

P4P and The Political Economy of Quality Improvement

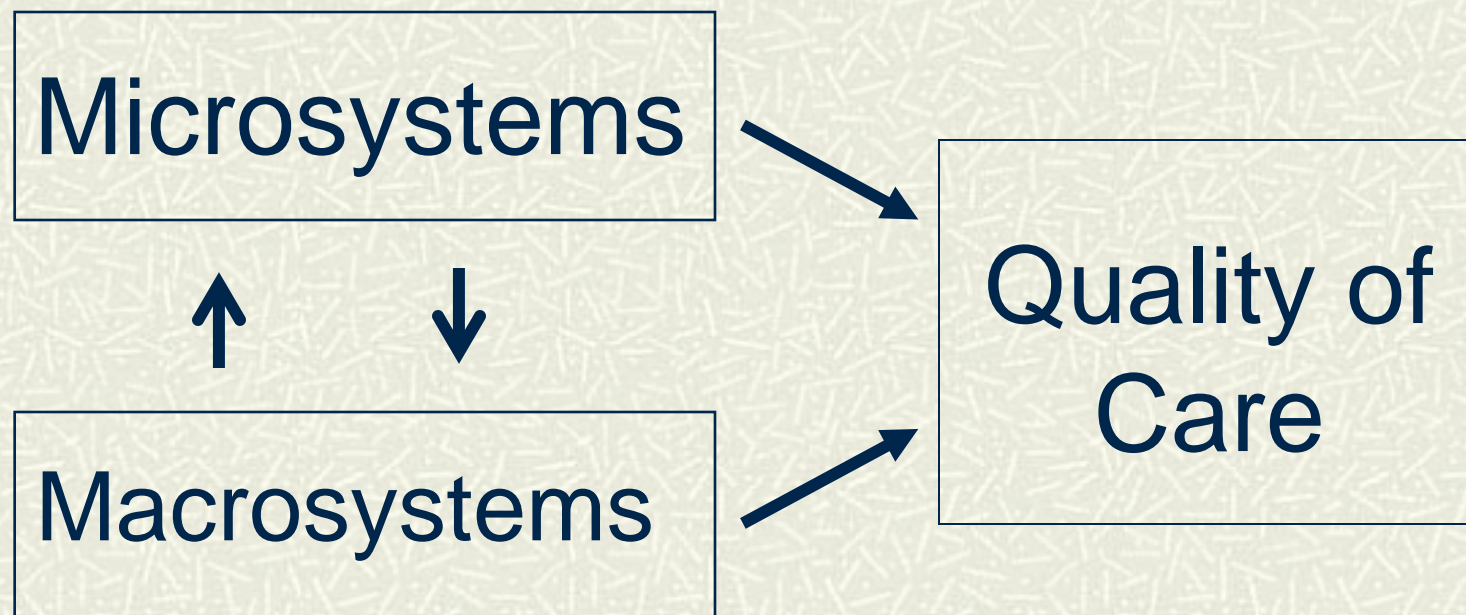
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The issue

- # Efforts to promote quality improvement – and performance improvement generally – require complex and integrated social strategies.
 - # These must take shape at both the technical/methodological and at the broader societal level.
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Levels of the health care system

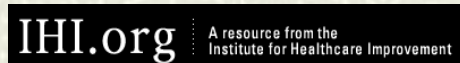


MANY GOOD, DOCUMENTED EXAMPLES OF SPECIFIC OPPORTUNITIES

Healthcare policy institutes surveyed



Massachusetts Coalition
for the
Prevention of Medical Errors



Pittsburgh Regional Healthcare Initiative



Improvement opportunities identified

- # Disease management
- # Preventive care
- # Rapid response teams
- # Standards-based prescribing
- # Intensivists/hospitalists
- # Healthcare-induced infections: VAP, central line, nosocomial, etc.
- # Healthcare-induced infections
- # Safe use of medications
- # Health information technology, EHRs, CPOE
- # Incentives: P4P

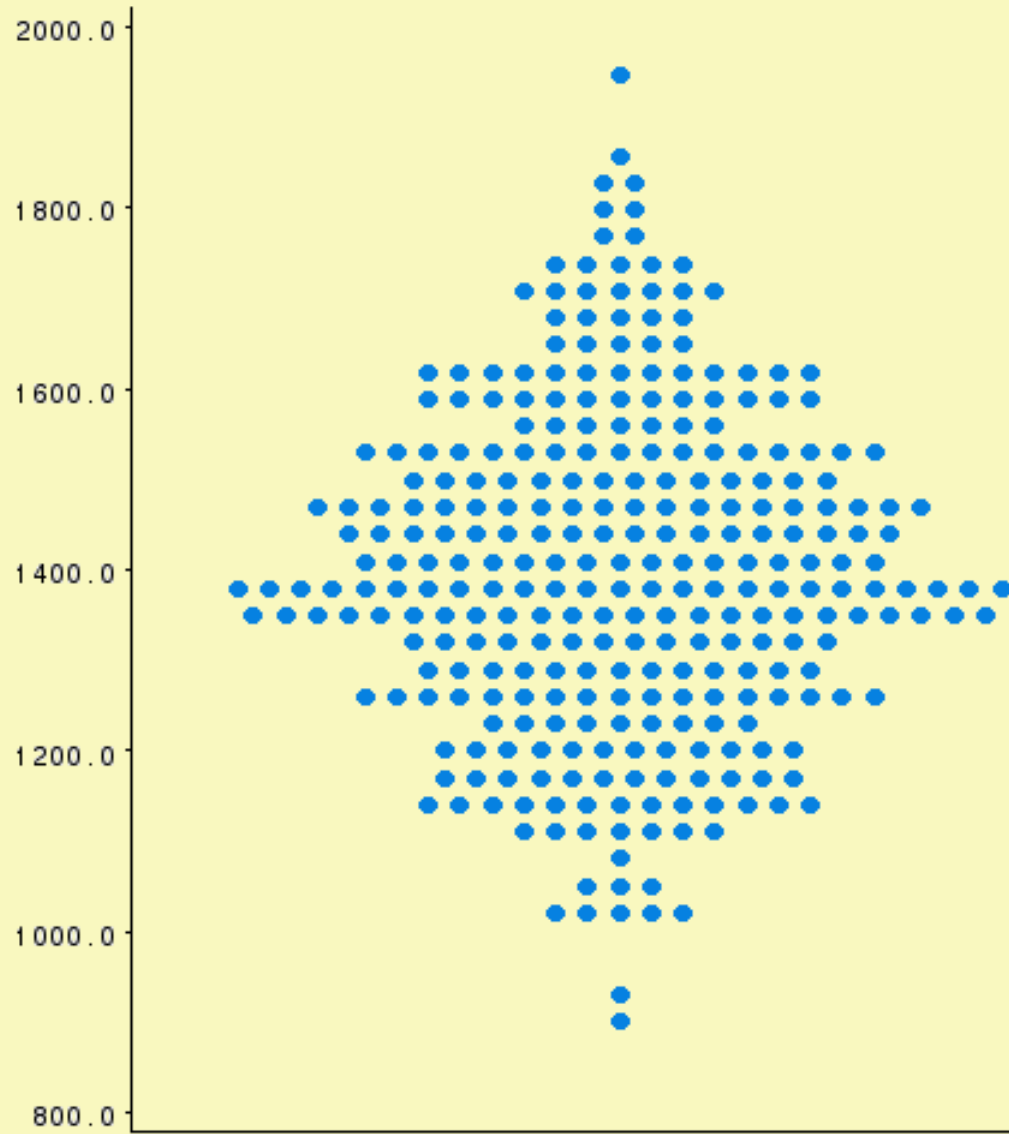
Thinking about macrosystems:

- # Macrosystems are multi-level:
 - The nation/state/region.
 - Public and private payers.
 - Health systems.
 - Professional societies and organizations.
 - # Action necessary at all these levels.
 - # But, want to make that case that market/region represents a crucial level of untapped opportunity.
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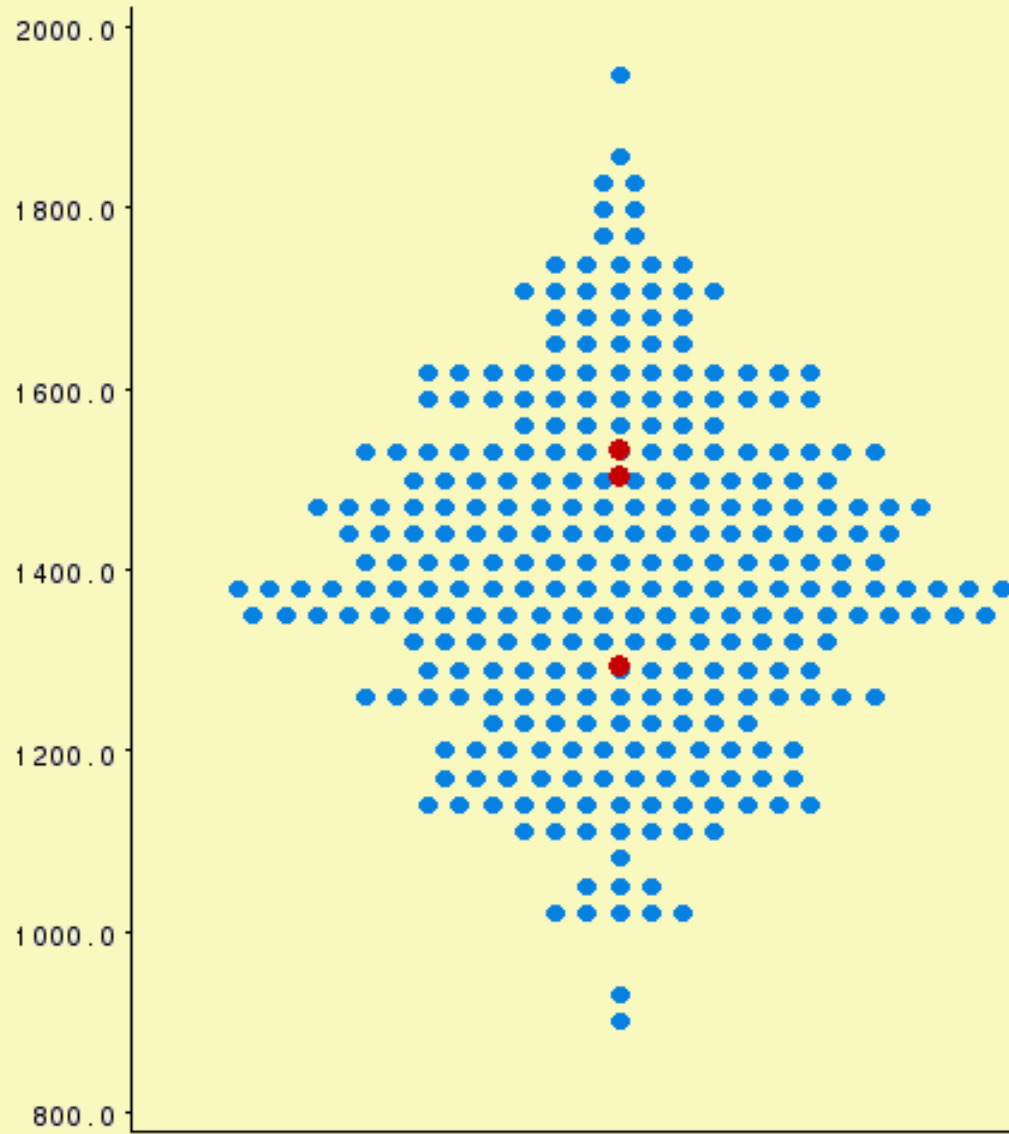
Why local markets?

- # Local markets are the smallest meaningful level at which collective action and coordination can occur.
 - # Local markets are where people get their health care.
 - Thus, local markets define consumers' health care choices.
 - # Local markets define populations that can be the target of population-based treatment and prevention initiatives.
 - # Local markets are where things go wrong – and perhaps can be made right.
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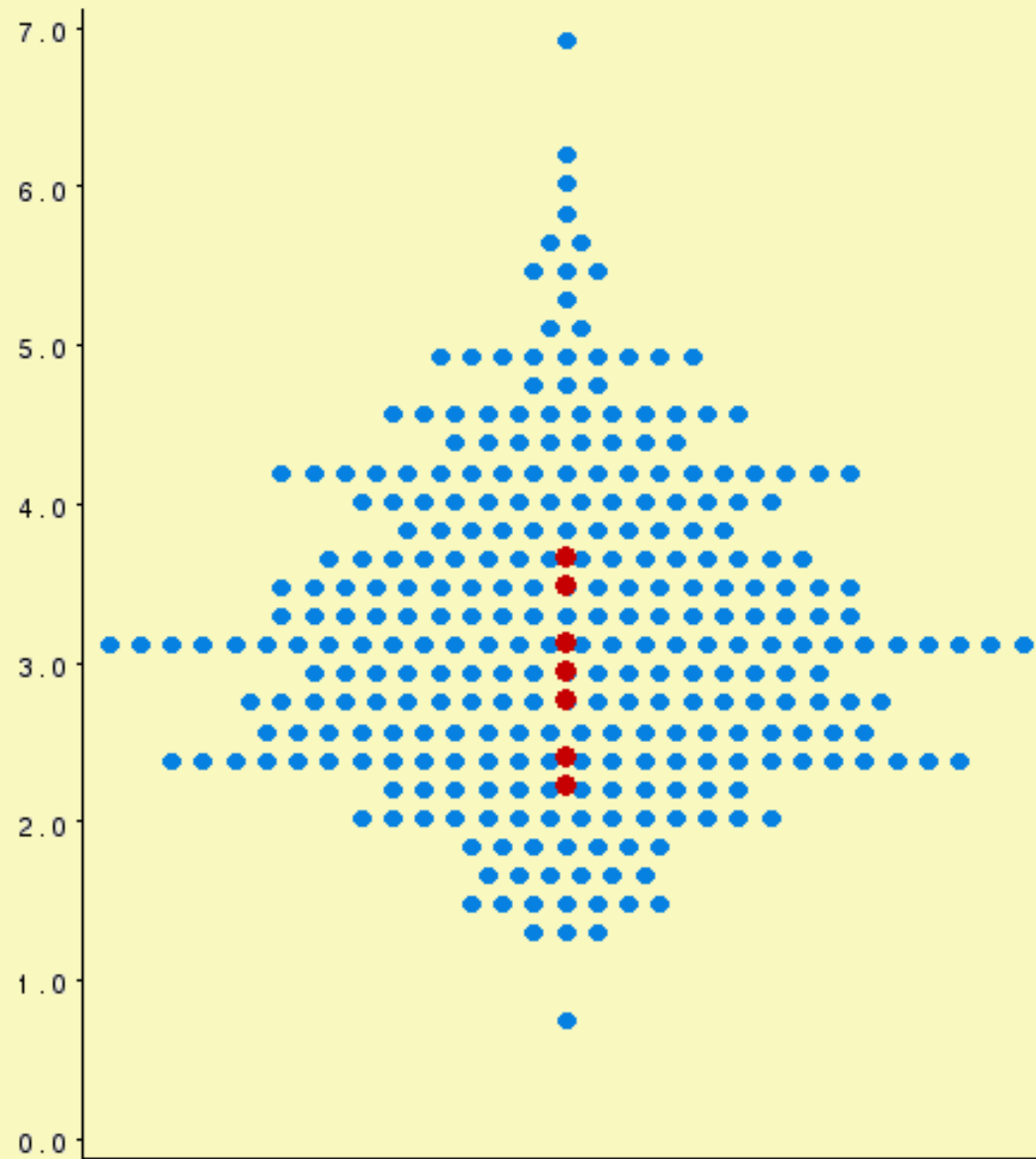
Hospital Admissions per 1,000 Medicare decedents
during the last six months of life (2003)
HRR Level Rates



Hospital Admissions per 1,000 Medicare decedents
during the last six months of life (2003)
HRR Level Rates



Carotid Endarterectomy per 1,000 Medicare Enrollees (2003)
HRR Level Rates

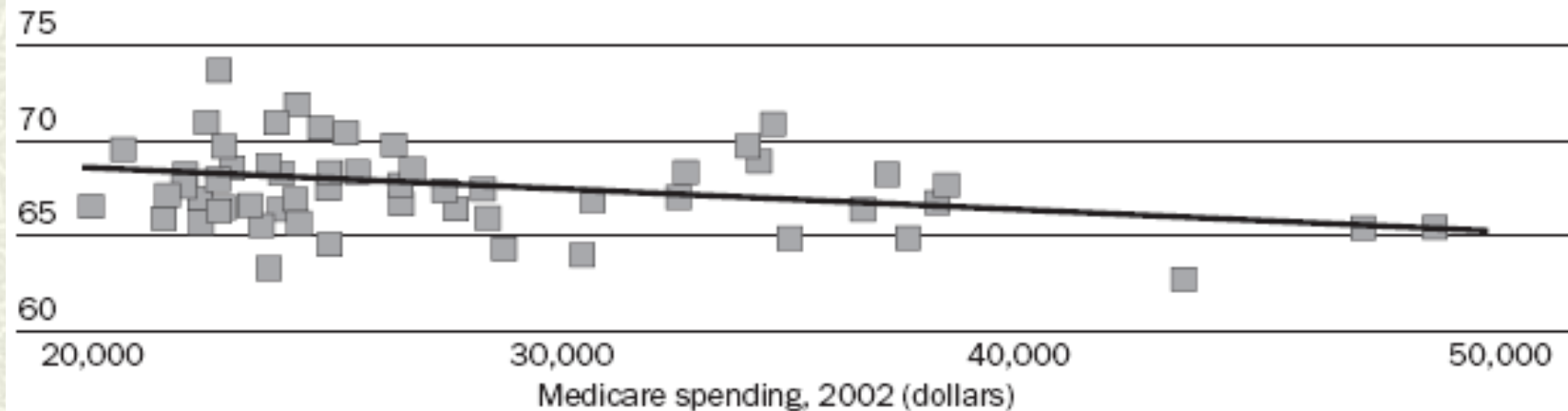


Source Dartmouth Atlas

Adjusted One-Year Survival After Acute Myocardial Infarction and One-Year Spending, by Hospital Referral Region, 2002

Association Between Adjusted One-Year Survival After Acute Myocardial Infarction (AMI) And One-Year Spending, By Hospital Referral Region (HRR), 2002

Percent surviving after one year



SOURCE: Authors' calculations using Medicare claims data.

NOTES: Each square represents an HRR with at least 250 people experiencing a heart attack in 1986 (n = 56). The sample is the elderly fee-for-service Medicare population (age sixty-five and older), and both survival rates and spending are adjusted for age, sex, race, comorbidities, and the severity of the heart attack.

Source: J.S. Skinner, D.O. Staiger, and E.S. Fisher, "Is Technological Change Always Worth It? The Case of Acute Myocardial Infarction," *Health Affairs* Web Exclusive, February 7, 2006.

Counterfactual:

- # If each payer and regulator in a given locale has different strategies for performance improvement, will their programs be effective?
 - Imagine:
 - Medicare, Medicaid, private payers with different financial incentives, quality and cost measurement approaches, disease management strategies.
 - Will the result be optimal performance at the local/regional level?
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Another reason to think about local markets:

- # Increasingly the focus of reform activity:
 - # HHS:
 - Transparency to occur at local/regional level:
 - Defines areas of consumer choice.
 - # RWJF
 - To focus reform activities on transforming local markets.
 - # Spontaneous development of local initiatives:
 - Pittsburgh, Minneapolis, Detroit, Indianapolis, Bay Area, Rhode Island.
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Still another reason:

- # Comprehensive health care reform at the national level unlikely in the short term, regardless of results of pending elections.
 - # Even in presence of a comprehensive national plan to improve value/quality/access, regional variation will be essential to accommodate, and this implies the need for a locus of local decision-making and collaboration.
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What is a local market?

Depends:

- State (Rhode Island)
- County (rural area)
- City (Pittsburgh)
- Part of a city (Southern half of Manhattan?)

Market defined by opportunity for collective action, patterns of health care provision and receipt.

How does change occur at market level?

- # Leadership
 - # Leadership
 - # Leadership
 - # External pressure
 - # Facilitation and participation from multiple stakeholders:
 - Payers, purchasers, providers, consumers
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Implications for P4P:

- # Making sense of P4P in Eastern Massachusetts/Boston:
 - How many different types of performance will be rewarded?
 - How will performance be measured?
 - How large will rewards be?
 - How predictable will programs be over time?
 - # If consistent answers across payers can be derived, impact likely to be much greater.
 - If providers can contribute to the development, likely to be more effective as well.
 - # Learning can occur by comparing market-level performance where markets use different approaches.
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P4P as Part of a Market-based Solution

- # P4P is a solution, but what is the problem?
 - # Includes, but is more diverse than, lack of appropriate incentives:
 - Lack of alignment between supply and need.
 - Local cultures of practice with respect to discretionary care (the residue of supply).
 - Levels of competition (or lack of competition) among key stakeholders.
 - Level of involvement, motivation, stability of key purchasers.
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Focus on the local macrosystem

- # P4P should be incorporated into comprehensive, long term, market level efforts to reform macrosystems.
 - # Strategies should be tailored to local politics, market structure, patterns of variation.
 - # Should include long and short-term goals and programs.
 - # Should include coordinated efforts at evaluation of varied strategies and combinations thereof.
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The goal

Mega collaboratives:

Collaboratives of collaboratives using P4P
in combination with the full range of other
performance enhancing tools.
