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Årsmøde i Dansk Selskab for Kvalitet i Sundhedssektoren

11.-12. januar 2019

Fælles løsninger: Europæiske erfaringer

Tema 1: Styring og Økonomi

Dr Søren Rud Kristensen
Centre for Health Policy - Institute of Global Health Innovation
Imperial NIHR Patient Safety Translational Research Centre

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Oversigt

- Hvad er det oplevede problem (med eksisterende afregningsmodeller)?
- Hvilke alternativer findes?
- Virker alternativerne efter hensigten (og hvad er hensigten egentlig?)
- Afrunding

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Hvad er det oplevede problem?

(med eksisterende afregningsmodeller)

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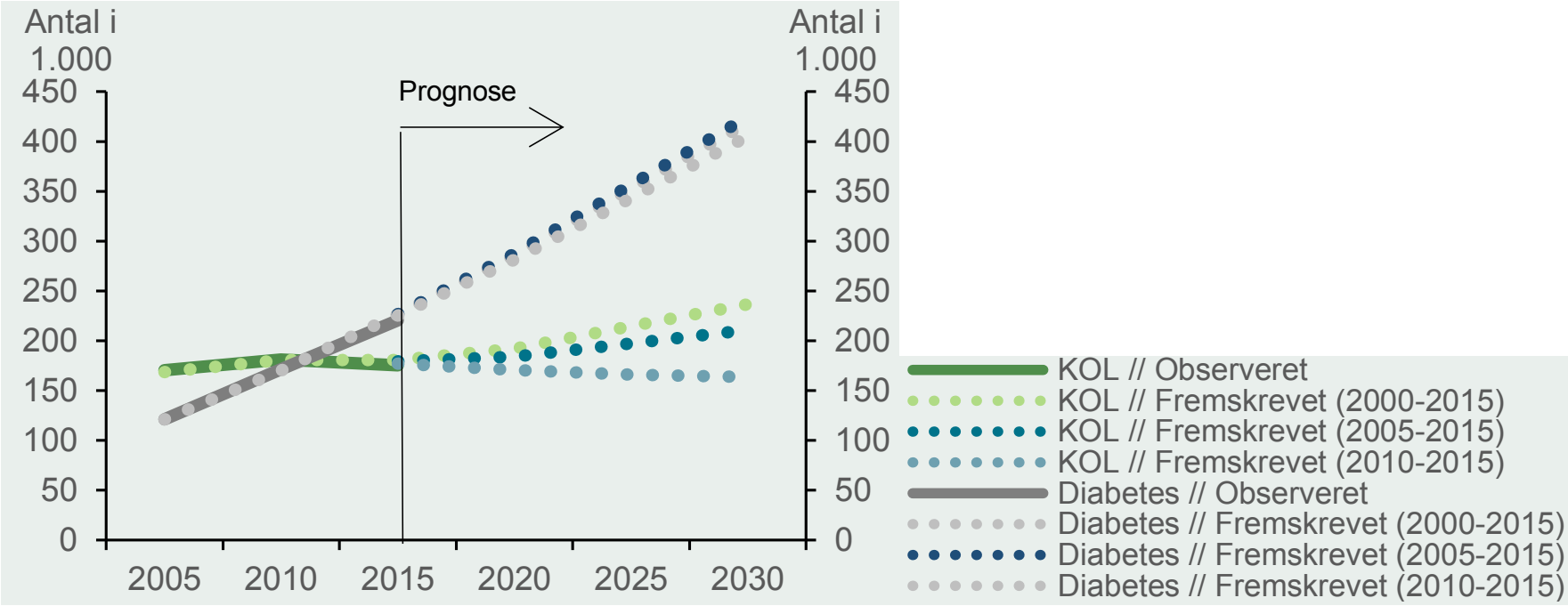
Flere lever længere med en kronisk sygdom



Sundheds- og Ældreøkonomisk Analyse, Sundheds- og Ældreministeriet, 2018

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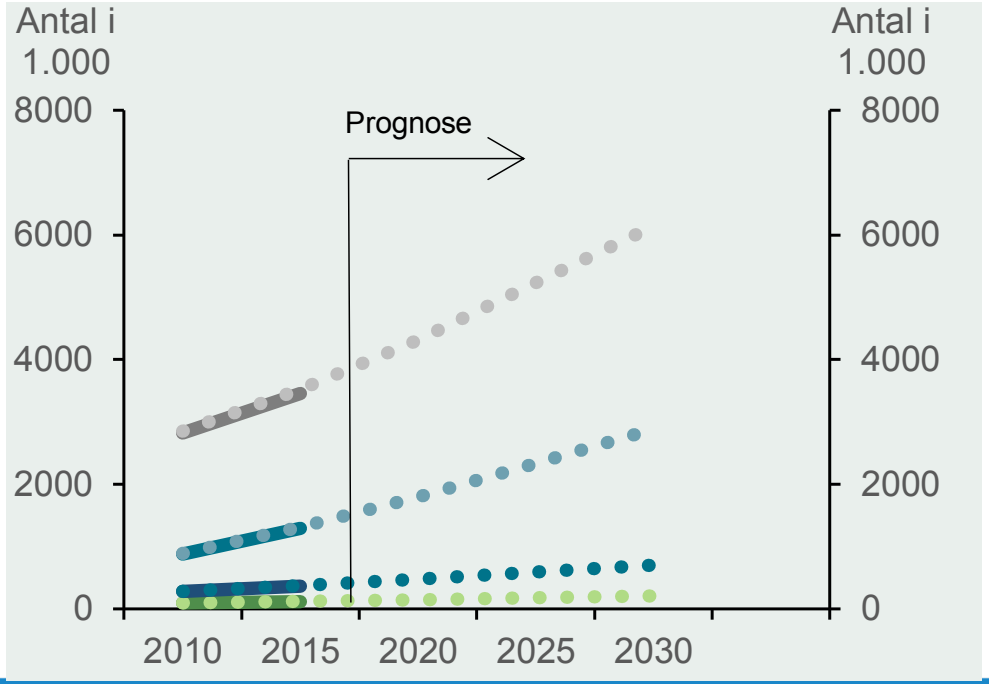
…så vi kan forvente øget aktivitet i sundhedssektoren



Sundheds- og Ældreøkonomisk Analyse, Sundheds- og Ældreministeriet, 2018

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Og oven I købet får vi nok…

- Flere multisyge
- Mere komplekse patienter
- Som kræver mere komplekse sundhedstilbud
- Med risiko for mere fragmeterede forløb…

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Så spørgsmålet er…

Giver eksisterende afregningssystemer de rette incitamenter til effektiv behandling af stadigt mere komplekse patienter og hvad er alternativet?

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“Problemer” med eksisterende afregningsordninger

- **Fee-for-service (FFS) / DRG**
  - Stærke incitamenter for aktivitet, dvs. favoriserer akut aktivitet over forebyggende arbejde
  - Risiko for overbehandling
- **Capitation / Rammeafregning**
  - Incitamenter til at minimere aktivitet (hvis ikke understøttet af andre incitamenter)
  - Incitament til at undgå komplekse (multisyge) patienter (hvis ikke risikojusteret)
- **Sectorspecifikke**
  - Få incitamenter til at samarbejde på tværs

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Hvilke alternativer findes?

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Afregningsmodeller med eksplicit fokus på integration

Afregningssytem	Beskrivelse
Pay for coordination	Særskilte betalinger for koordinerende indsats
Pay for performance	Betaling for at nå prædefinerede kvalitetsmål
“Bundled payments”	En takst der dækker et forløb / en population evt tværsektoralt

Tsiachristas, A., Dikkers, C., Boland, M.R.S., Rutten-van Mölken, M.P.M.H., 2013. Exploring payment schemes used to promote integrated chronic care in Europe. Health Policy 113, 296–304.

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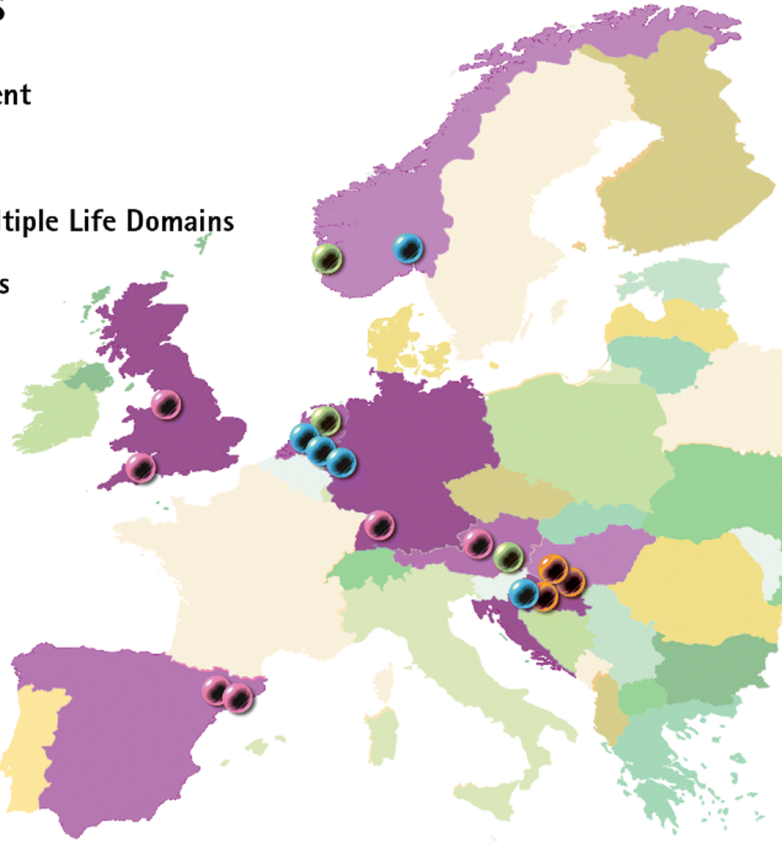
Selected programmes

- Population Health Management
- Frail Elderly
- Persons with Problems in Multiple Life Domains
- Palliative & Oncology Patients



SELFIE 2020

SUSTAINABLE INTEGRATED CARE MODELS FOR MULTI-MORBIDITY DELIVERY, FINANCING AND PERFORMANCE

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Nationale incitmentsystemer i de 8 SELFIE lande

Country	Macro level incentives for integration
Austria	Reformpool (2005-2013)
Croatia	Some pilot funding previously available for integration, but no current financial incentives for integration
Germany	Pilots of Disease Management Programmes (1993-), Integrated care programmes (2000-), Federal Joint Committee (Innovation Fund) (2016-2019)
Hungary	Previous initiatives reliant on EU funding. No current macro incentives except one P4P indicator in primary care
The Netherlands	**Bundled payments (2010), Population based payment pilots (ongoing)**
Norway	**Coordination reform (2012)**
Spain (Catalonia)	GMA: Adjusted multimorbidity groups, P4P
England	Integrated Care Pilots (2009-12), **Better Care Fund,** Integrated Care and Support Pioneers (2013), Vanguards (2015), Devolution (2016)

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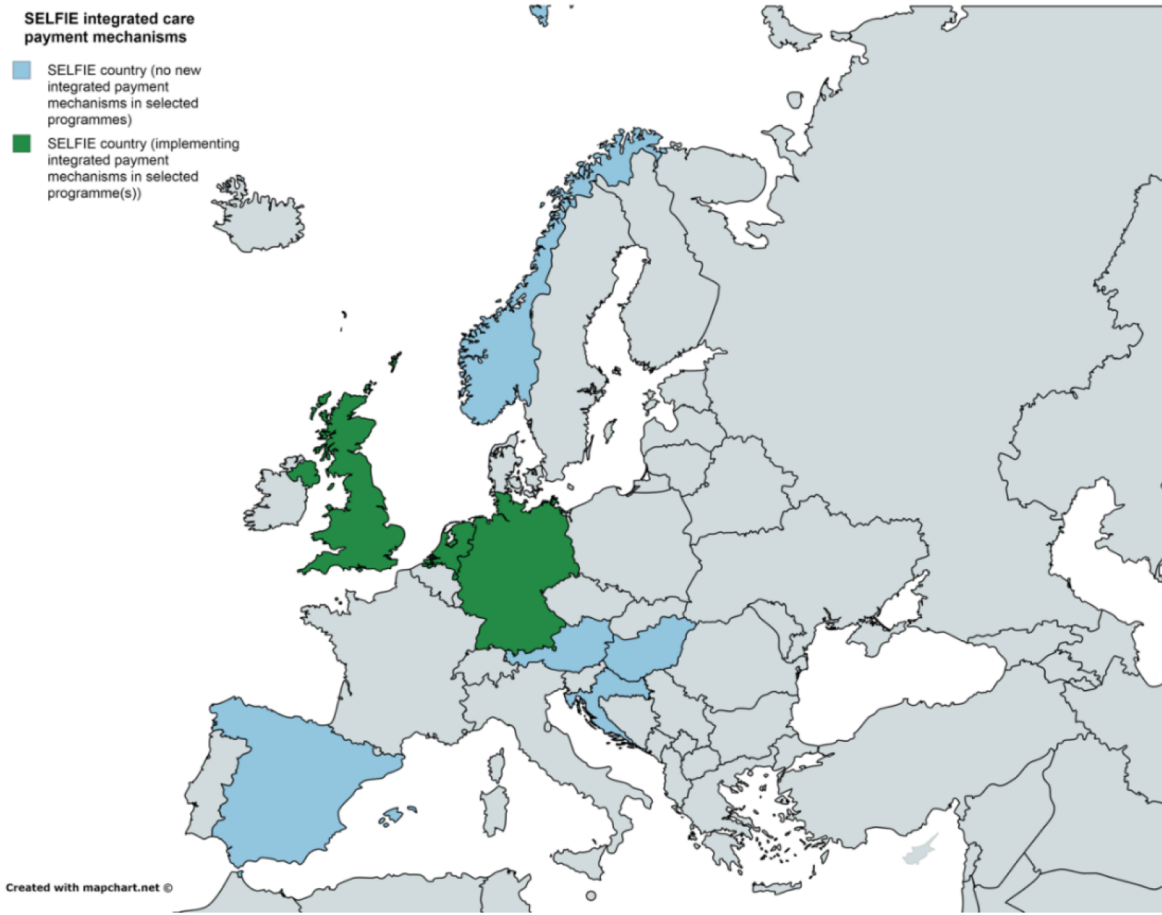
Særlige afregnings-modeller for integration I 6 af de 17 undersøgte programmer



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En mere præcis definition af “bundles”

Dimension	Lav integration	Med. Integration	Høj integration
Population	En gruppe fx højrisiko	Flere grupper fx +65 år	Alle patienter
Tid	En kontakt	Flere kontakter	Alle i periode
Sektorer	En sektor	Flere sektorer	Alle sektorer
Økonomisk integration	Ingen	Nogen fx shared savings	Fuld integration
Budgetandel	Lille	Mellem	Stor
Sygdomsområder	Et fx diabetes	Flere fx alle kron. sygdomme	Alle kontakter
Kvalitetsmål	Procesmål	Mellemlange outcomes	Health outcome fx quality of life

Stokes, J., Struckmann, V., Kristensen, S.R., Fuchs, S., Ginneken, E. van, Tsiachristas, A., Mölken, M.R. van, Sutton, M., 2018. Towards incentivising integration: A typology of payments for integrated care. Health Policy

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To hollandske payment bundles

Dimension	Dutch - diabetes	Dutch - frail elderly
Target population	Covers care only for diabetes patients [1]	Covers care for frail elderly patients only [1]
Time	Fees negotiated per patient per year [3]	Fees paid for 3-month periods [2]
Sectors	Primary care only in care groups. They can also subcontract (e.g. dieticians) [1]	All primary care, but very small amount of secondary (geriatrician telephone consult) [1.2]
Financial pooling/sharing	Only care group shares in risk/reward [1.5]	Only care group shares in risk/reward [1.5]
Provider coverage	Care groups select multiple, but not necessary from all, provider organisations [1.5]	Pilot, limited number of care groups [1.3]
Income	No detailed info, but since a single disease the providers are treating, bound to be a small % of total population [1]	Frail elderly up to 1% of practice's total patient population [1]
Multiple disease/needs focus	Comprehensive diabetes care covered, but not care for other conditions [1]	All primary for any condition and small bit of secondary care (Geriatrics consult) covered, but not other care, e.g. emergency secondary care [2]
Quality measurement	Paid for guideline components of care, e.g. check-ups, testing [1]	Payment on basis of number of case management MDT meetings etc performed [1]

Stokes, J., Struckmann, V., Kristensen, S.R., Fuchs, S., Ginneken, E. van, Tsiachristas, A., Mölken, M.R. van, Sutton, M., 2018. Towards incentivising integration: A typology of payments for integrated care. Health Policy

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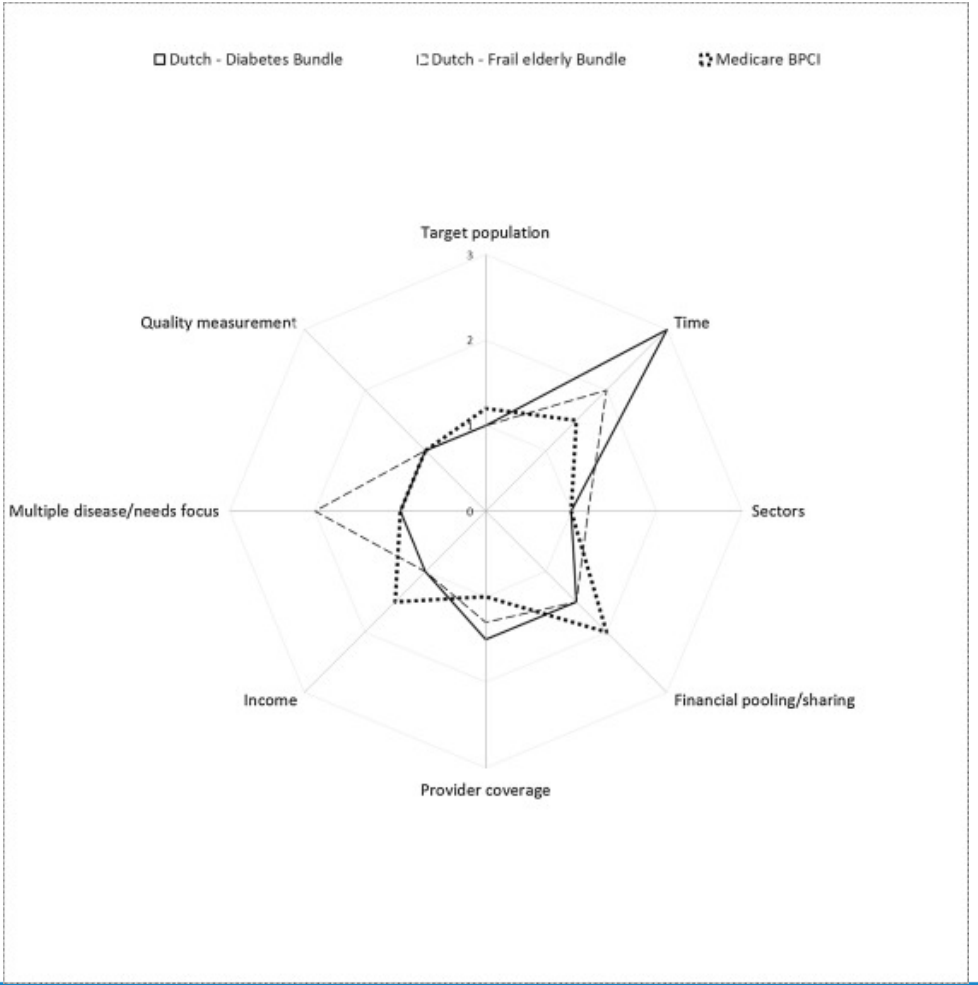
Eller grafisk…



Stokes, J., Struckmann, V., Kristensen, S.R., Fuchs, S., Ginneken, E. van, Tsiachristas, A., Mölken, M.R. van, Sutton, M., 2018. Towards incentivising integration: A typology of payments for integrated care. Health Policy

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Virker det så?

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Hvad menes med virker?

Table 2 Overview of the core set and programme-type specific outcomes in SELFIE

Outcomes for integrated care for individuals with multi-morbidity					
Triple Aim	Core set outcomes	Programme-type specific outcomes			
		Population health management	Frail elderly	Palliative and oncology	Problems in multiple life domains
Health & well-being	Physical functioning	Activation & engagement	Autonomy	Mortality	Self-sufficiency
	Psychological well-being			Pain and other symptoms	
	Social participation/ relationships				
	Resilience				
	Enjoyment of life				
Experience	Person-centeredness		Burden of medication	Compassionate care	
	Continuity of care		Burden of informal caregiving	Timely access to care	
				Preferred place of death	
				Burden of informal caregiving	
Costs	Total health- and social care costs	Ambulatory care sensitive hospital admissions	Living at home		Justice contacts
		Hospital re-admissions	Falls leading to ER or hospital admissions		

- *Sundhed og velvære*
- *Patientoplevelse*
- *Omkostninger*

Rutten-van Mölken, M., Leijten, F., Hoedemakers, M., Tsiachristas, A., Verbeek, N., Karimi, M., Bal, R., de Bont, A., Islam, K., Askildsen, J.E., Czypionka, T., Kraus, M., Huic, M., Pitter, J.G., Vogt, V., Stokes, J., Baltaxe, E., on behalf of the SELFIE consortium, 2018. Strengthening the evidence-base of integrated care for people with multi-morbidity in Europe using Multi-Criteria Decision Analysis (MCDA). BMC Health Services Research 18, 576.

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Resultater fra de nationale programmer (enkeltstudier)

- England: The Better Care Fund: Pooling af sundheds og pleje budgetter med fælles health and well being boards
  - Ingen effect på omkostninger / forbrug af ydelser generelt
  - Lille nedgang i forbrug for multisyge
- Norge: Koordinationsreformen
  - Fald i liggetid og stigning i overlevelse for patienter overført fra sygehus til institutioner
- Holland: Bundled payments
  - Øgede omkostninger for patienter der modtager “integrated care” hovedsageligt drevet af

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Effekt af integrationsincitamenter på væksten i sundshedsudgifter

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Impact of financial agreements in European chronic care on health care expenditure growth

Apostolos Tsiachristas[a,b,*], Carolien Dikkers[c], Melinde R.S. Boland[b], Maureen P.M.H. Rutten-van Mölken[b]

[a] Health Economics Research Centre, Nuffield Department of Population Health, University of Oxford, United Kingdom
[b] Department of Health Policy and Management, Erasmus University Rotterdam, The Netherlands
[c] Erasmus Medical Centre, The Netherlands

- *25 lande*
- *OECD og WHO data*
- *1997-2012*

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Hvad gør de andre?

Overview of financial agreements in chronic care per country by year.

	Year/Country	Classification	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
1	Austria	Intervention									PFC	PFC	PFC	PFC	PFC	PFC		
2	Belgium	Control																
3	Czech Republic	Control																
4	Denmark	Intervention											PFC	PFC	PFC	PFC	PFC	PFC
5	Estonia	Intervention										PFP	PFP	PFP	PFP	PFP		
6	Finland	Control																
7	France	Intervention									PFC	PFC	PFC	PFC	PFC, PFP	PFC, PFP		
8	Germany	Intervention							ALL,PFC	ALL,PFC	ALL,PFC	ALL,PFC	ALL,PFC	ALL,PFC	ALL,PFC	ALL,PFC	ALL,PFC	ALL,PFC
9	Greece	Control																
10	Hungary	Intervention			PFC	PFC	PFC	PFC	PFC	PFC	PFC	PFC	PFC	PFC	PFP	PFP	PFP	
11	Iceland	Control																
12	Ireland	Control																
13	Italy	Control																
14	Luxembourg	Control																
15	Netherlands	Intervention														ALL	ALL	ALL
16	Norway	Control																
17	Poland	Control																
18	Portugal	Intervention										PFP	PFP	PFP	PFP	PFP	PFP	
19	Slovak Republic	Control																
20	Slovenia	Control																
21	Spain	Control																
22	Sweden	Control																
23	Switzerland	Control																
24	Turkey	Control																
25	United Kingdom	Intervention								PFP	PFP	PFP	PFP	PFP	PFP	PFP	PFP	

Control payments

(blank) no information
FFS
salary
capitation

Intervention payments

ALL = all-inclusive
PFC = pay-for-coordination
PFP = pay-for-performance

Tsiachristas, A., Dikkers, C., Boland, M.R.S., Rutten-van Mölken, M.P.M.H., 2016. Impact of financial agreements in European chronic care on health care expenditure growth. Health Policy 120, 420–430

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Resultater: Sundhedsudgifter

	Tot. udg.	Amb.	Indl.	Medicin	Admin
PFC		(ned)			
P4P			(ned)		(ned)
Bundle		(ned)			

Tsiachristas, A., Dikkers, C., Boland, M.R.S., Rutten-van Mölken, M.P.M.H., 2016. Impact of financial agreements in European chronic care on health care expenditure growth. Health Policy 120, 420–430

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Effekt af integrationsincitamenter på patient rapporteret sundhed og forbrug af sundhedsydelser

The effect of payment method and multimorbidity on health and health care utilisation

Helen Hayes, Jonathan Stokes, Søren Rud Kristensen, Matt Sutton (2018)

Ikke publiceret

- *Samme lande*
- *SHARE data*
- *2002-2015*
- *Skelne mellem multisyge og andre*

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Effekter: Brug af sundhedsvæsenet

	Totale Lægekontakter		Andel kontater m prakt. læge		Antal kontakt. m prakt. læge	
	Ej MS	MS	Ej MS	MS	Ej MS	MS
PFC			(N)	(N)		
P4P	(N)		(O)		(O)	(N)
Bundle	(O)		(N)		(O)	(N)

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Effekter: Sundhed og velvære

	Problemer med ADL		Selvrapporteret sunhed (1-5)		Livskvalitet (CASP (12pkt))	
	Ej MS	MS	Ej MS	MS	Ej MS	MS
PFC	(N)	(O)	(O)		(O)	
P4P					(O)	
Bundle			(N)			(O)

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Fortsættelse følger…

Table 4 Calculating overall value scores

	Range performance score	Performance		Standardised performance[a]		Weights		Weighted aggregation			
								Integrated care		Comparator	
	worst-best	Integrated care	Comparator	Integrated care	Comparator	P1	P2	P1	P2	P1	P2
Health & well-being											
Physical functioning	0–100	60	70	0.65	0.76	0.100	0.250	0.065	0.163	0.076	0.190
Psychological well-being	0–100	70	50	0.81	0.58	0.150	0.100	0.122	0.081	0.087	0.058
Social participation & relationships	0–4	3	4	0.60	0.80	0.125	0.100	0.075	0.060	0.100	0.080
Resilience	1–5	2	4	0.45	0.89	0.050	0.100	0.022	0.045	0.045	0.089
Enjoyment of life	0–4	4	3	0.80	0.60	0.300	0.150	0.240	0.120	0.180	0.090
Experience											
Person-centeredness	1–4	4	3	0.80	0.60	0.100	0.050	0.080	0.040	0.060	0.030
Continuity of care	1–5	5	3	0.86	0.51	0.125	0.050	0.107	0.043	0.064	0.026
Costs											
Total health and social care costs	8500–5500	8000	6000	0.20	0.40	0.050	0.200	0.010	0.040	0.020	0.080
Overall value score								**0.722**	0.592	0.632	**0.643**

Performance: hypothetical average performance values, Weights: hypothetical weights obtained in DCE for stakeholder group 1 (P1) and 2 (P2), weighted

Rutten-van Mölken, M., Leijten, F., Hoedemakers, M., Tsiachristas, A., Verbeek, N., Karimi, M., Bal, R., de Bont, A., Islam, K., Askildsen, J.E., Czypionka, T., Kraus, M., Huic, M., Pitter, J.G., Vogt, V., Stokes, J., Baltaxe, E., on behalf of the SELFIE consortium, 2018. Strengthening the evidence-base of integrated care for people with multi-morbidity in Europe using Multi-Criteria Decision Analysis (MCDA). BMC Health Services Research 18, 576.

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SELFIE 2020

Final conference

Integrated care for multi-morbidity

June 13, 2019

https://www.selfie2020.eu/2018/12/10/save-the-date-selfie-final-conference/

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Spørgsmål til diskussion

- Skaber eksisterende afregningssystemer og organisering egentlig barrier for mere sammenhængende patientforløb?
- Hvad kan vi realistisk forvente af mere integration?
  - Færre akutte (gen)indlæggelser?
  - Lavere omkostninger?
  - Bedre livskvalitet ?
- Kræves organisatorisk integration for at opnå forbedringer eller kan samme resultater opnås med de rette økonomiske incitamenter?
-

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Appendix

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Landeklassifikation fra Tsiachristis

Overview of financial agreements in chronic care per country by year.

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2	Belgium	Control																
3	Czech Republic	Control																
4	Denmark	Intervention											PFC	PFC	PFC	PFC	PFC	PFC
5	Estonia	Intervention										PFP	PFP	PFP	PFP	PFP		
6	Finland	Control																
7	France	Intervention									PFC	PFC	PFC	PFC	PFC, PFP	PFC, PFP		
8	Germany	Intervention							ALL,PFC	ALL,PFC	ALL,PFC	ALL,PFC	ALL,PFC	ALL,PFC	ALL,PFC	ALL,PFC	ALL,PFC	ALL,PFC
9	Greece	Control																
10	Hungary	Intervention			PFC	PFC	PFC	PFC	PFC	PFC	PFC	PFC	PFC	PFC	PFP	PFP	PFP	
11	Iceland	Control																
12	Ireland	Control																
13	Italy	Control																
14	Luxembourg	Control																
15	Netherlands	Intervention														ALL	ALL	ALL
16	Norway	Control																
17	Poland	Control																
18	Portugal	Intervention										PFP	PFP	PFP	PFP	PFP	PFP	
19	Slovak Republic	Control																
20	Slovenia	Control																
21	Spain	Control																
22	Sweden	Control																
23	Switzerland	Control																
24	Turkey	Control																
25	United Kingdom	Intervention								PFP	PFP	PFP	PFP	PFP	PFP	PFP	PFP	

Control payments

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BMJ Open

Effectiveness of multidisciplinary team case management: difference-in-differences analysis

Jonathan Stokes,[1] Søren Rud Kristensen,[2] Kath Checkland,[3] Peter Bower[1]

To cite: Stokes J, Kristensen SR, Checkland K, *et al*. Effectiveness of multidisciplinary team case management: difference-in-differences analysis. *BMJ Open* 2016;**6**:e010468. doi:10.1136/bmjopen-2015-010468

► Prepublication history and additional material is available. To view please visit the journal (http://dx.doi.org/10.1136/bmjopen-2015-010468).

Received 5 November 2015
Revised 28 January 2016
Accepted 9 February 2016

ABSTRACT

Objectives: To evaluate a multidisciplinary team (MDT) case management intervention, at the individual (direct effects of intervention) and practice levels (potential spillover effects).

Design: Difference-in-differences design with multiple intervention start dates, analysing hospital admissions data. In secondary analyses, we stratified individual-level results by risk score.

Setting: Single clinical commissioning group (CCG) in the UK's National Health Service (NHS).

Participants: At the individual level, we matched 2049 intervention patients using propensity scoring one-to-one with control patients. At the practice level, 30 practices were compared using a natural experiment through staged implementation.

Intervention: Practice Integrated Care Teams (PICTs), using MDT case management of high-risk patients together with a summary record of care versus usual care.

Direct and indirect outcome measures: Primary measures of intervention effects were accident and

Strengths and limitations of this study

- This study addresses a number of shortcomings found in related literature from a recent systematic review.
- The difference-in-differences methods can provide a rigorous assessment under certain conditions while evaluating an intervention in a real-world setting.
- Results are analysed and presented at two levels to show direct effects of the intervention, as well as wider spillover effects of integrated care.
- At the practice level, there may be some selection bias due to voluntary recruitment, although we predict this to be minimal based on our robustness checks.
- At the individual level, results may be prone to some bias in favour of control participants due to the ongoing recruitment strategy versus a single time point propensity matching. Again, we predict this to be minimal, as participants and controls were well matched at the first start date.

DOI 10.1186/s12913-017-2475-x

BMC Health Services Research

RESEARCH ARTICLE Open Access

Does the impact of case management vary in different subgroups of multimorbidity? Secondary analysis of a quasi-experiment

Jonathan Stokes[1,2*], Søren Rud Kristensen[2], Kath Checkland[3], Sudeh Cheraghi-Sohi[1] and Peter Bower[1]

Abstract

Background: Health systems must transition from catering primarily to acute conditions, to meet the increasing burden of chronic disease and multimorbidity. Case management is a popular method of integrating care, seeking to accomplish this goal. However, the intervention has shown limited effectiveness. We explore whether the effects of case management vary in patients with different types of multimorbidity.

Methods: We extended a previously published quasi-experiment (difference-in-differences analysis) with 2049 propensity matched case management intervention patients, adding an additional interaction term to determine subgroup effects (difference-in-difference-in-differences) by different conceptualisations of multimorbidity: 1) Mental-physical comorbidity versus others; 2) 3+ chronic conditions versus <3; 3) Discordant versus concordant conditions; 4) Cardiovascular/metabolic cluster conditions only versus others; 5) Mental health-associated cluster conditions only versus others; 6) Musculoskeletal disorder cluster conditions only versus others 7) Charlson index >5

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Typology of payments for integrated care. The number in [] indicates the score in terms of level of integration, as described below.

Category	Level of integration Domain	Low integration [1]	Medium integration [2]	High integration [3]
Scope of payment	Target population	Payment covers one specific patient group e.g. 'high-risk'	Payment covers slightly wider defined group e.g. over 65 s	Payment covers all patients in catchment area
	Time	Payment covers one contact	Payment covers multiple contacts e.g. during an episode of care	Payment covers care over a longer period e.g. a year
	Sectors	Payment covers care delivered by single sector e.g. primary care only	Payment covers care delivered by two sectors e.g. primary and social care/ primary and secondary care	Payment covers care delivered by three or more sectors e.g. primary, secondary and social care
Participation of providers	Provider coverage	Payment covers one provider only within the participating sectors e.g. a single GP practice within primary care	Payment covers care at multiple providers within the participating sectors e.g. all primary care providers and a proportion of secondary care providers	Payment covers care at all providers within the participating sectors e.g. all primary and secondary care services within the area
	Financial pooling/sharing	No pooled funding/ shared savings for providers	Proportion of budget is pooled/ savings shared for the defined horizon for providers	Total health and care budget is pooled/savings shared for the defined horizon for providers
Single provider/patient involvement	Income	Payment provides a small proportion of providers' total income	Payment provides a relatively large proportion of providers' total income	Payment provides the largest proportion of providers' total income
	Multiple disease/needs focus	Payment covers care for one condition for a single patient e.g. diabetes care only	Payment covers care for multiple conditions for a single patient e.g. all chronic condition care	Payment covers all care for a single patient e.g. all health and social care needs
	Quality measurement	Payment measures/rewards process measures e.g. number of health checks	Payment measures/rewards intermediate measures and lifestyle behaviour e.g. HbA1c, smoking	Payment measures/rewards health outcome measures e.g. Quality of life

Stokes, J., Struckmann, V., Kristensen, S.R., Fuchs, S., Ginneken, E. van, Tsiachristas, A., Mölken, M.R. van, Sutton, M., 2018. Towards incentivising integration: A typology of payments for integrated care. Health Policy

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Danmark I Heyes et al.

	Reform	Target of reform	Integrated care incentive	Hypothesised effect	
				Health outcomes	Utilisation
Denmark	Administrative reform 2007	Region	-Reallocating responsibilities between five newly established Danish regions (replacing original 14)	+Patient centred care	-Incentive to reduce the need for hospitalisation
		Municipalities	-Regional coordinators, (non-) financial incentives and interdisciplinary care teams		
			-Regions provided with €70 million to improve chronic care	-Co-financing of hospital care- incentive to reduce costs/potentially at expense of quality	+Comprehensive, well evaluated programs- could increase use in implementation
			-15% of regional healthcare budgets for ICPs- rewarding municipalities that reduced need for hospitalisation		
			-Municipalities co-financing hospital care		