2013, A.Roos, S. 12.

…. but how does that compare to others?



Development of German base rate in the DRG system

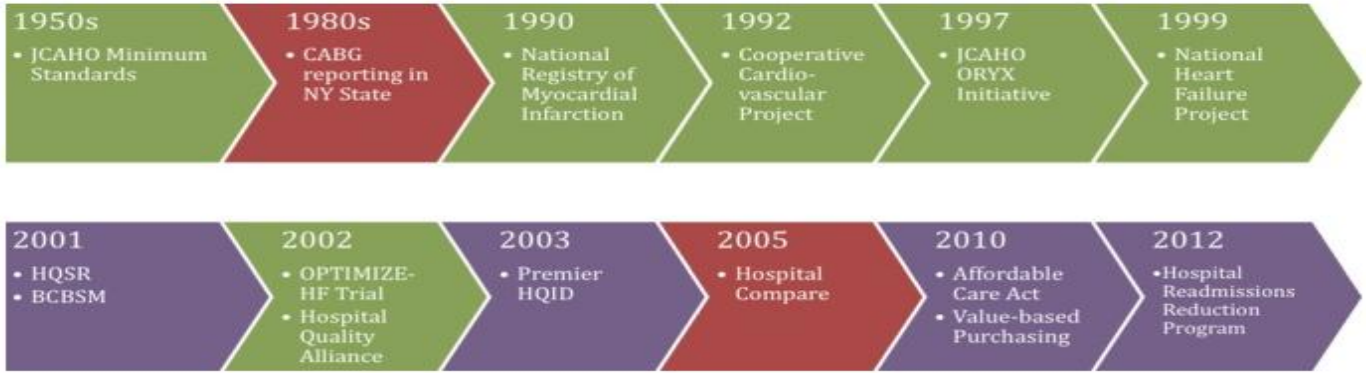


Quelle: Krankenhaus Rating Report 2015, Bad Bank für Krankenhäuser – Krankenhausausstieg vor der Tür?, medhochzwei, Heidelberg, S. 15, S. 38.

Do Cardiology Quality Measures Actually Improve Patient Outcomes?

Paula Chatterjee, MPH; Karen E. Joynt, MD, MPH

Figure 1.



Timeline of quality improvement programs in cardiovascular care. Green: quality measurement programs; red: public reporting; purple: pay-for-performance programs. BCBSM indicates Blue Cross Blue Shield of Michigan Participating Hospital Agreement Incentive Program; CABG, coronary artery bypass graft; HQID, hospital quality incentives demonstration; HQSR, Hawaii Medical Service Association Hospital Quality Service and Recognition Pay-for-Performance Program; JCAHO, Joint Commission on Accreditation of Healthcare Organizations; OPTIMIZE-HF, Organized Program to Initiate Lifesaving Treatment in Hospitalized Patients With Heart Failure.

J Am Heart Assoc. 2014;3:e000404 doi: 10.1161/JAHA.113.000404.

Evidence Report/Technology Assessment
Number 208

5. Public Reporting as a Quality Improvement Strategy

Closing the Quality Gap: Revisiting the State of the Science

Executive Summary

Introduction

A substantial amount of research exists demonstrating that health care frequently fails to meet the current standards of quality care.[1,2] Errors, suboptimal management or control of disease, and overutilization or underutilization of services are more likely to occur when high-quality evidence-based health care is not provided.

In a quality improvement framework that includes measuring, influencing, and improving quality, public reporting (making quality, safety, or performance data publicly available) is categorized as a means of influencing quality by providing incentives for change.[3,4] This report focuses on how the public reporting of health care quality information may provide incentives for quality improvement that ultimately produce higher quality care. It is part of the Closing the Quality Gap: Revisiting the State of the Science series, which examines the role of several interventions in promoting quality health care.

Quality might be influenced by the different incentives public reports create for different people and organizations. The incentives may be for the consumers of health care, including patients, families, or advocates who act on the behalf of patients, or for other purchasers of health care services, such as employers, who select the options available to their employees. Public reporting can also provide incentives

Evidence-based Practice Program

The Agency for Healthcare Research and Quality (AHRQ), through its Evidence-based Practice Centers (EPCs), sponsors the development of evidence reports and technology assessments to assist public- and private-sector organizations in their efforts to improve the quality of health care in the United States. The reports and assessments provide organizations with comprehensive, science-based information on common, costly medical conditions and new health care technologies. The EPCs systematically review the relevant scientific literature on topics assigned to them by AHRQ and conduct additional analyses when appropriate prior to developing their reports and assessments.

AHRQ expects that the EPC evidence reports and technology assessments will inform individual health plans, providers, and purchasers as well as the health care system as a whole by providing important information to help improve health care quality.

The full report and this summary are available at www.effectivehealthcare.ahrq.gov/reports/final.cfm.

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

Evidence-Based Practice

Does Public Reporting increase quality?

Table A. Summary evidence table: Effectiveness of public reporting of health care quality as a quality improvement strategy

Key Question	Outcome: Conclusion	Total Studies,[a] Settings (Number of Studies)	Strength of Evidence
Key Question 1 Does public reporting result in improvements in the quality of health care (including improvements in health care delivery structures, processes, or patient outcomes)?	**Reduction in mortality:** Public reporting was associated with a small decline in mortality after controlling for trends in reductions in mortality.	19 Hospitals (18) Individual clinicians (1)	Moderate
	Quality and process indicators (e.g., CAHPS, HEDIS, Nursing Home Compare): Most studies found that public reporting is associated with improvement in quality and process indicators, although this varies across specific measures.	19 Hospitals (5) Health plans (5) Long-term care (9)	High

Does Public Reporting do harm?

Key Question	Outcome: Conclusion	Total Studies,[a] Settings (Number of Studies)	Strength of Evidence
Key Question 2 What harms result from public reporting?	**Increase in mortality:** In one study, an increase in mortality was attributed to public reporting.	1 Hospitals	Insufficient
	Inappropriate diagnosis and treatment: In one study, the hypothesis that a publicly reported measure would lead to overdiagnosis and overprescribing was not supported.	1 Hospitals	Insufficient
	Access restrictions: Most studies concluded that public reporting does not contribute to reduced access for patients (e.g., avoiding high-risk patients, referring high-risk patients out of State). Fewer studies have identified instances of reduced access, suggesting this conclusion could be changed based on future research.	13 Hospitals (8) Individual clinicians (2) Long-term care (3)	Low
	Unintended provider behavior: There was some evidence from LTC that public reporting motivates NHs to change coding and readmit patients to the hospital. No evidence supported a link with surgeons or organizations withdrawing from the market or with declines in quality for items not measured (crowding out).	5 Individual clinicians (1) Health plans (2) Long-term care (2)	Moderate

Does Public Reporting change behavior?

Key Question 3 Does public reporting lead to change in health care delivery structures or processes?	**Provider actions:** The evidence suggested that individual clinicians and organizations respond to public reporting in positive ways, including adding services, changing policy, and increasing focus on clinical care. One study found that low-quality surgeons leave practice (considered a positive action). A study of vaccination rates was the only one that found no effect.	10 Hospitals (4) Individual clinicians (1) Long-term care (5)	Moderate
Key Question 4 Does public reporting lead to change in the behavior of patients, their representatives, or organizations that purchase care?	**Selection (market share/volume):** Studies found no or minimal impact of public reporting on selection as measured by market share or volume. Contracting patterns suggested purchasers give only minimal consideration to publicly reported quality when selecting providers.	47 Hospitals (15) Individual clinicians (9) Health plans (17) Long-term care (6)	Moderate

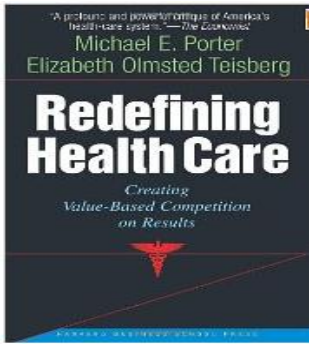
Contextual factors influence the effects of Public Reporting?

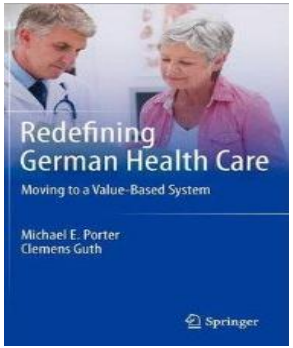
Key Question	Outcome: Conclusion	Total Studies,[a] Settings (Number of Studies)	Strength of Evidence
Key Question 5 What characteristics of public reporting increase its impact on quality of care?	**Mode and tone of message:** One study found that mode (email vs. mail) affects use of public reports, while tone of the message (risks vs. benefits) does not.	1 Individual clinicians	Insufficient
	Accuracy and usefulness: One study found that the quality information contained in public reports is accurate and useful for patient selection, even if there is a substantial delay between data collection and publication.	1 Individual clinicians	Insufficient
Key Question 6 What contextual factors (population characteristics, decision type, and environmental) increase the impact of public reporting on quality of care?	**Competitive market:** Studies have found that public reporting is more likely to result in improvements in quality if the clinician or provider is in a competitive market.	7 Hospitals (2) Long-term care (5)	High
	Baseline performance: The likelihood of improvement after public reporting was greater for entities with lower quality before or at the first instance of reporting.	5 Health plans (2) Long-term care (3)	High
	Nursing home characteristics: Characteristics (e.g., ownership) did not reliably predict how NHs reacted to public reporting. Studies found no consistent difference across characteristics.	6 Long-term care (6)	Low
	Patient characteristics/subgroups: Different patient characteristics, such as age, specific health care needs, and insurance coverage, may have increased the likelihood that publicly reported data affected choice.	3 Health plans (1) Individual clinicians (2)	Low
	Variation in quality: Public reporting was more likely to influence quality if the level of quality varied across plans in the market.	1 Health plans	Insufficient

Should policy makers implement public reporting and/or P4P/NP4NP?

- Scientific evidence if weak (at best)
- Typical decision in the condition of profound uncertainty
- What are the major influences under these conditions?
- Is there any possibility for not taking the decision
- What are alternatives and what is known about these?

The perspective of value generation

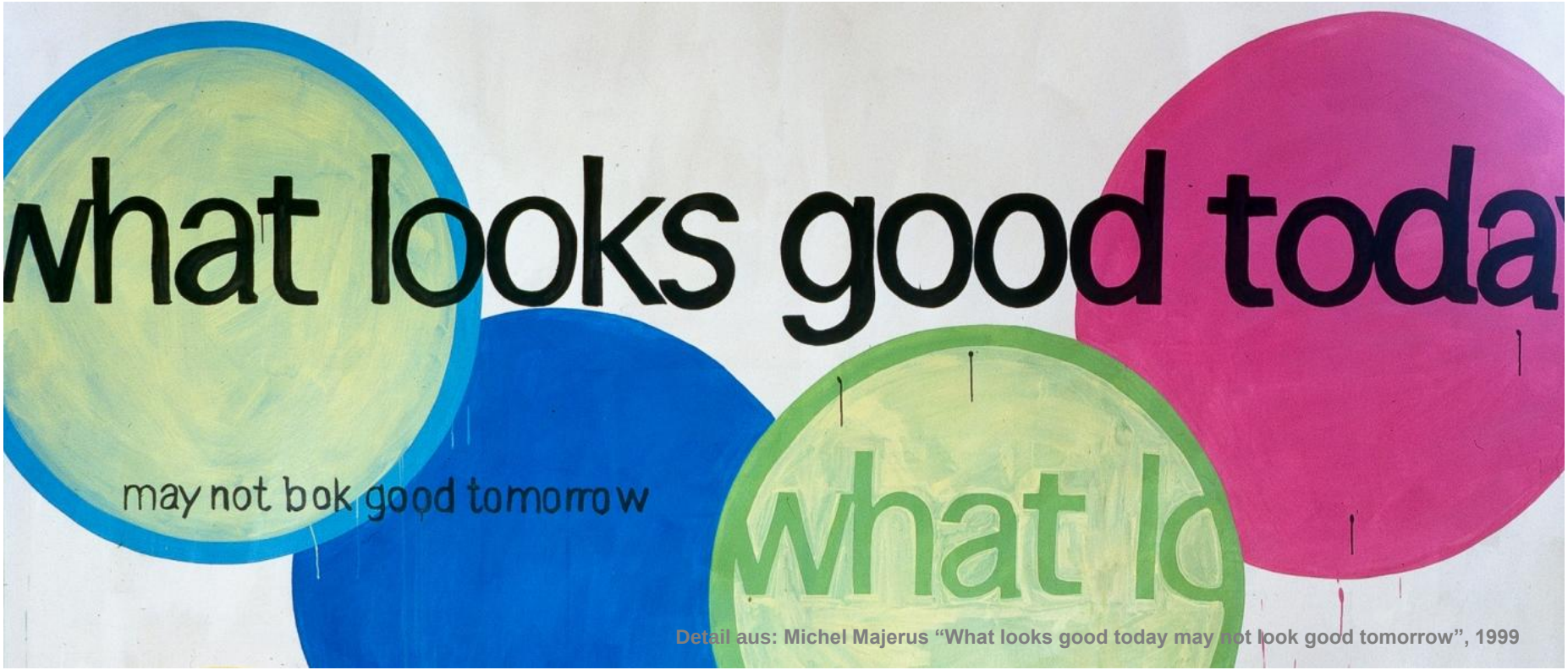




Conclusion of a hospital administrator

1. Keep politics out of our business as much as possible
2. Many of the problems we ask policy makers to solve should be addressed by experts instead
   - Volume outcome should be openly addressed by scientific societies, hospital associations, patient representatives
     - (Understandable) Conflict of interest do not only prevent policy makers from deciding rational
3. Every system will finally follow its own incentives.
   - Quality and added value should be much more focused then structure and procedural costs
4. I doubt the existence of the perfect system – I do believe that we have to consistently reinvent our approaches

The preliminary end….



Detail aus: Michel Majerus “What looks good today may not look good tomorrow”, 1999