



Opportunities for Collaboration between Funders and Hospitals

**Presentation to HASA Conference
June 2008**

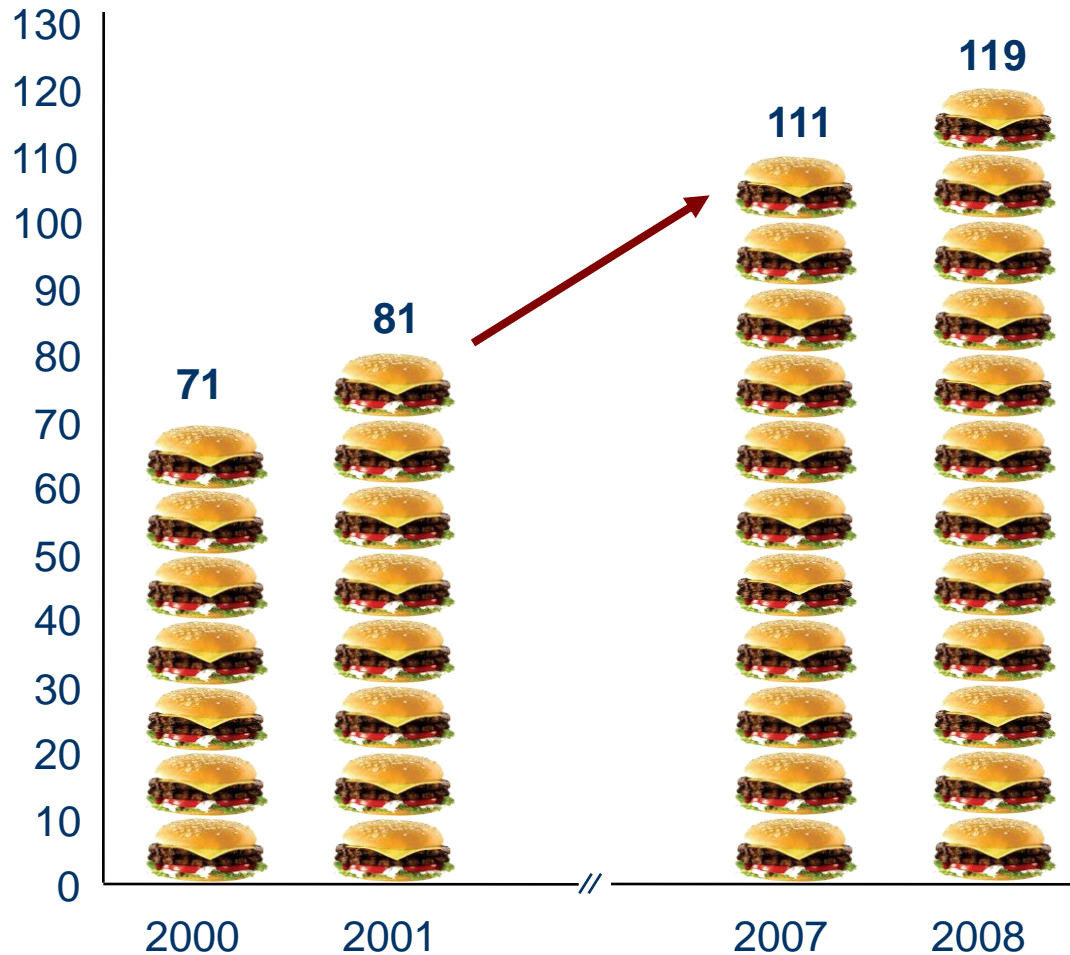
**Dr Jonny Broomberg
Discovery Health**



Affordability Issues in Healthcare

“The Big Mac Index”

Equivalent number of burgers per month for comprehensive medical aid cover for a single member



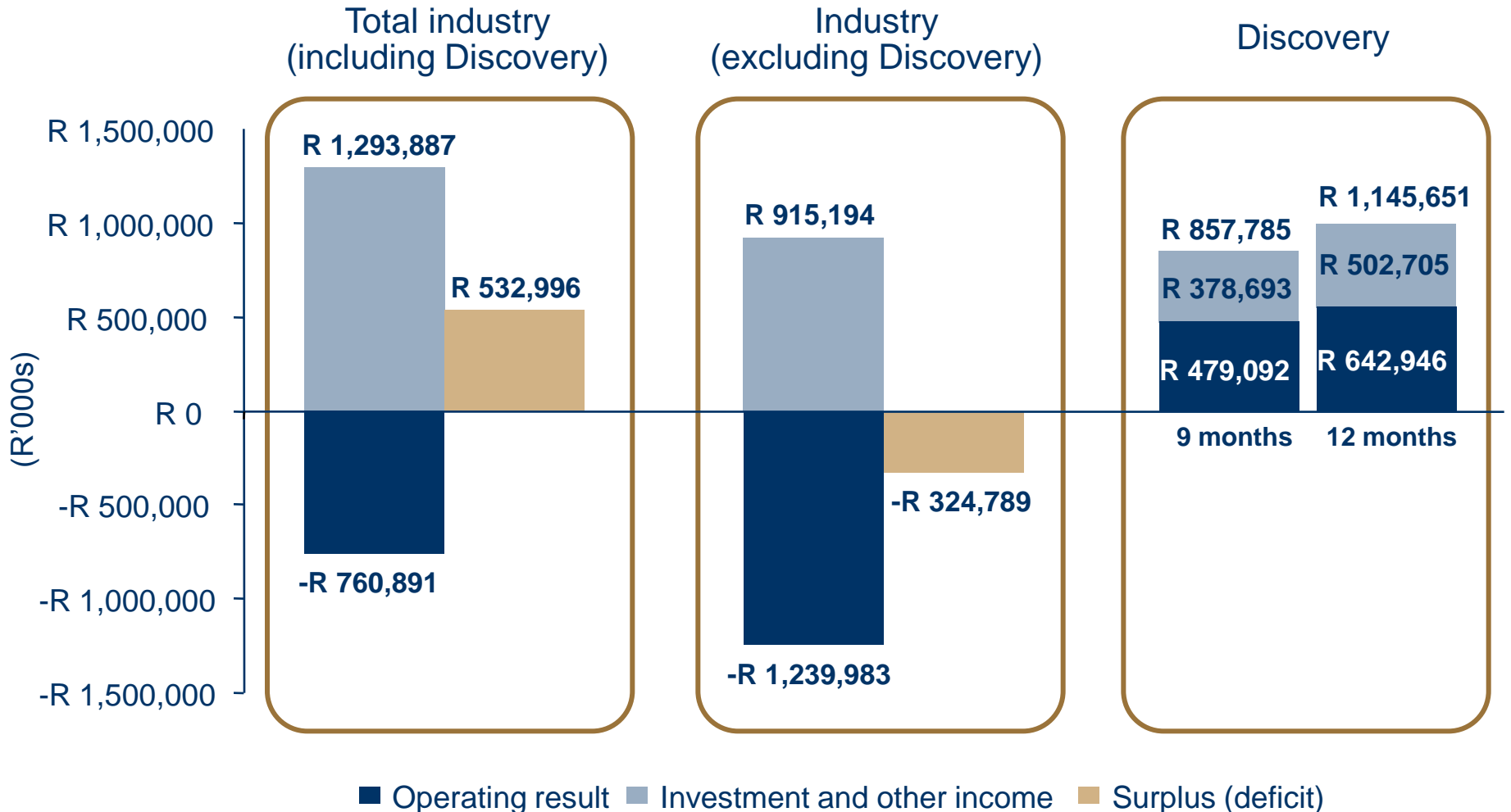
Hamburgers vs. Healthcare

- Utilisation
- New technologies
- Increasing disease burden
- Supply shortages

Health inflation exceeds “Big Mac” inflation by 8% p.a.

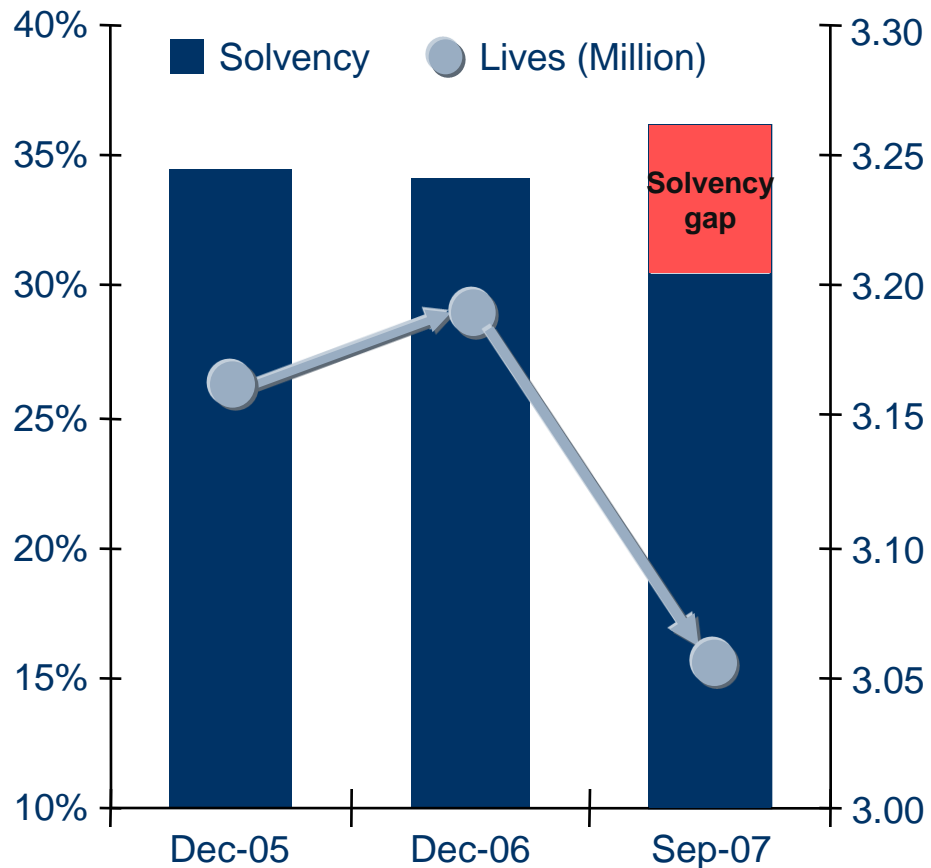
Industry Underperformance Highlights the Cost Pressure on Medical Schemes

Operating results for the 9 months to 30 September 2007

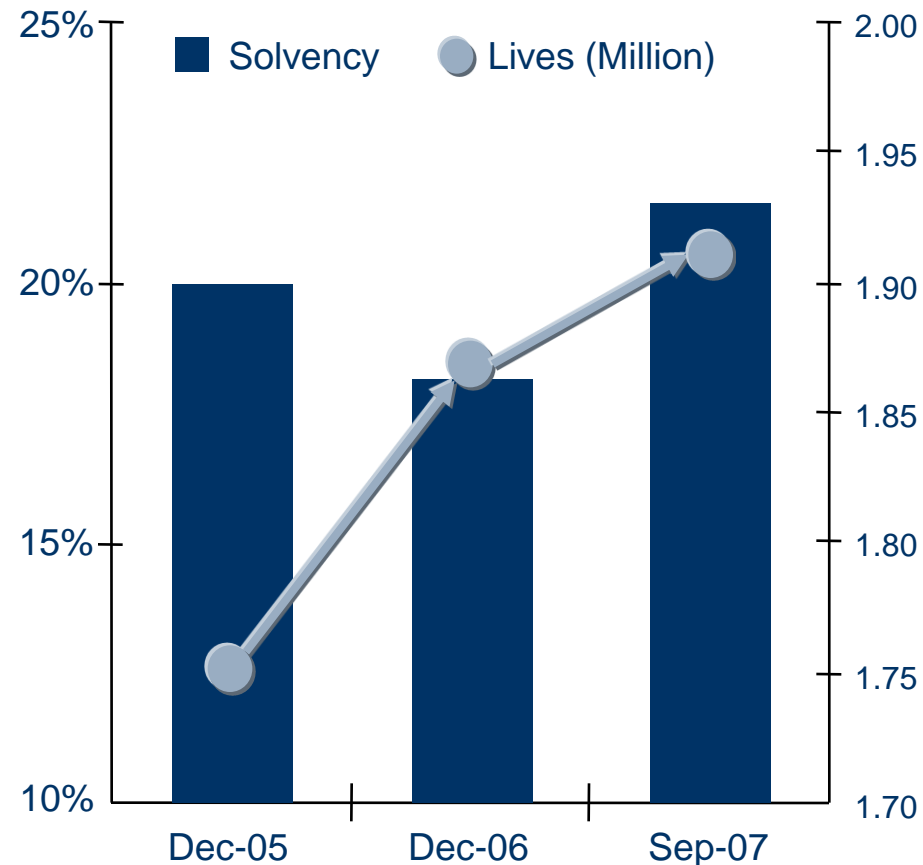


Tail of Two Cities

Open Schemes (excl. Discovery):
Member loss and solvency deterioration

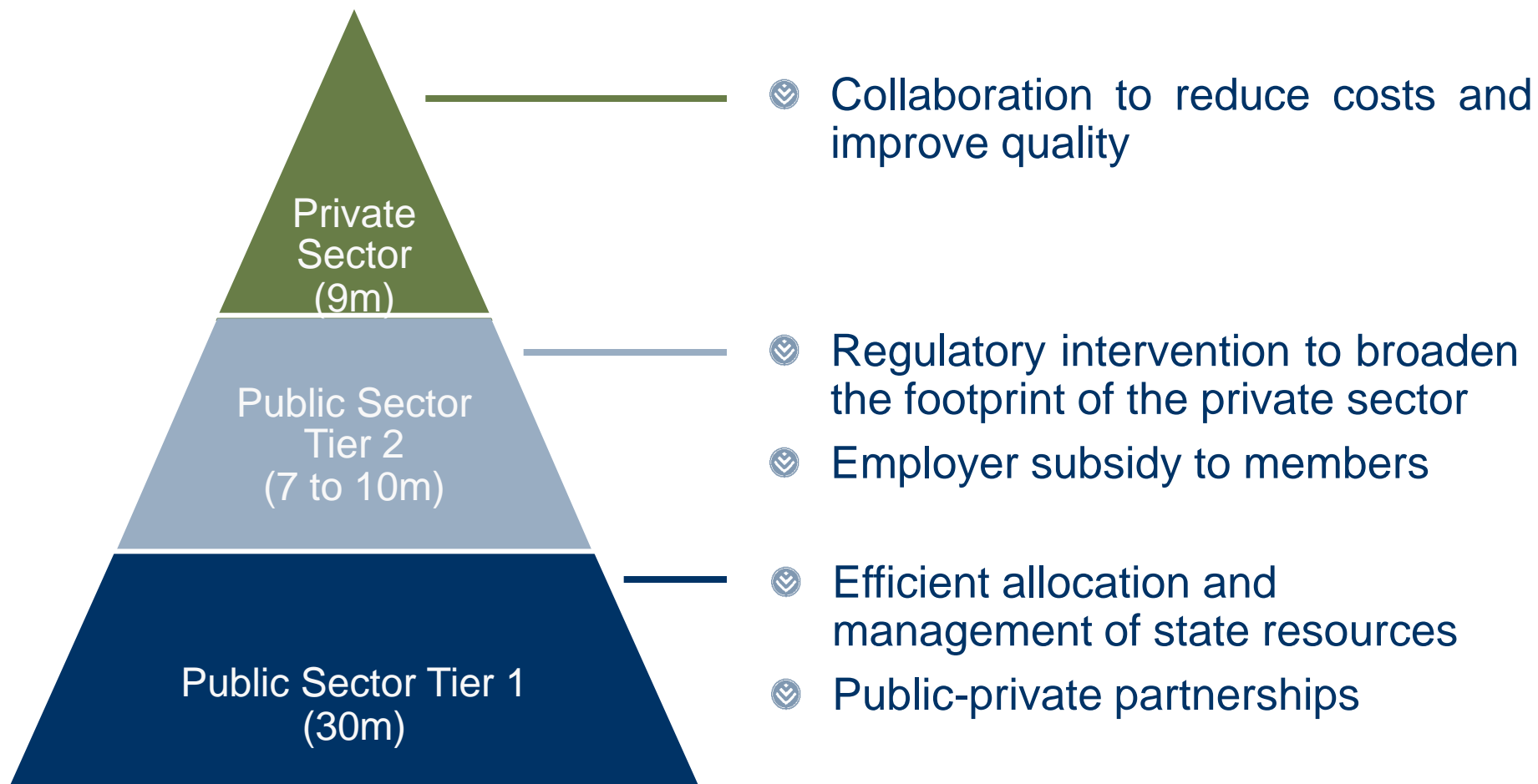


Discovery Health Medical Scheme:
Membership and solvency growth



Source: Council for Medical Schemes 3rd Quarter 2007 report

Solvency reflects relative loss ratio difference and likely future movements



Leadership is required

Key Challenges and Opportunities for Collaboration

- ④ Optimising value for money in hospital care
 - Ensure appropriate admissions – manageable vs. non manageable drivers
 - Reduce cost per admission without compromising quality
 - Improve overall quality of hospital care and outcomes
 - Greater focus on networks and pricing

- ④ Active collaboration on expanding access to low income families
 - New delivery models
 - Scheme options to support these

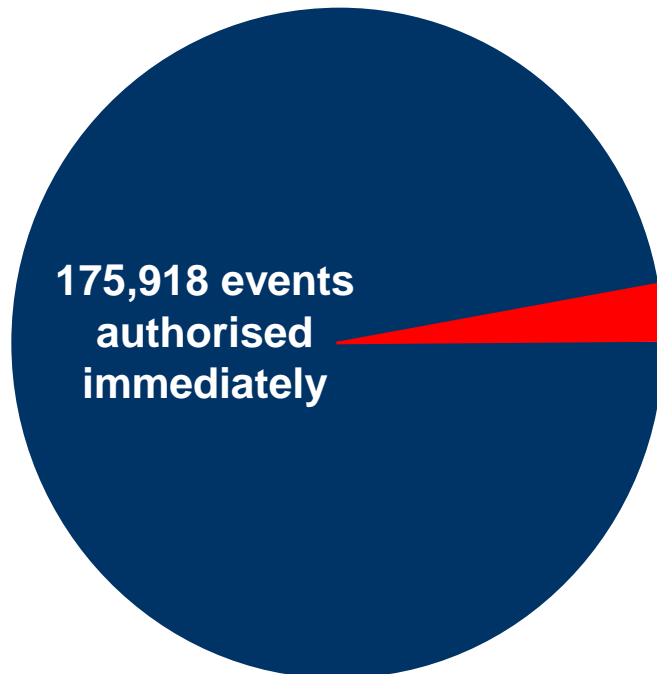
- ④ Major drivers are non-manageable
 - Changing disease and practice patterns
 - Autonomous medical practice

- ④ Focused efforts on manageable drivers
 - Inappropriate admission patterns and profiles
 - Active collaboration between schemes, hospitals and specialists
 - Day Surgery

Discovery Practices Highly Focused Admit Rate Management

Pre-authorisation analysis: In-hospital funding

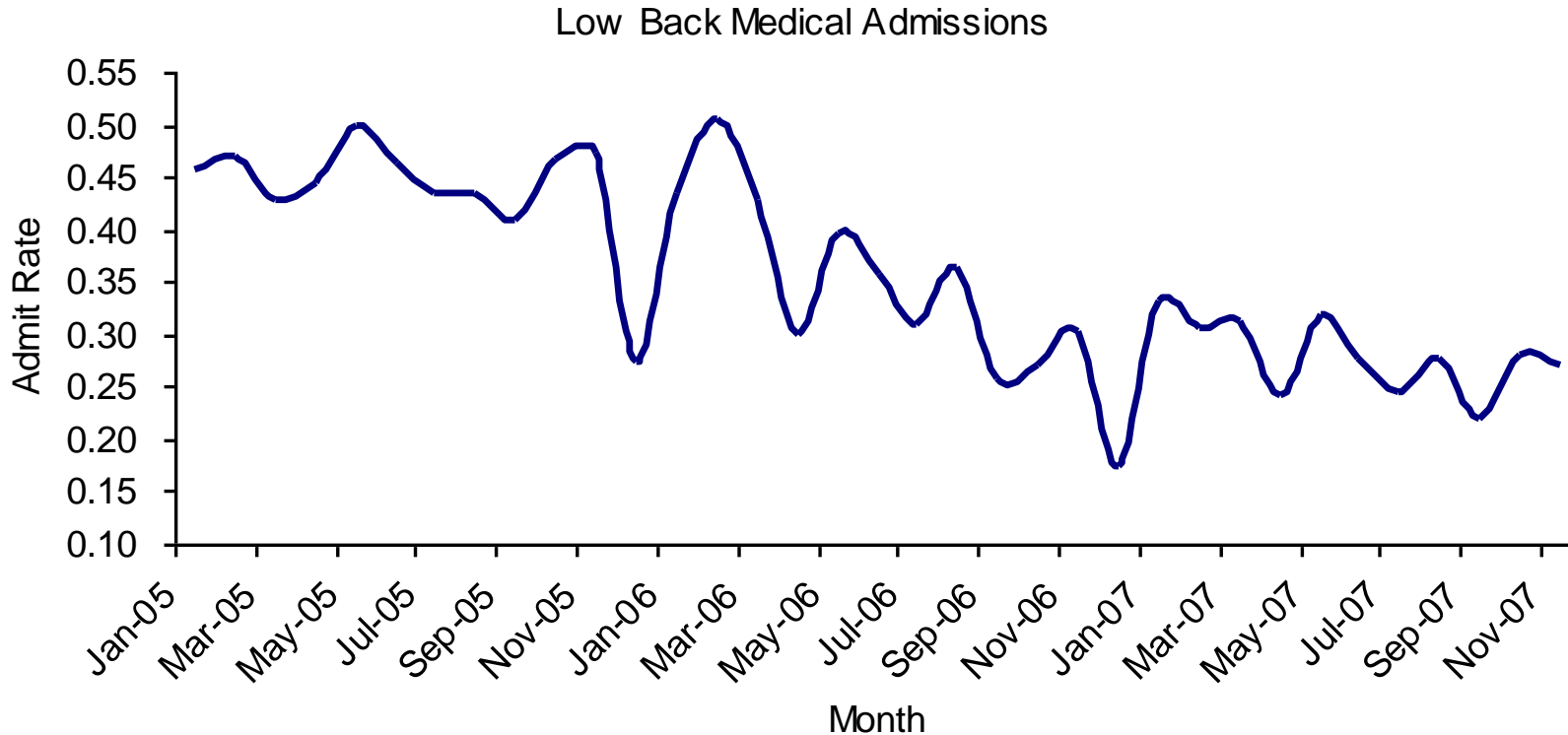
97% of pre-authorisation events were resolved immediately



Primary reasons for events pending

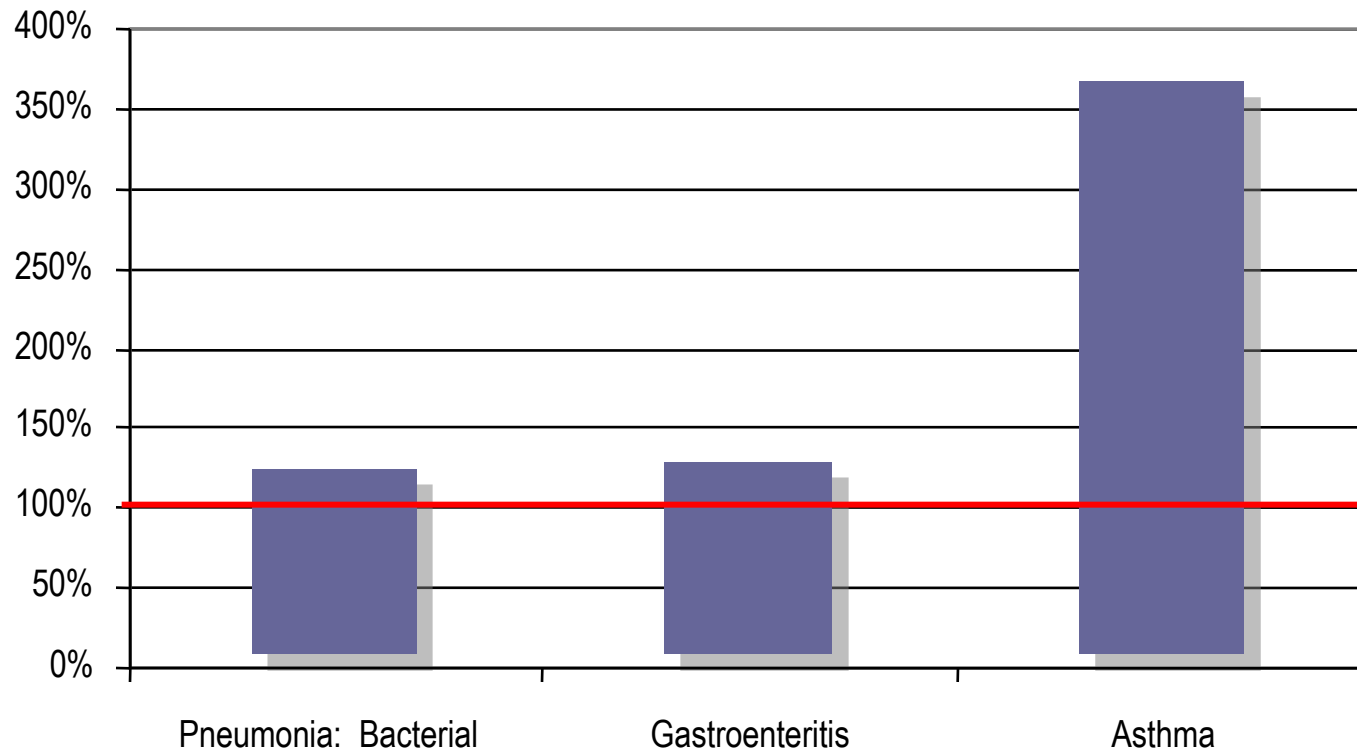
	Number of cases	% of events
Forensic investigation required	2,631	1.5%
Newborn registration required	948	0.5%
Incomplete information	762	0.4%
Awaiting to inform member of protocol restrictions	296	0.2%
Referred for medical review / external panel review	205	0.1%
Other	359	0.2%
Total events pended	5,201	2.9%

Medical Admissions for Lower Back Pain



Impact of an evidence based, externally validated protocol

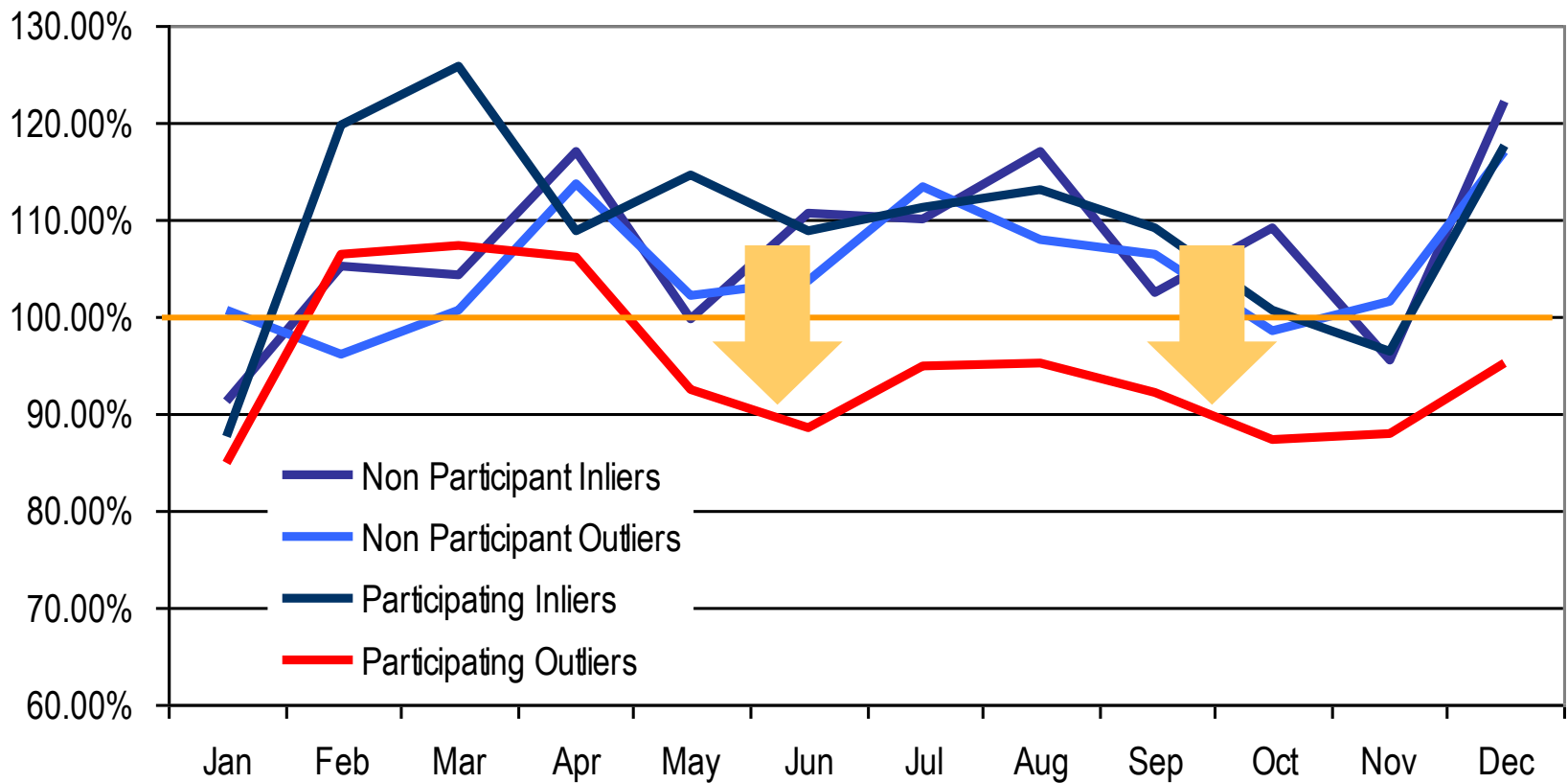
Dr Y, Pretoria, Actual Versus Expected Admission Rate



Your admission rate was **51%** above predicted, resulting in **180** more admissions than expected

Significant Reduction in Outlier Admission Rate

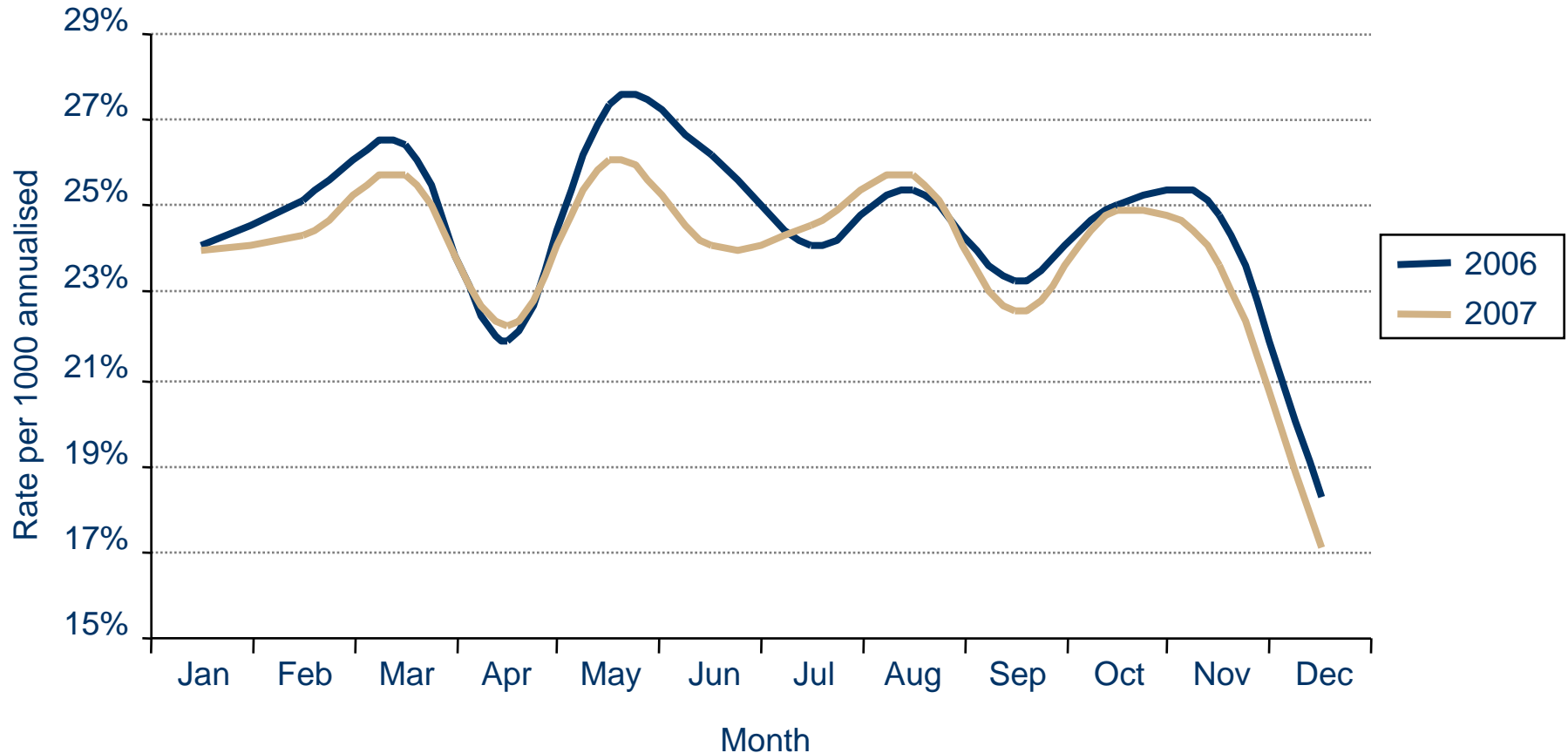
Results: 2006/2005 Admission Rates



8% drop in Outlier Admit rate, Other groups unchanged

Significant Impact on DHMS Admission Rate

Admission Rate Management



Overall 2.1% decrease in 07, building on a 1.8% decrease in prior year

Future Collaboration on Admission Rate Interventions

- ④ Scheme, hospital and specialist collaboration to ensure appropriate admissions
 - Hospitals have to move away from role as ‘passive’ receivers of patients:
 - Active engagement with health professional teams
 - Structured admission protocols/triage in Emergency Rooms
 - Clinical Governance/Pay for Performance Programmes
 - Re-activate Day Surgery industry

- ④ Alternative Reimbursement Contracts

- ④ Expanding the scope of costs that hospitals actively manage
 - Move away from passive attitude
 - Length of Stay
 - Pricing and utilization of medicines and surgicals /devices
 - Appropriate use of facilities: Day surgery / ICU / High Care

- ④ Highest strategic priority for Discovery Health
 - 70% of hospital admissions in 2008 covered by ARM
 - Aiming for 90%+ in 2009

- ④ Multi-year agreements are key to developing trust based partnerships

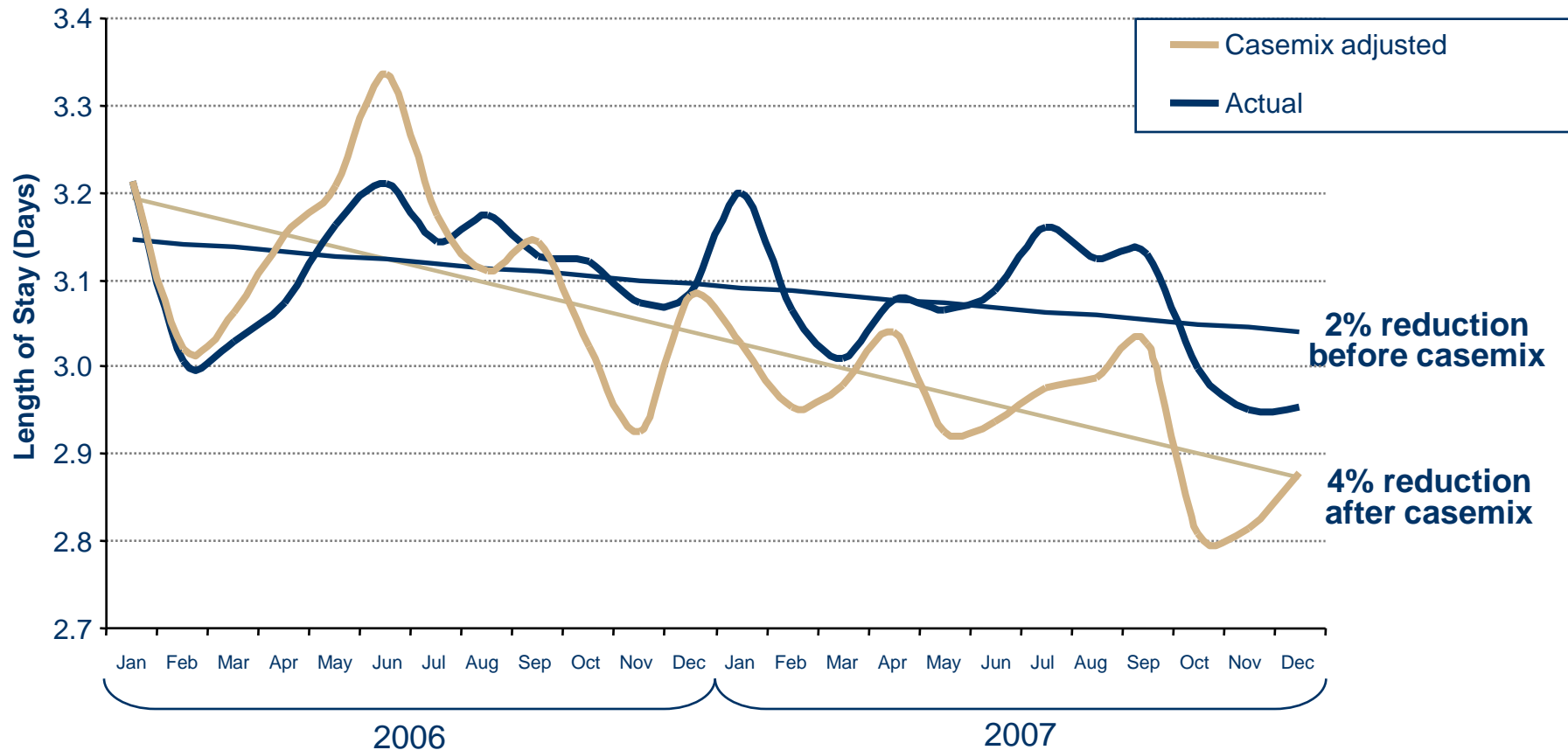
- ④ Very promising outcomes from initial contracts

- ④ Trust and outcomes dependent on:
 - Shared view of data and risk adjustment
 - Increasing co-operation on cost savings

Key Focus Areas for Co-operation in ARMs

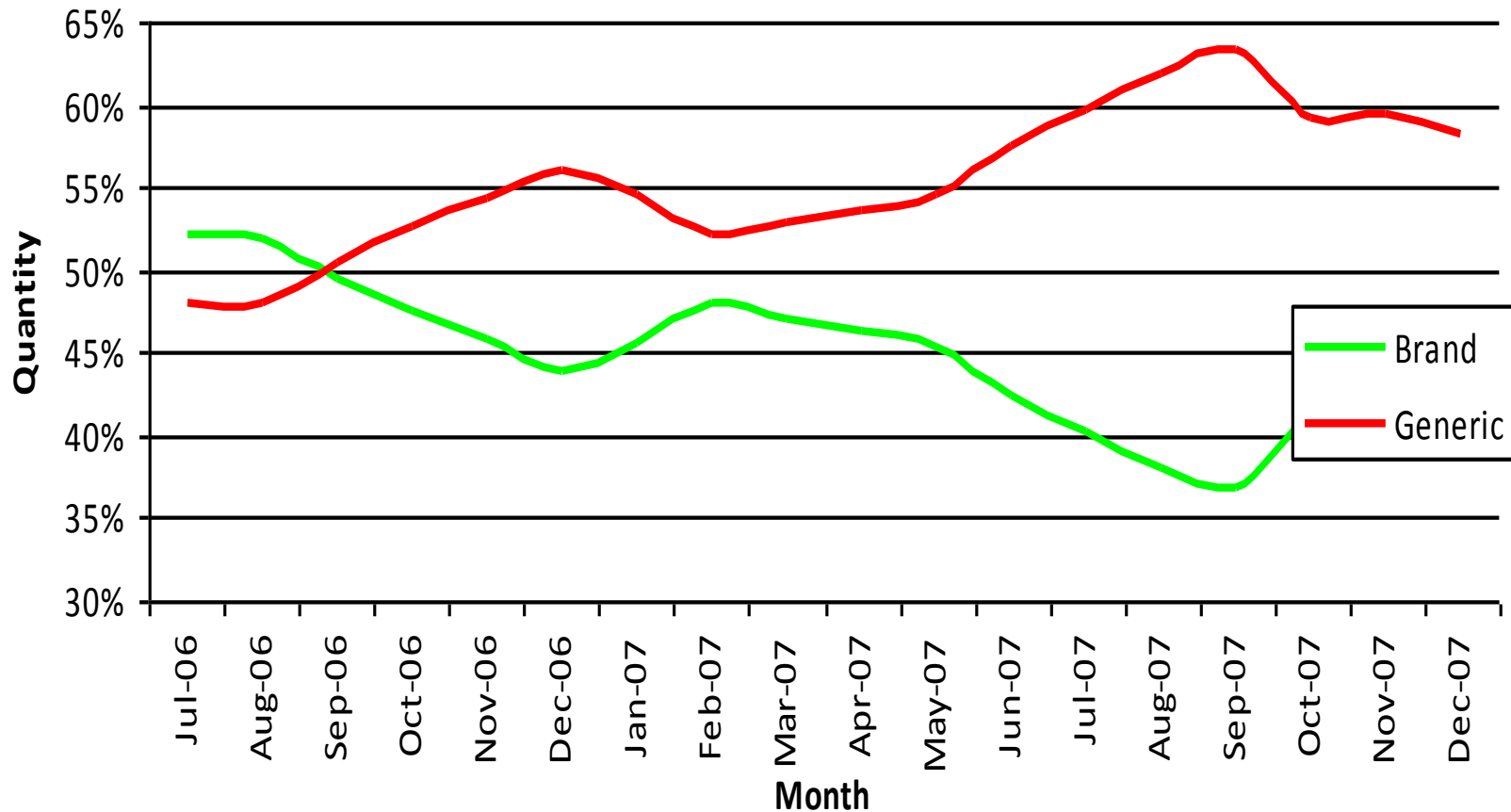
- ④ Active collaboration on managing input costs without compromising quality
- ④ Improving Coding Quality
- ④ Reaching shared view on DRG Grouper

Management of Length of Stay



Use of clinically appropriate LOS Benchmarks

DH Preferred Drug List

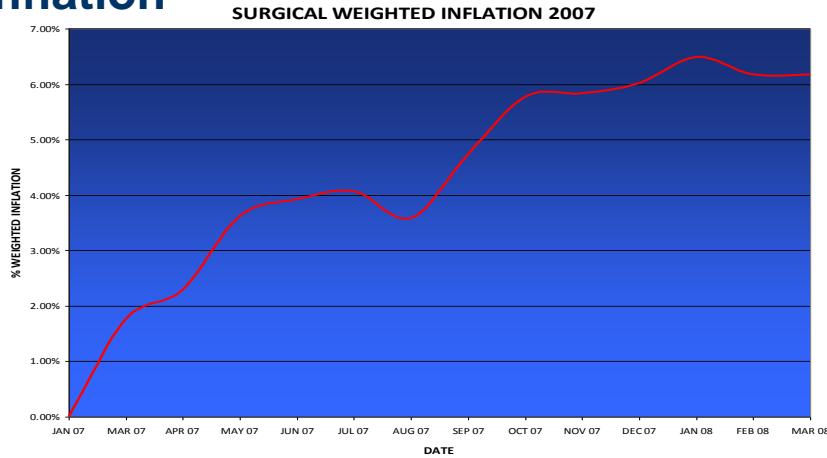


Impact of a 'Soft' In Hospital Formulary

Management of Surgicals and Devices

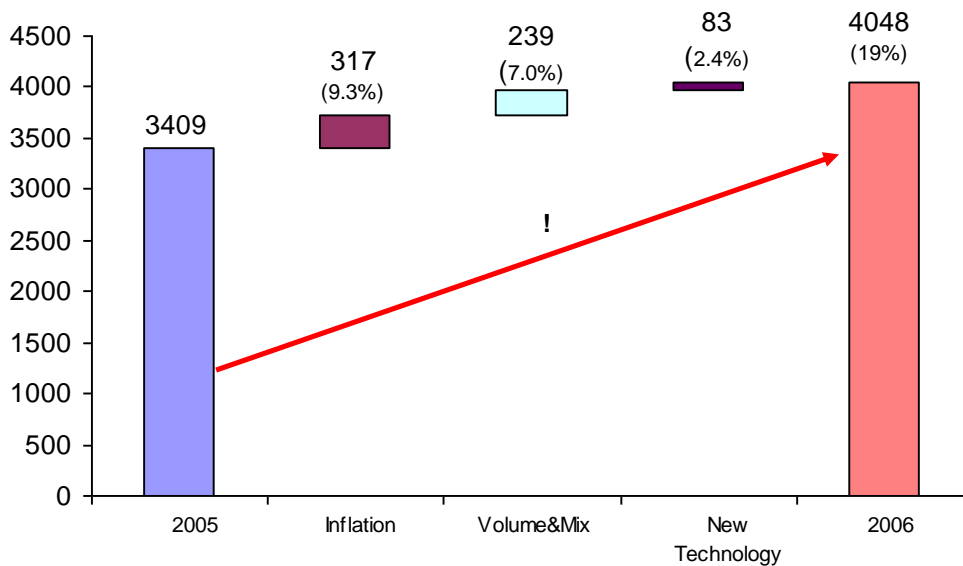


Inflation



Inflation approx 7%

Volume & Mix



Volume and mix anticipated to be between 3% and 6%

10% to 13% combined increase

Key Short Term Strategies

Issues

Solutions

- High volume of new NAPPI codes
- NAPPI Manipulation
- Volume and mix



- Freeze the product file for each period
- Review new items for price and clinical appropriateness

- Price Inflation



- Freeze prices
- 1 annual increase only
- Negotiate actively

- Gaming of Kits and Packs



- Basic Kit/s Packs
- Eliminate duplication/waste
- Transparent billing

Significant Early Progress

📌 Review of New NAPPI Coded Items

- Over 8000 new products reviewed since January 2008
- Approx 3000 initially rejected, leading to price reductions in many cases
- Example: New Nappi for drug-eluting stent (R12 000 vs R14 000) – 14% cheaper

📌 Mitigating Price Inflation

- Many suppliers requesting high double digit increases due to exchange rate
- DH and hospital groups have mitigated price increases in several cases

📌 Active collaboration with some groups on procurement

Medium and Longer Term Strategies

⌵ DH Activities

- Surgical Formularies for selected items
- Reference pricing
- Tenders for Discovery members on selected items

⌵ Joint Activities

- Price negotiation
- Collaborative Procurement

⌵ Hospital Activities

- Greater focus and resources on extracting savings from medicines, surgicals

⌵ Critical for Hospitals

- Management Information Systems
- Quality Assurance
- Benefit Confirmation
- ARM's
- Performance on Quality and Cost evaluations: Rating Index

⌵ Critical for Funders

- Overall risk management
- Pre-authorisation
- Analysis of hospital cost and quality for profiling and rating
- Case Management and Disease Management

Collaboration to Improve Coding Quality



Ⓢ Patient Discharge Summary Form

Comprehensive Clinical Coding Summary (draft 01-05-2008)

Patient name: _____
 Medical Aid & Membership number: _____
 Event/authorization number: _____

Primary treating doctor: _____
 Admission Date: _____
 Discharge Date: _____

Diagnosis:

	Diagnosis Flag	Doctor's written description	ICD-10 Codes		
Conditions "Present on Admission"¹:					
	a) Pre-existing / known co-morbidity(s) or chronic ² conditions:				
	b) Other pre-existing non-chronic ³ conditions present on admission:				
	c) Complication of known diagnosis ⁴ present on admission:				
Conditions treated during admission⁵:					
	Admission diagnosis (signs & symptoms / reason(s) for encounter):				
	Principle Discharge Diagnosis ⁶ (diagnosis/condition most responsible/clinically significant for patient's stay in hospital)				
	Other significant secondary condition(s):				
	External Cause(s) of Injury(s): [V, W, X or Y codes]				
	Complication(s) occurred during hospitalization:				
	External Cause(s) of medical / surgical complications : [V, W, X or Y codes]				
	Co-morbid / chronic condition(s) newly identified during admission:				

Procedures:

	Procedure type	Doctor's written description	CCSA (CPT) codes		
1	Primary / main procedure performed:				
2	Other significant procedures / interventions performed during hospitalisation				

Signatures:

Doctor: _____
 Date: _____

Coder: _____
 Date: _____

¹ Clinical conditions that are already in existence at the time of admission or encounter with clinical services.

² Conditions known to the patient, for which they are on chronic long-term treatment e.g. asthma, hypertension.

³ Conditions experienced by the patient for which chronic treatment may not be in place and which may not necessarily be the reason for current admission e.g. sinusitis.

⁴ Known complication of a known diagnosis e.g. gangrene of diabetic foot.

⁵ May be the same as conditions "Present on Admission".

⁶ As per South African standard definition of a Principle Diagnosis.

📌 Coding Quality Audits

- Standard Auditing Guidelines
- Establish hospital-based auditing processes

📌 Benefits of Collaboration

- Coding becomes a true and useful reflection of patients clinical conditions – promotes efficiency e.g. on readmission
- Measure quality of coding practice
- Feedback for training
- Accurate billing

⌵ IR DRG Grouper

- No updates since 2003
- DH has done extensive local customisation
 - 30% of Grouper – evaluated
 - 57 new DRG's
 - R² improvement – 43% to 54%

⌵ Active collaboration with current ARM partners

- Provide Grouper on Black Box basis

⌵ Ultimate vision: Industry standard that all parties trust and use with confidence

- No religion re Discovery Grouper

Collaboration to Improve Quality of Care and Outcomes



④ Discovery Hospital Rating Index

④ Hospital Acquired Infections

⌵ Measures:

- Strongly aligned with AHRQ (US Federal government measurement tool) ~ Mortality, Preventable Complications
- Re-admissions, Cost

⌵ 60 select categories of elective (surgical and obstetrical)

⌵ Factors used for scoring

- ICD-10 codes
- IR-DRG groupings and co-morbidities
- Age, gender and MedStat (disease staging) for additional risk-adjustment

⊕ Current Weaknesses:

- “Source” Coding quality
- Statistical confidence re hospital units with low volumes and poor outcomes
- Adverse events reported as one number

Relaunch Updated Hospital Rating Index - 2009



- ④ Focus on High Risk, High Volume Admissions
- ④ Preventable Complications into coherent groups
- ④ Patient Experience – based on a survey post-hospitalisation
- ④ Supported by IR DRG Updating and Patient Discharge Summary

Hospital Acquired Infections

International incidence – 5%

- Greater in high risk groups

Impact

- Morbidity and Mortality
- Direct healthcare costs – CDC estimates - \$10bn
- Indirect costs – lost productivity
- No National Surveillance Programs in SA

International Experience

- Surgical site infection (SSI) increases costs by 119% (Kane and Siegrist, 2002)
- MRSA triples average hospital costs (Noskin, 2005)

Collaboration to Reduce Hospital Acquired Infections

⊕ Critical for Funders

- Duty to members
- Direct healthcare costs

⊕ Critical for Hospitals

- Duty of care to patients
- Shared risk in ARM's
- Litigation
- Reputational Risk
- Retain doctor loyalty

Discovery Proposals: Hospital Acquired Infections

- ④ Increase transparency and collaboration
- ④ Establish a forum (FIDSSA)
 - Standardize the definitions and reporting of HAI
 - Develop joint curricula and training programs
 - Share successful strategies and practices
 - Design cost-effective intervention strategies
- ④ Establish a voluntary surveillance program
 - Set benchmarks
 - Monitor infection rates and patterns
 - Compile summaries for feedback

Increased Focus on Networks and Pricing

- ④ Medical Schemes Amendment Bill
 - Basic benefits at single premium
 - Critical role for discounted networks

- ④ Critical for hospital sector to demonstrate true competitiveness
 - More open attitude to hospital networks – not only in low income plans

- ④ Discovery intends to use hospital profiling tools to deepen and extend networks
 - Price / Cost
 - Regional
 - Quality of care
 - Centres of excellence
 - Day surgery



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