



ICHOM International Consortium for
Health Outcomes Measurement

HOW THE NHS IS LEVERAGING AN ICHOM STANDARD SET FOR VALUE-BASED PURCHASING

AUGUST 2014



WHAT YOU WILL FIND IN THIS CASE STUDY

The Bedfordshire Clinical Commissioning Group (BCCG) is the public health care payer for Bedfordshire in England, covering a population of approximately 441,000. In April 2014, BCCG launched a five-year contract for musculoskeletal care with Circle Partnership—a provider network—built on a capitation-based funding formula incorporating financial incentives for delivering improved patient and clinical outcomes. This case study describes the context in which this new contract was developed and how outcome indicators have been incorporated in the contract, as well as the expected benefits and high-level business case.

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CONTEXT

In recent years, we have seen the beginning of a shift across the globe away from the traditional fee-for-service payment model toward one based on value. Starting with incentives for following medical guidelines (e.g., payment of an extra premium if pre-defined medical guidelines are followed), models evolved toward bundled payments. For example, in Sweden, Stockholm County launched in 2009 a bundled payment for total hip and knee replacement. Eligible patients' health care costs are covered by a capitated amount. Their risk of complications is borne by the provider, who thus has an incentive to provide high-quality care. But these are *avant-garde*; there are very few examples of payment models that are truly based on the value that is delivered to patients. What the National Health Service (NHS) Clinical Commissioning Group is doing on musculoskeletal care in Bedfordshire County is among the first of its kind.

In England, health care is organized at the county level. The public payer—and by far the largest payer—is the NHS, which commissions care to a Clinical Commissioning Group (CCG) for each county. There are about 210 CCGs across the country. Each CCG is responsible for managing the delivery of care to the county's population. One of these counties, Bedfordshire, developed an innovative payment model for musculoskeletal (MSK) care.

Musculoskeletal conditions include all medical conditions linked to soft tissues, such as muscles, tendons, and nerves. MSK diseases include back pain, arthritis, bodily injuries, and osteoporosis. The typical care pathway in these conditions starts when a patient visits a general practitioner (GP). This visit is often followed by sessions with a physical therapist (PT). When surgery (e.g., spine surgery) is needed, patients typically have a hospital stay, again followed by physical therapy in community centers or at home. MSK care costs approximately £3.5 billion per year in the UK. In Bedfordshire, it accounts for approximately £25 million per year (about six percent of the budget) and covers a patient population of roughly 45,000.

The Bedfordshire CCG (BCCG) aimed to improve the quality of care while controlling costs through an outcomes-based capitation contract. They started a pilot to develop an innovative outcomes-based bundled payment model for MSK care. They chose MSK as the first medical condition for three main reasons. It is one of the largest conditions in terms of both spending and number of patients. Furthermore, MSK care often requires a full cycle of care from GPs to community-based services through hospital-based care. Finally, there were disparities in MSK care between the northern and southern regions of Bedfordshire. Care provided in northern region tended to be community center-based, while care in the southern region was more hospital-based. BCCG saw an opportunity, therefore, to develop a uniform care cycle across all regions that would improve the overall quality of care and leverage all stakeholders.

TOWARD VALUE

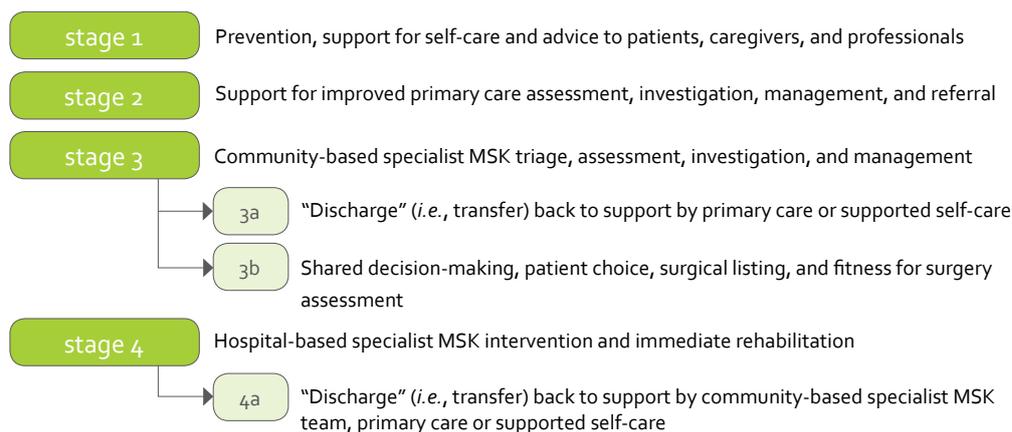
Prior to BCCG's reforms, there were around 20 different contracts for MSK care in Bedfordshire. There were some small contracts directly with physical therapists and some larger contracts with hospitals that were not MSK-specific. This made monitoring the funding of MSK care across providers difficult. In 2011, BCCG initiated the process to transition from multiple contracts for MSK care to a single five-year capitated, outcomes-based contract with a preferred provider. In so doing, BCCG sought to achieve four objectives:

1. Improve population health
2. Improve the experience and outcomes of the patients of Bedfordshire
3. Lower per capita costs—delivering better value through better care
4. Enhance the overall management of the integrated system

MSK CONTRACT AND INTEGRATED CARE

In April 2014, BCCG signed a five-year contract with Circle Partnership (“Circle”) for integrated MSK care. This established Circle Partnership as the preferred provider of MSK care with BCCG, such that any patient in Bedfordshire seeking MSK care would be treated in Circle’s network of subcontracted providers. The contract covers all MSK-related medical conditions with the exception of suspected cancer, immediate life-threatening conditions, acute trauma, and MSK patients under the age of 18.

The following stages of care are within the scope of the contract:



Also according to the contract and in its capacity as preferred provider, Circle was required to meet the NHS Constitution expectations of quality and patient experience, including ensuring that patients are seen by specialists within maximum waiting times.

Almost all of the general practices in Bedfordshire use the same IT system (SystemOne). The Circle collaborative produced a template for MSK care that acts as both a management guide for the GP and a referral letter should a patient need care beyond the scope of the GP. This referral can be sent electronically to an integrated MSK referral hub, where it is reviewed within one to two days by an MSK specialist (enhanced scope PT, rheumatologist or orthopedic surgeon) and the onward management of the patient suggested. This could take the form of an appointment with a relevant specialist, advice to the GP for management within primary care, or advice to the patient on self-management.

BOX 1 | ABOUT THE BCCG AND CIRCLE PARTNERSHIP

NHS Bedfordshire Clinical Commissioning Group (BCCG) is the public health care payer for Bedfordshire County in the UK. BCCG is responsible for planning, organizing and buying NHS-funded healthcare for the 441,000 people who live in Bedfordshire. NHS-funded health care includes hospital services, community health services and mental health services. BCCG is comprised of 55 GPs and had a budget of £430M in 2013.

Circle Partnership is a hospital group co-owned by its employees. It covers all care practices over five locations: Bath (general private hospital of 61 beds), Reading (general private hospital of 50 beds), Nottingham (treatment center without emergency care) and Hinchingbrooke (general hospital of 266 beds). Circle was co-founded in 2004 by Ali Parsa (social entrepreneur) and Massoud Faloudi (consultant ophthalmologist) and currently treats ~121,000 patients per year. Most of Circle’s hospitals and centers provide NHS-funded care.

FINANCIAL INCENTIVES AND OUTCOMES

The entire contract over five years is worth £120 million, which corresponds to about £25 million per year. The payment consists of two parts: a fixed part (bundled payment) and a variable part (outcomes-based payment).

Over time, BCCG has the ambition to increase the share of the variable part to 20 percent, but decided to start with a smaller variable portion to facilitate the adoption by Circle and test-run the model during a couple of years.

BCCG will assess outcomes and give a "quality" premium of up to 20 percent

To start with, the fixed part accounts for 97.5 percent and was calculated based on historical cost of care and population growth. The variable part (2.5 percent, or about £0.75 million per year as of the second year) incentivizes excellence in quality.

This financial incentive is calculated based on five quality criteria:

1. Innovative use of technology (T)
2. Truly integrated care (I)
3. Improved patient outcomes (O)
4. Quality of patient experience (E)
5. Production of an annual report (AR)

Every quarter, Circle will have to report its performance against these criteria. Its results will then be calculated as follows.

$$\text{FINANCIAL INCENTIVE} = 20\% (T) + 20\% (I) + 30\% (O) + 20\% (E) + 10\% (AR)$$

Circle will therefore be able to receive additional payment up to £200 thousand per quarter based on its performance.

BCCG evaluates some indicators qualitatively and others quantitatively. It uses a qualitative (binary) assessment with regard to innovative use of technology and production of annual reports. Evaluations of all other indicators are based on quantitative assessment. Once baselines are determined, trajectories for improvement in both coverage of patients responding to surveys and questionnaires and actual patient outcomes will be determined and payment will be based on the results.

To link, for the first time, patient outcomes to payment, BCCG has adopted the International Consortium for Health Outcomes Measurement (ICHOM) Standard Set for Low Back Pain (see "Go further" at the end of the report for more information). This Standard Set of outcomes was developed by an international community of physicians and other health care specialists, as well as a patient representative.

This it is the first payment model in the history of England that truly pays for the results that matter most to the patients

The Standard Set is a minimum list of the outcomes that matter most to patients with low back pain.¹ As Diane Bell, Director of Strategy at BCCG, explained, this is the first payment model in the history of England that truly pays for the results that matter most to the patients. The portion of payment actually linked to patient outcomes is relatively small, but it is a first step.

For other conditions than low back pain included in the MSK care, BCCG leveraged indicators from the National Rheumatoid Arthritis Society (NRAS), as well as generic measures of patient outcomes, such as the EQ-5D™.

¹ The outcomes recommended by the Standard Set are major surgical complications, need for reoperation, need for pain medications, disability, work status, back and leg pain, and health-related quality of life. For more information, visit <http://www.ichom.org/project/low-back-pain/>.

JOURNEY TO GET THERE

BCCG started to think about developing such a contract in 2011. The success of the new payment model depended in part on the involvement of all key health care stakeholders in Bedfordshire and nationally (GPs, PTs, provider associations, patient associations, the Department of Health, and others), so BCCG tasked four working groups with discrete aspects of the initiative.

1. **INTEGRATED CARE:** designed the full integrated care pathway to ensure the best quality of care
2. **MSK CONTRACT:** developed the prime contractor, capitation and outcomes-based payment mechanism in collaboration with legal counsel
3. **PROVIDERS:** discussed and collected feedback from associations of local and national providers about new payment model
4. **GENERAL PRACTITIONERS:** conducted several workshops to collect GPs' feedback; GPs also developed the central referral system and form

Including all health care stakeholders in the development of this new payment model has been an important element to the success and acceptance of the model.

EXPECTED RESULTS

At the time this case study was written, the contract had just been signed, so the results are not yet known. However, BCCG clearly aims to improve the quality of MSK care in Bedfordshire while better controlling costs.

QUALITY OF CARE

BCCG expects to improve the quality of MSK care through the integrated care model, the central referral system and the incentives based on patient outcomes. The combination of an integrated care model and a central referral system will allow care teams to provide patients the best care at the right time and at the most suitable facility.

First, it will emphasize the need for prevention. However, once the patient needs care, the central referral system will enable the best care for the patient, refer the patient to the most appropriate provider, decrease waiting time, and allow flexibility in terms of location. At the same time, the incentives based on patient experience and patient outcomes promise to improve quality by focusing intervention on what really matters to patients.

*The plan was designed
by GPs, for GPs*

Another expected benefit from this new contract is around patient choice. The central referral systems, combined with the community aspect, will allow patients to participate in decision-making with their providers. Before this contract, GPs typically sent patients to one of a small group of PTs, hospitals or community centers. Today, patients will be able to participate in that decision and base their choice on waiting times, patient satisfaction, and other important factors.

BOX 2 | WHAT'S IN IT FOR CIRCLE?

Circle identifies several reasons why they decided to move in the direction BCCG proposed. **Enabling patient decision-making** was critical to Circle. **Driving quality** by encouraging providers to deliver on a set of clearly defined indicators also appealed to them. Previously, several providers were reporting quality indicators, but they did so only inconsistently and sporadically. The new approach to quality indicators will be more consistent across providers, drive quality by focusing caregivers on the most important indicators and enable a holistic view of patient care. **Circle has identified a series of levers to drive financial success:** continue to decrease unnecessary procedures, push for more local activity at local (reduced) prices, improve overall efficiency, invest in prevention and early intervention, and choose appropriate treatment for each patient.

BUSINESS CASE

Before deciding to launch such a new contract model, BCCG developed a business case to forecast the expected costs of MSK care in the absence of commissioning intervention. The business case also established the investment required to design and implement the new specification and contract form, thereby enabling analysts to determine the potential return on investment.

BCCG estimated that the costs of redesigning and procuring the new integrated MSK system would be on the order of £500 thousand (including project management and the referral system). For the cost savings estimate, BCCG compared the expected MSK care budget over the next five years with and without an outcomes-based capitation system. BCCG estimated that approximately £750 thousand could be saved each year by adopting the outcomes-based capitation system.

BCCG signed the contract with Circle Partnership in April 2014. By the end of 2014, BCCG will assess this new payment model by looking at several indicators: volume of patients in hub compared to expectations, results of patient outcomes and experience, feedback from GPs and actual costs. The financial impact and improved care quality have yet to be proven, but they are expected to result in better care at similar or lower cost.

CONCLUSION

Even in this early stage, BCCG's pioneering efforts to tie reimbursement to outcomes—the results that matter most to patients—point the way forward for private and public payers around the world currently transitioning toward value-based health care. Indeed, only when quality, defined on the basis of patient outcomes, is a major determinant of payment will *value* systematically improve, driving quality, curbing inefficiencies, and cutting costs.

KEY LEARNING

- **CONTROLLING COSTS AND IMPROVING QUALITY IS POSSIBLE:**
BCCG designed a payment model that ensures strong control of costs through capitation while ensuring—and ultimately increasing—quality through a variable premium based on outcomes.
- **PATIENT-REPORTED OUTCOMES CAN BE USED IN PAYMENT MODELS AND TO IMPROVE QUALITY:**
BCCG wanted to drive quality by focusing on what matters most to patients. To do so, they leveraged an internationally-recognized set developed by the international health care community: the ICHOM Standard Set for Low Back Pain.
- **VALUE-BASED PAYMENT IS A WIN-WIN FOR PAYERS AND PROVIDERS:**
The deal sealed between Circle and BCCG is attractive to both parties: BCCG controls costs while maintaining or improving quality, while Circle gains access to a lucrative care contract and the opportunity to roll out a standard outcomes measurement model that promotes quality.
- **START SMALL, WITH HIGH AMBITIONS:**
BCCG decided to start this contract with a small portion of outcomes-based payment. In the beginning, the small 2.5 percent premium minimizes the risk to the provider and demonstrates the robustness of the model. When all parties are comfortable with the premium calculation model, the long-term target of 20 percent variable payment can be reached.

- **INVOLVING ALL STAKEHOLDERS IS KEY:**
Physicians have been involved in the process of developing this new payment model. For example, the referral system was fully developed by physicians for physicians. This strongly promoted the plan's acceptance within the community.
- **STARTING WITH ONE MEDICAL CONDITION IS ALSO FEASIBLE:**
This contract was developed was developed for MSK care, which covers several medical conditions. The specific power dynamics allowed the BCCG to push for such a large contract. Payers in other health care systems may start with one medical condition as a pilot and then expand to a large scope.



GO FURTHER

- Circle Partnership website: <http://www.circlepartnership.co.uk/>
- NHS BCCG website: <http://www.bedfordshireccg.nhs.uk>
- ICHOM website: <http://www.ichom.org/>

SOURCES

- Interviews with Diane Bell (NHS Bedfordshire)
- Interview with Tennille Madigan, Will Smith and Marvin Nyadzayo (Circle)
- Briefing notes, March 2014 from NHS BCCG
- NHS BCCG Invitation to Tender for: Prime Contractor - Musculoskeletal (MSK)

ABOUT ICHOM

The International Consortium for Health Outcomes Measurement (ICHOM) is an independent non-profit organization dedicated to unleashing the potential of value-based health care and transforming health care systems worldwide. At ICHOM, we believe that outcomes are the ultimate measure of quality in health care, and only by measuring the outcomes that matter to patients can we improve value for patients. In pursuit of our goal, we define Standard Sets (minimum data sets) of health outcomes and associated risk factors for specific medical conditions, support the adoption of outcomes measurement in routine practice, facilitate improvement through global learning communities, and engage stakeholders to promote transparency and reporting of quality and value.



