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?
   • Provide and control criteria for payment?
   • P4P? NP4NP?
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Hospitals market – Major trends

Number of hospitals: -18%
- 1991: 2,411
- 2014: 1,980

Beds: -25%
- 1991: 666,000
- 2014: 500,680

Patients in m: +31%
- 1991: 16,6
- 2014: 19,2

Average length of stay: -6.6 days
- 1991: 14.0
- 2014: 7.4

Physicians: +58.3%
- 1991: 95,200
- 2014: 150,757

Non-physician employees: -9.2%
- 1991: 780,600
- 2014: 708,670

Sources:
1) full-time physician
2) On a full-time basis converted
Source: Statistisches Bundesamt

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

0,7

1

0,6
Average length of stay …
How many ICU admission per 100 inhabitants do different countries have p.a.? Again, who is Germany?

1.9

2.4

0.2

Do not want to know
Number of Intensive Care beds in different countries

[Graph showing the number of Intensive Care beds per 100,000 population vs. hospital beds per 100,000 population for various countries.]
Comparing is the end of happiness and the start of feeling uncomfortable (Kierkegaard)
Volume-Outcome relationships - Practice makes perfect…..

- Malcolm Gladwell – the 10,000 h rule
Evidence supporting volume – outcome relationship

HOSPITAL VOLUME AND SURGICAL MORTALITY IN THE UNITED STATES


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). Several recent reviews suggest that thousands of preventable

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...

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     • P4P? NP4NP?
Perspectives on reimbursement

Decreasing base rates in Swiss…..

…. but how does that compare to others?

Mean BR Switzerland 2014: 4.490 € (normalized for different buying value, and different cost)

Mean BR Germany 2014: 3.151,47 €

Erste Analysen zeigen, dass tendenziell vor allem höhere Baserates sinken

Development of German base rate in the DRG system

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.

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

<table>
<thead>
<tr>
<th>Key Question</th>
<th>Outcome: Conclusion</th>
<th>Total Studies, Settings (Number of Studies)</th>
<th>Strength of Evidence</th>
</tr>
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<tbody>
<tr>
<td><strong>Key Question 1</strong>&lt;br&gt;Does public reporting result in improvements in the quality of health care (including improvements in health care delivery structures, processes, or patient outcomes)?</td>
<td><strong>Reduction in mortality:</strong> Public reporting was associated with a small decline in mortality after controlling for trends in reductions in mortality.</td>
<td>19 Hospitals (18) Individual clinicians (1)</td>
<td>Moderate</td>
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<td></td>
<td><strong>Quality and process indicators (e.g., CAHPS, HEDIS, Nursing Home Compare):</strong> Most studies found that public reporting is associated with improvement in quality and process indicators, although this varies across specific measures.</td>
<td>19 Hospitals (5) Health plans (5) Long-term care (9)</td>
<td>High</td>
</tr>
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## Does Public Reporting do harm?

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<th>Strength of Evidence</th>
</tr>
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<td><strong>Key Question 2</strong>&lt;br&gt;What harms result from public reporting?</td>
<td><strong>Increase in mortality:</strong>&lt;br&gt;In one study, an increase in mortality was attributed to public reporting.</td>
<td>1 Hospitals</td>
<td>Insufficient</td>
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<td><strong>Inappropriate diagnosis and treatment:</strong>&lt;br&gt;In one study, the hypothesis that a publicly reported measure would lead to overdiagnosis and overprescribing was not supported.</td>
<td>1 Hospitals</td>
<td>Insufficient</td>
</tr>
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<td><strong>Access restrictions:</strong>&lt;br&gt;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.</td>
<td>13 Hospitals (8) &lt;br&gt;Individual clinicians (2) &lt;br&gt;Long-term care (3)</td>
<td>Low</td>
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<td></td>
<td><strong>Unintended provider behavior:</strong>&lt;br&gt;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).</td>
<td>5 Individual clinicians (1) &lt;br&gt;Health plans (2) &lt;br&gt;Long-term care (2)</td>
<td>Moderate</td>
</tr>
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### Does Public Reporting change behavior?

#### Key Question 3
Does public reporting lead to change in health care delivery structures or processes?

<table>
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<th>Provider actions:</th>
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<td>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.</td>
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<th>Hospitals (4)</th>
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<tr>
<td>Individual clinicians (1)</td>
</tr>
<tr>
<td>Long-term care (5)</td>
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#### Key Question 4
Does public reporting lead to change in the behavior of patients, their representatives, or organizations that purchase care?

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<th>Selection (market share/volume):</th>
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<td>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.</td>
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<table>
<thead>
<tr>
<th>Hospitals (15)</th>
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<td>Individual clinicians (9)</td>
</tr>
<tr>
<td>Health plans (17)</td>
</tr>
<tr>
<td>Long-term care (6)</td>
</tr>
</tbody>
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**Moderate**
Contextual factors influence the effects of Public Reporting?

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<tr>
<th>Key Question 5</th>
<th>Outcome: Conclusion</th>
<th>Total Studies, Settings (Number of Studies)</th>
<th>Strength of Evidence</th>
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<tbody>
<tr>
<td>What characteristics of public reporting increase its impact on quality of care?</td>
<td>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.</td>
<td>1 Individual clinicians</td>
<td>Insufficient</td>
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<td>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.</td>
<td>1 Individual clinicians</td>
<td>Insufficient</td>
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<th>Key Question 6</th>
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<td>What contextual factors (population characteristics, decision type, and environmental) increase the impact of public reporting on quality of care?</td>
<td>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.</td>
<td>7 Hospitals (2) Long-term care (5)</td>
<td>High</td>
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<td>Baseline performance: The likelihood of improvement after public reporting was greater for entities with lower quality before or at the first instance of reporting.</td>
<td>5 Health plans (2) Long-term care (3)</td>
<td>High</td>
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<td>Nursing home characteristics: Characteristics (e.g., ownership) did not reliably predict how NPs reacted to public reporting. Studies found no consistent difference across characteristics.</td>
<td>6 Long-term care (6)</td>
<td>Low</td>
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<td>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.</td>
<td>3 Health plans (1) Individual clinicians (2)</td>
<td>Low</td>
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<td>Variation in quality: Public reporting was more likely to influence quality if the level of quality varied across plans in the market.</td>
<td>1 Health plans</td>
<td>Insufficient</td>
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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

"A patient can perceptibly assess good health care only if they have been exposed to other good health care systems. This is the essence of competition between systems. German health care systems are not built on the foundation of competition, but rather on the principle of providing high-quality care at the lowest possible cost. Hence, they can be improved by introducing value-based competition, which also brings about a more efficient allocation of resources."

Michael E. Porter

"Redefining German Health Care: Moving to a Value-Based System"

Michael E. Porter

"... the focus must be on increasing value for patients — the health outcomes achieved per dollar spent. Good outcomes that are achieved efficiently are the goal, not the false ”savings” from cost shifting and restricted services. Indeed, the only way to truly contain costs in health care is to improve outcomes: in a value-based system..."

Michael E. Porter, Ph.D.

"A Strategy for Health Care Reform — Toward a Value-Based System"

Michael E. Porter, Ph.D.
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