UNIKLINIK KÖLN

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Pay-for-Performance in Disease Management Programs – a Perspective for Germany?

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The Problem

FACING THE FACTS — World Health Organization — http://www.who.int/chp/chronic_disease_report/en/

THE IMPACT OF CHRONIC DISEASE IN GERMANY

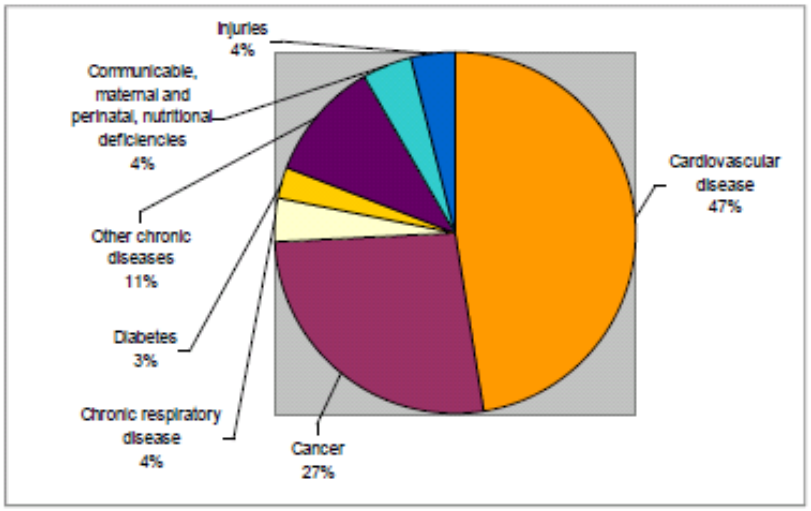
Chronic diseases are the major cause of death and disability worldwide

Facts:

- In Germany, chronic diseases accounted for 92% of all deaths in 2002 (see chart, right).
  - Total deaths in Germany, 2002 = 815,000.
  - Total deaths due to chronic disease in Germany, 2002 = 748,000.

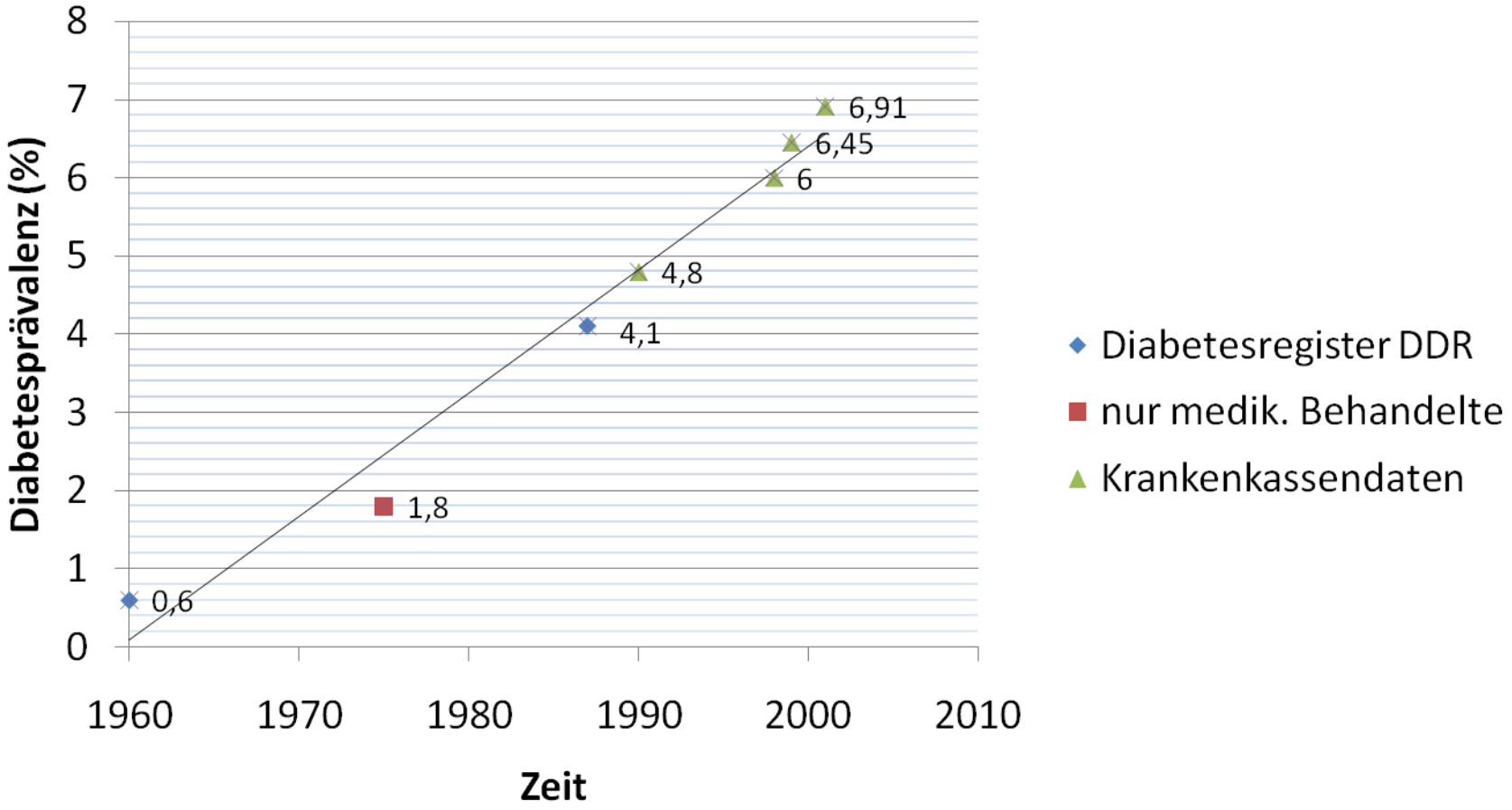
Note:
The data presented in this information sheet were estimated by WHO using standard methods to maximize cross-country comparability. They are not necessarily the official statistics of WHO Member States.

Deaths by cause, all ages, Germany, 2002



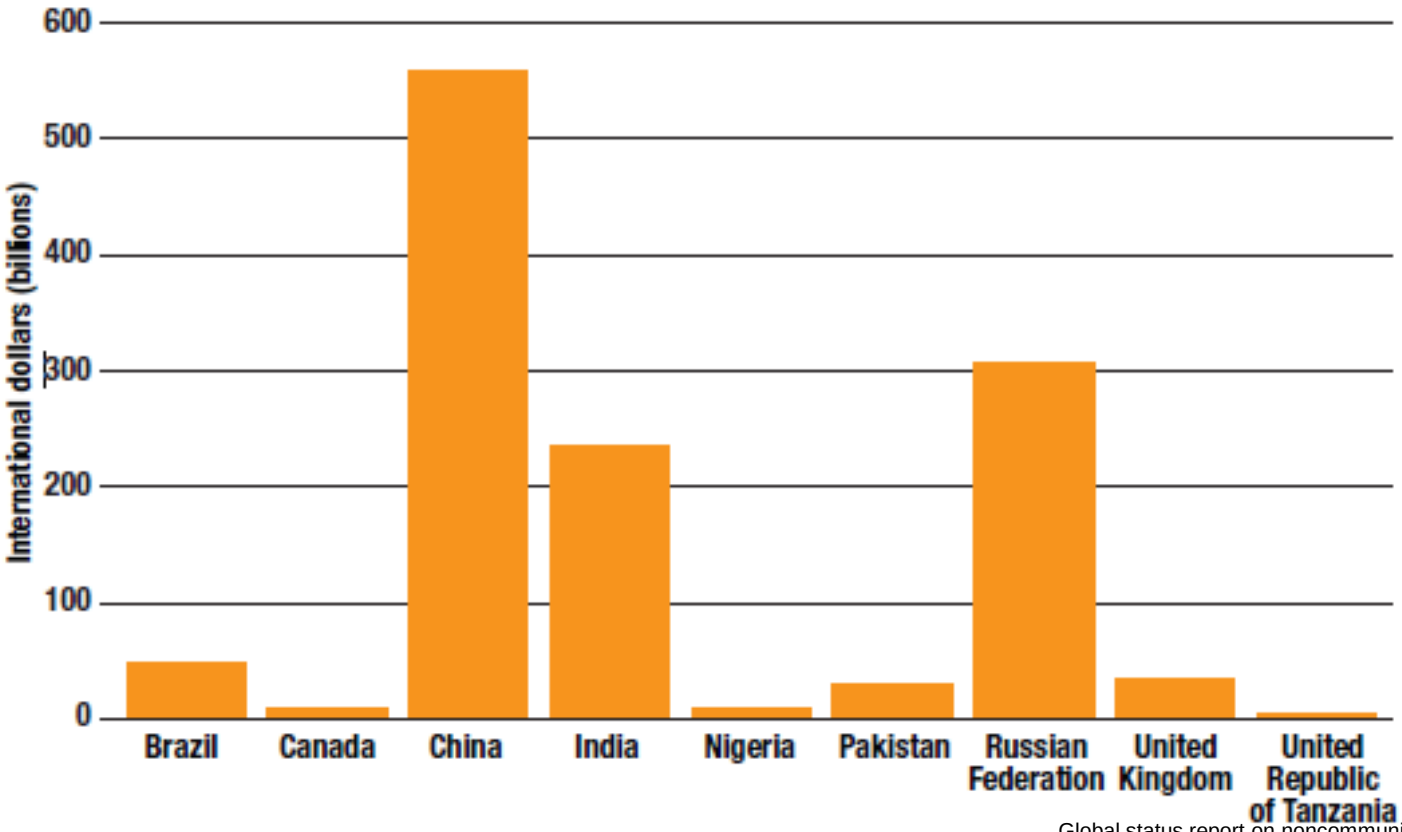
Global status report on noncommunicalbe diseases in 2010
http://www.who.int/topics/chronic_diseases/en/

Prevalence of Diabetes Mellitus in Germany



Source: Hauner et al., Stock et al.,

Projected foregone national income due to heart disease, stroke & diabetes selected countries



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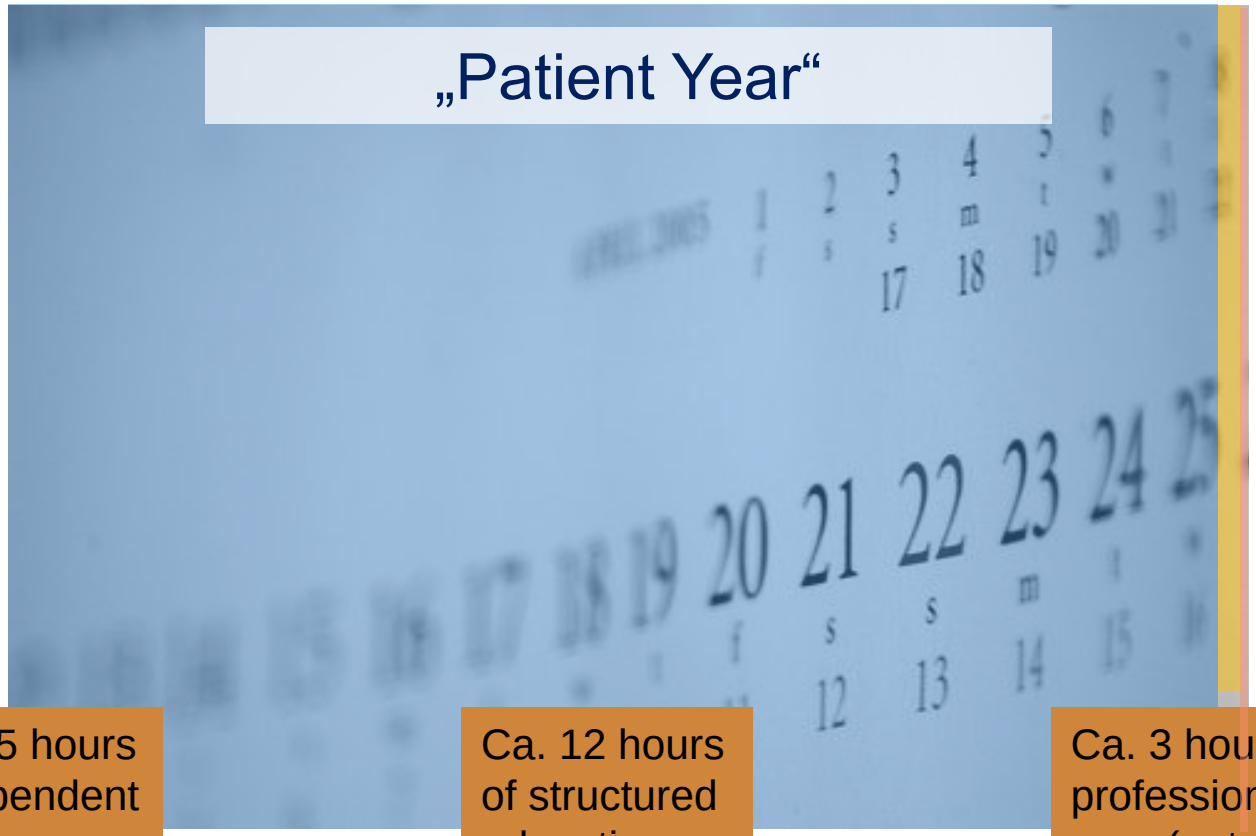
Features in Dealing with Chronic Disease



About 8745 hours of self dependent therapy

Ca. 12 hours of structured education

Ca. 3 hours of professional care (outpatient care)

Lange, 2006

Why Disease Management?

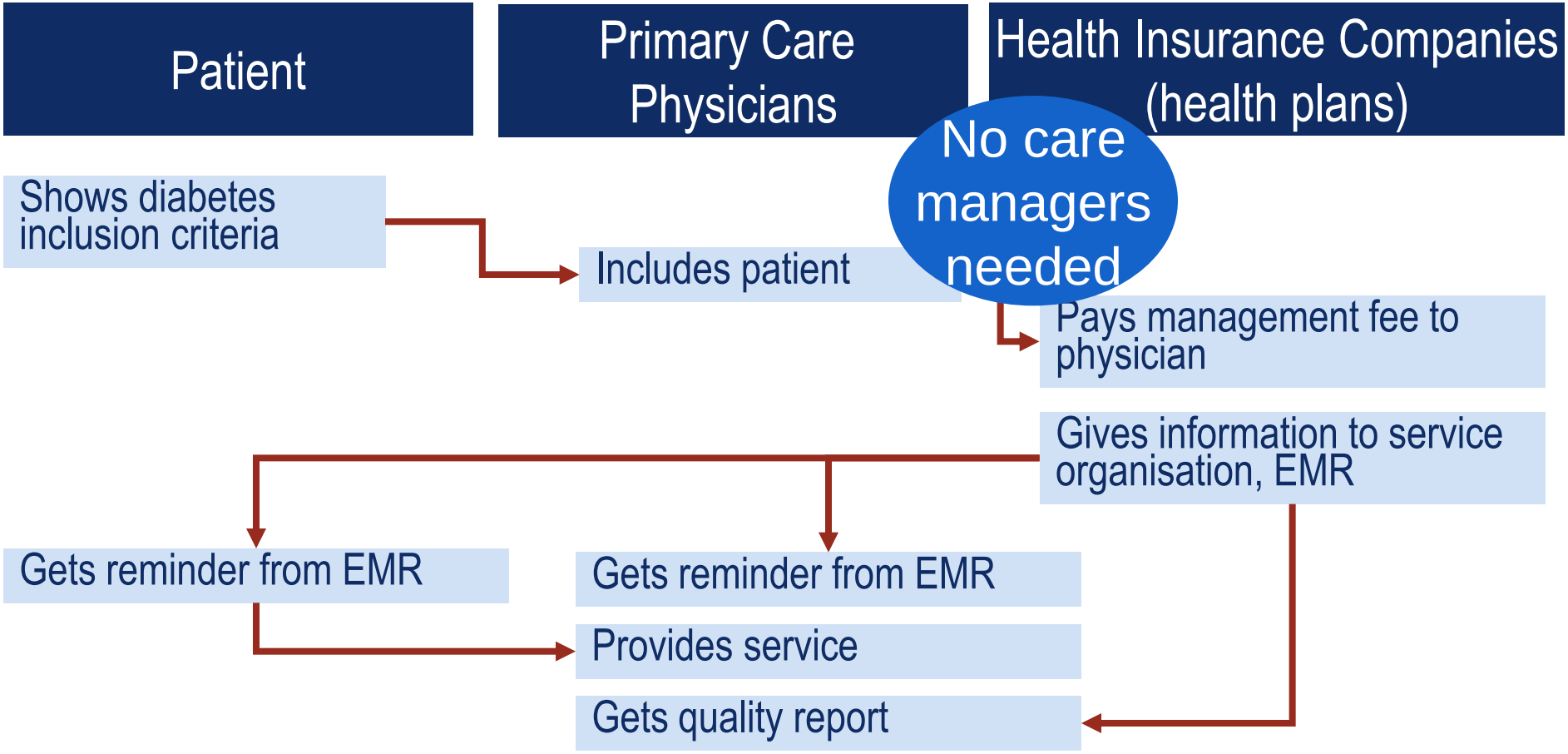
„Disease Management is the only remaining strategy to deal with chronic diseases…

Perhaps the greatest contribution of Disease Management lies in the fact that it has the potential to drive change in the way we approach healthcare.

As a new concept in healthcare delivery, Disease Management is pushing the envelope in how we manage chronic disease.“

Warren Todd - Executive Director,
Past President, and founding Board Member
of the Disease Management Association of America (DMAA)

Coordination of care in Disease Management Programs in Germany



Requirements of the Bundesversicherungsamt

Enrolment	Written patient consent
Enrolment criteria	Physician diagnosis
Quality regulations	Quality is measured by process and outcome quality indicators (for instance HbA1C, blood pressure readings, yearly eye inspections, participation in patient education). With regard to diabetes better control of hypertension, more eye exams, regular foot exams, better cholesterol control, and improved patient understanding of the disease were important quality targets
Documentation	Enrolment criteria, lab readings, documentation of diagnostic and therapeutic interventions, participation in patient education
Incentives	Bonus for patients and participating physicians Sickness fund receives money from risk pool for enrolled patients
Scientific support	National committee of experts agreed on evidence based treatment goals

DMP – Evaluation

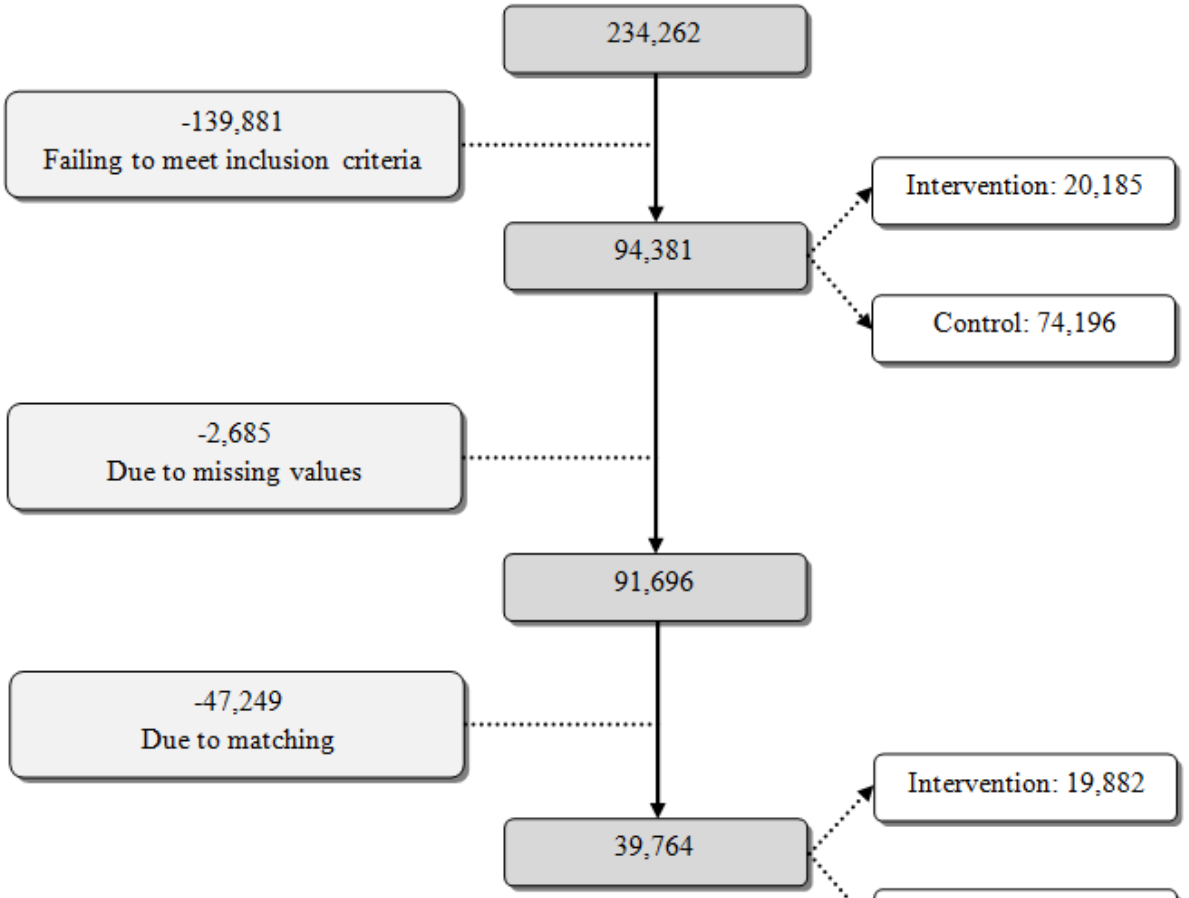
Methods I

DMP Group

Enrollment in DMP and continous enrollment over study period

Control Group

No enrollment in DMP Over study period



Propensity Score Matching

Primäre Endpunkte Mortalität & Kosten

Stock et al., 2010

DMP – Evaluation

Methods II

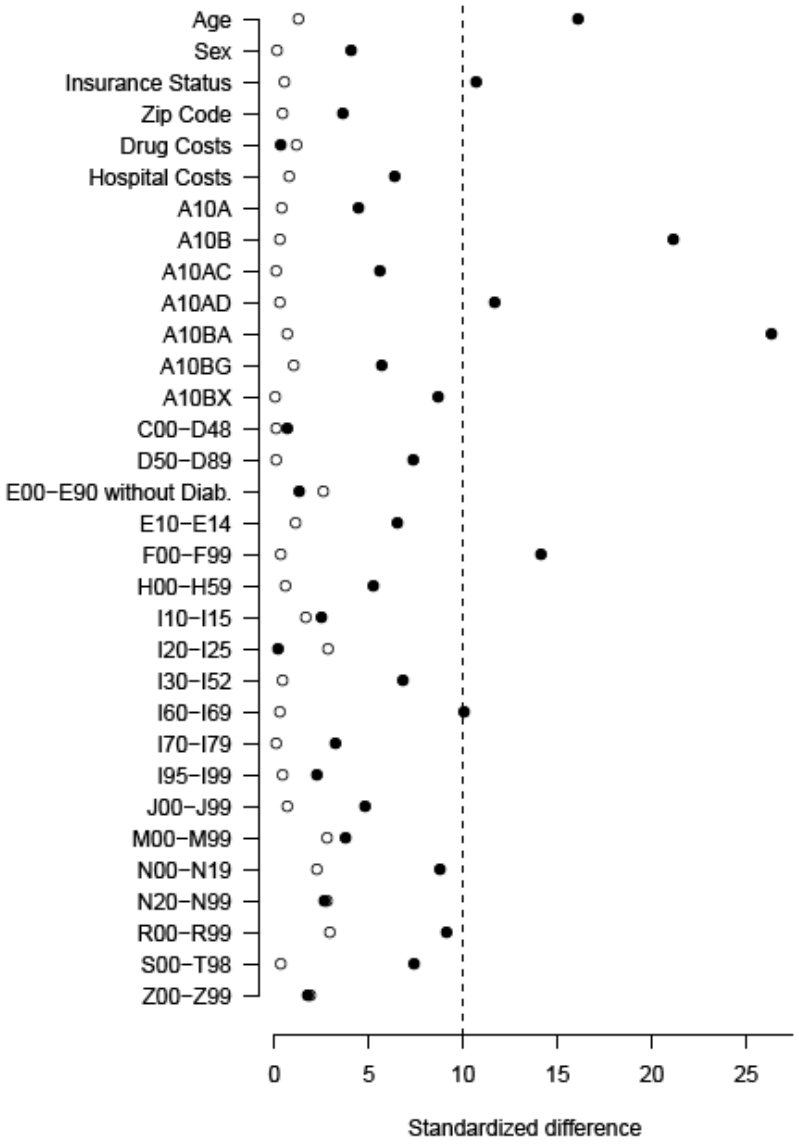
	Co-variates for regression analysis
sociodemgraphic	Gender
	Age
	Insurance status
	Zip code (first 3 digits)
Disease severity	Drug costs 2003
	Hospital costs 2003
	ATC-Codes (Antidiabetika)
	19 ICD-Codes

Stock et al., 2010

DMP – Evaluation

Methods III

After Matching all included variables were balanced (Standardized difference < 10%)



Stock et al., 2010

DMP – Evaluation

Results

Outcome	Intervention group	Control group
Mortality (p < 0,001)	458 (2,30%)	935 (4,70%)
Difference of over all cost (2007 – 2003) (p < 0,001)	1.094,27 €	1.432.90 €
Overall cost 2007	3.997, 63 €	4.469,52 €
Drug cost 2007	1977,81 €	1.973,72 €
Hospital cost 2007	2.019,82 €	2.495,80 €
Average no of hospitalizations	0,5	0,62
Average duration of hospitalization	4,79 days	6,41 days

Stock et al., 2010

DMP: levels for links to P4P

Care levels for available evidence for improvement in care

- Change of Behavior
  - Succesfull change in physician / patient behavior
  - i.e. smoking cessation / prescribing
- Change of Clinical / Physiologic Parameters
  - Changes in blood pressure, HbA1c,
  - stroke or amputation rates
- Change in healthcare utilization / cost
  - Decrease in hospitalization rates, length of stay

Management Components in German DMP (DMAA*)

Komponente	Deutsche DMPs
Population identification process	Enrollment criteria / DMP physician
Evidence based guidelines	National care guidelines
Collaborative practice models	Integration between sectors and within sectors (referral routines)
Patient self-management education	Patient education
Process & outcomes measurement	Routine documentation
Evaluation and management	Evaluation and management routines (i.e. referral routines)
Feedback loops	Benchmarking and feedback reports, reminder

*Disease Managmeent Association of America

Links to P4P in German DMPs

Physician requirements
Hospital requirements
Practice personal requirements
Practice requirements

BVA
Akkreditierung

Physician / hospitals
SF
patients

Guidelines
Referral routines
Documentation
reminder

processes

Benchmarking
Feedback
Evaluation

Outcomes

Are we doing The right things?

process

Are we doing the things right?

Outcomes / result

Focal quality

structure

Features of P4P schemes, their dimensions and possible links to German DMPs

	Dimension	German DMP	In place	Possible
Type	Reward Penalty	Both possible	Documentation payment (Phy) Administration fee payment (SF)	Yes
Nature incented entity	Individual Group	Both possible	Documentation payment (Phy) RCS (SF)	yes
Focal quality behavior targeted by incentive	Structure Process Outcomes	All possible	Requirement w/o incentive Requirement w/o incentive Requirement w/o incentive	yes
Scope	General Selective	Both possible	Documentation (Phy)	yes

Adapted from Conrad & Perry, 2009
And De Bruin et al., 2011

Features of P4P schemes, their dimensions and possible links to German DMPs

	Dimension	German DMP	In place	Possible
Motivation	Intrinsic Extrinsic	Both possible	Waiving of co-payments (PT)	yes
Scale	Relative Absolute	Not possible Possible	---------- Documentation (Phy) Enrollment (SF)	Yes
Size	Amount of money	Small amount possible.	Documentation (Phy) Waiving of co-payments (PT)	Yes
Certainty	Certain Uncertain	Possible ----------	Documentation (phy) ----------	yes
Frequency & Duration	No of times No of years	Possible ?????	Documentaion (Phy) RCS & administration payment (SF)	yes

Adapted from Conrad & Perry, 2009
And De Bruin et al., 2011

P4P in German DMPs- Pro and Contra

- Could target what has not been addressed so far:
- Delivery system re-desing
- Patient self management support/ SDM
- Suitable diseases for P4P
- All dimensions of P4P can be addressed
- P4P could be implemented on a national level which yields more uniform results

- Not all diseases are suited for P4P
- High quality improvement already achieved which leaves little room for improvement (ceiling effects)
- No additional money available – where should the money come from?

P4P in German DMPs – Policy issues

- Does P4P also affect cost / efficiency of care or only quality?
- Size of incentive? Reward or penalty?
- National roll out or pilot project?
- What happens when the targets are met?
- Are there unintended consequences?
- Should P4P involve quality of service and patient satisfaction?
- Should results be made transparent?

Thank you for your attention!