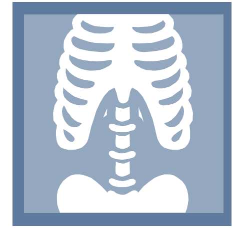

Referred Services Management Strategy

July 2004

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

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The Strategy in Summary

One of the six key goals of MidCentral District Health Board is to have effective and efficient healthcare services. To assist in achieving that goal, the Board has developed this Referred Services Management Strategy. This Strategy expresses the Board's commitment to maximising the health outcomes from referred services expenditure.

The goal of this strategy is to:

> Work within existing resources to focus, motivate and incentivise providers to maximise health benefits from referred services expenditure such that any efficiencies can be re-directed into additional services.

The vision is:

> The provision of referred services will be a shining example of our commitment to quality, our providers and our community. We will have confidence in the diagnostic ability of our services, utilised as best practice dictates. Our provision and use of pharmaceutical and pharmacy services will be second-to-none and the gains we have made will have been re-invested in proactive health protection of our community.

The five key directions to achieve the vision are:

1. Establish a Clinical Governance Quality Council (CGQC)
2. Take a partnership approach to Referred Services Management
3. Focus on quality and removing inequalities
4. Continuously improve quality using quality information
5. Improve access to primary radiology.

The referred services management vision emphasises collaboration as key to success - it will only be through everyone focusing on the same goals that we will be able to maximise health gains from managing referred services expenditure.

The strategy will be implemented over the next three to five years in a staged approach. We realise that the primary sector is currently undergoing rapid change with the introduction of primary health organisations and the referred services management strategy will be implemented with this in mind.

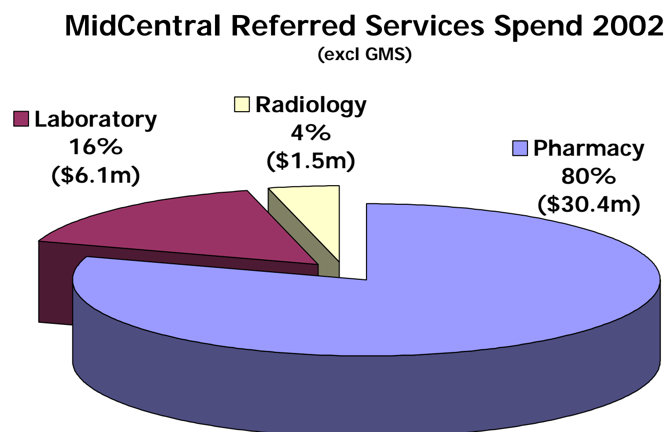
Defining Referred Services

Referred services, in the context of this Referred Services Management Strategy, relate to pharmaceuticals, laboratory tests and radiology tests which are accessed through the primary care team (and usually the general practitioner) that are funded by MidCentral District Health Board. Referred services are funded on a fee-for-service, uncapped basis with large variation in utilisation not explained by population need.

Referred services management includes various initiatives used to improve the quality of utilisation of these services in terms of what is prescribed and ordered, and for whom. Reducing the variation in use of pharmaceuticals and laboratory tests to align more closely to best practice and population need has the potential for improved resource use and substantial health gains.

In 2000/2001 the Government spent $6.9 billion dollars on health care and of this $1.95 billion was spent in the area of primary health care.

In the MidCentral District over $38 million was spent on referred services in 2002 (excluding general medical services - GMS). As shown in the adjacent diagram, the total pharmaceutical spend accounted for 80% of this figure, community referred laboratory 16% and community referred radiology 4%.



The Strategy in Context

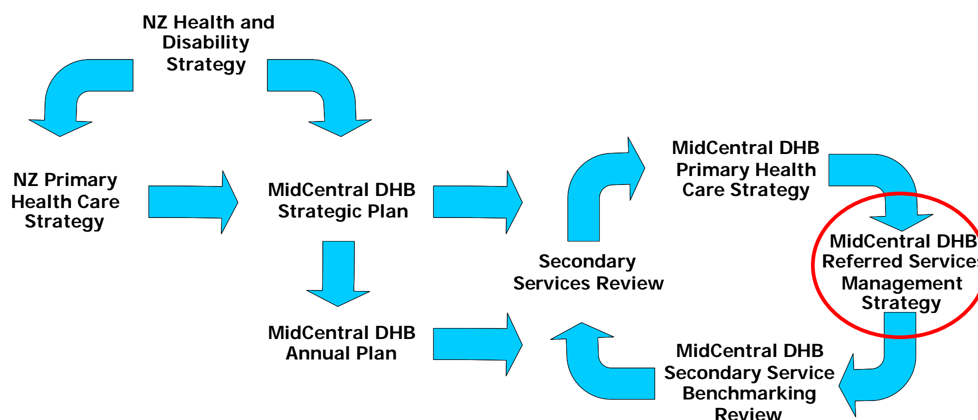
> *A strong primary health care system is central to improving the health of New Zealanders and, in particular, tackling inequalities in health.*

New Zealand Primary Health Care Strategy, 2001

The health system is currently undergoing significant change being driven by the Ministry of Health and District Health Boards.

Taking its lead from the New Zealand Primary Health Care Strategy, MidCentral District Health Board developed a primary health care strategy to enable MidCentral District to work towards achieving a strong primary health care system. Referred services are a large and key part of the primary health care system; we must ensure referred services expenditure is optimal. Maximising the health outcomes from referred services expenditure will also assist in achieving the Board's goal *to have effective and efficient healthcare services.*

For MidCentral District Health Board to achieve its vision that *"the people of our district enjoy the best possible health and independence"* a number of planning pieces need to work together, in particular the Board's Strategic and Annual Plans and Primary Health Care Strategy, and this Referred Services Management Strategy.



The Strategy is the culmination of work by many people - a Technical Advisory Group, and health professionals in the primary health care and secondary care sectors. As part of developing the Strategy, the Board sought feedback from stakeholders on a discussion document that highlighted the issues surrounding referred services management, challenged thinking and illustrated the possible options going forward.

Issues in Referred Services

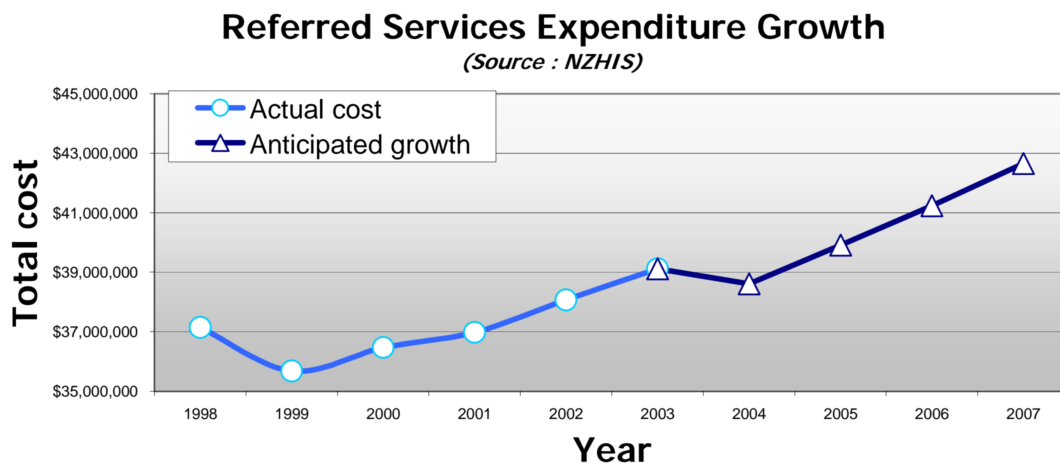
The current systems and processes for the provision of referred services have a number of issues that need to be addressed to increase efficacy in primary health care.

Quality focus

MidCentral District Health Board wants to focus on quality health outcomes. Although the Board is confident that providers in the MidCentral District have a good focus on quality, the current payment mechanism and incentives do not adequately focus on quality health outcomes.

Expenditure growth

Referred services pose a significant financial risk to the Board due to their uncapped, demand driven nature. Based on the current expenditure trends, the graph below shows that the anticipated savings due to the introduction of stat dispensing will result in negative growth in 2004, but after then a steady increase in the total cost of referred services is likely.



It is important to appreciate that there are a number of drivers for both appropriate and inappropriate growth. Appropriate drivers include: demographics, changing patterns of care, equity initiatives and proactive interventions. Inappropriate drivers include: defensive medicine practice, lack of information on best practice and costs, and inappropriate incentive models.

Variation in health outcomes

Analysis determined the extent to which District Health Boards are spending above or below their equitable level[1] on referred services. It was found that DHBs serving more disadvantaged populations are, in general, spending below budget while DHBs with more advantaged populations are spending above budget. This situation is leading to observable variations in health outcomes.

Population approach

The vision of the New Zealand Primary Health Care Strategy places a greater emphasis on population health and the advantages of funding based on population needs rather than fees for service. The current arrangements for funding primary health care are focused primarily on a fee-for-service basis. A report from the Office of the Auditor-General (2002) observed that these arrangements "fell well short of what is needed to ensure the provision of effective and efficient services."

Variability in prescribing and ordering

In developing the Referred Services Management Strategy, one of the objectives was to identify and contain inappropriate expenditure growth. A desired outcome of the budget management approach was to focus on General Practitioner prescribing and ordering to limit the amount of inappropriate prescribing and ordering.

The scatter diagram displays the variability in the MidCentral District. Each point on the diagram represents an individual General Practitioner's relative level of laboratory test ordering and pharmaceutical prescribing per consultation[2]. The correlation trend line indicates that there is a positive correlation between the cost of laboratory tests and the cost of pharmaceuticals dispensed.

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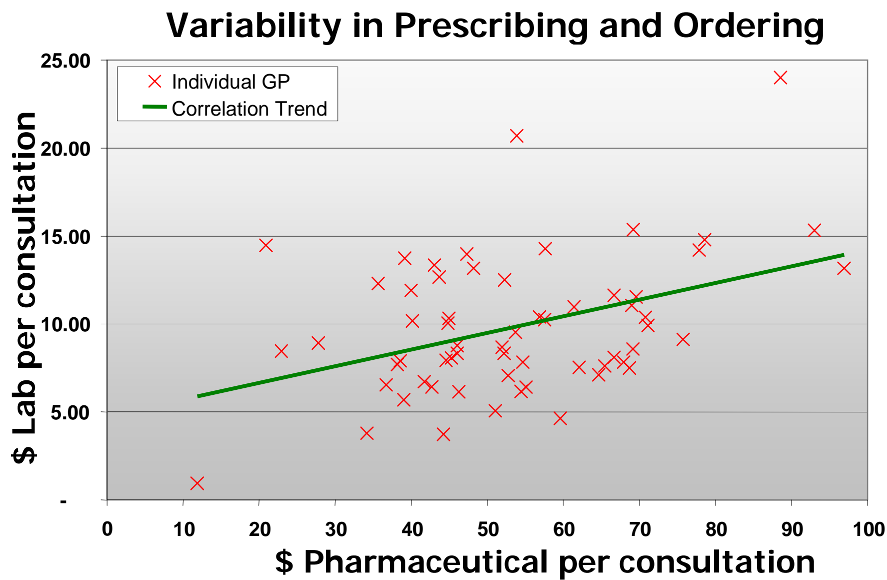
[1] Determined by a needs-based formula developed by Francis Sutton

[2] Source MIPA and NZHIS



A number of factors, including patient demographics, can explain a percentage of the variability although it is unlikely that all the variability can be explained by these factors.

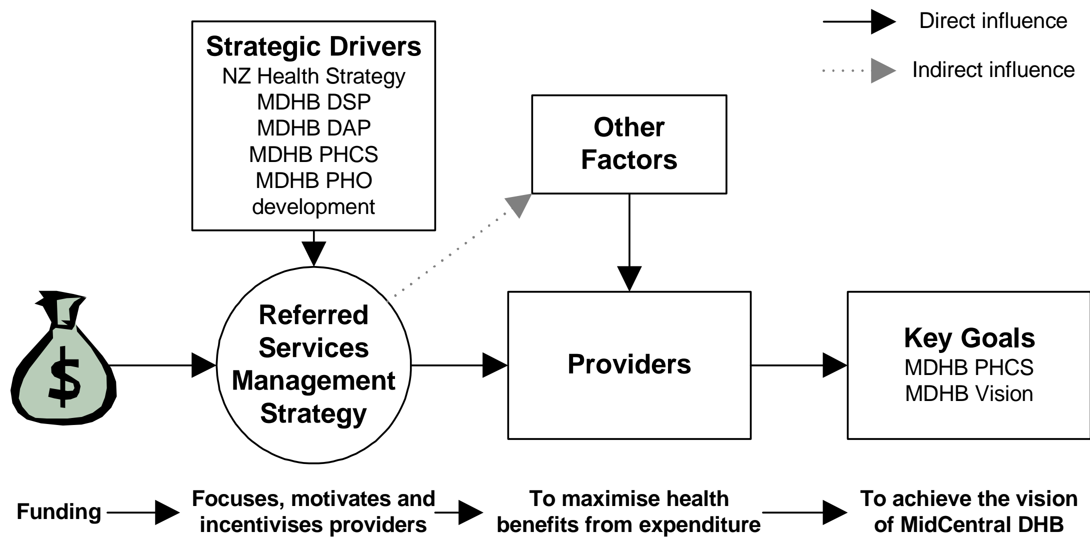
Budget management issues

The management of a notional budget under budget management or holding has been a key strategy for many District Health Boards. There are issues with budget management system, such as:

- Often the budget offers no realistic incentive
- Information quality issues
- Timeliness of budget setting and payments
- Payment for past interventions
- A lack of clarity over terms.

Referred Services Management Strategy Purpose

The Board determined that to contribute to the goal of effective and efficient healthcare services a Referred Services Management Funding and Re- investment Strategy was required. Working within existing resources, the strategy would focus, motivate and incentivise providers to maximise health benefits from referred services expenditure such that any efficiencies can be re-directed into additional services.

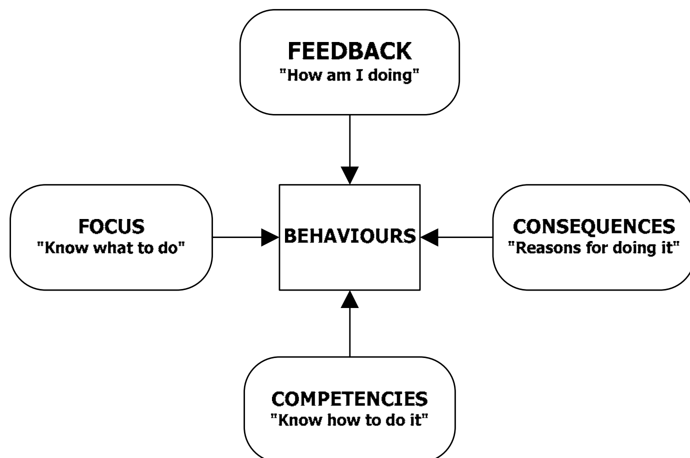


MDHB: MidCentral District Health Board

DSP: District Strategic Plan | DAP: District Annual Plan

PHCS: Primary Health Care Strategy | PHO: Primary Health Organisation

Funding is only one of the factors that influence the decisions made by providers. For example, the relative experience of a General Practitioner may have a large influence on prescribing patterns. The adjacent diagram displays the four key areas that influence behaviour; encompassing these will help create an holistic and effective strategy.



The Referred Services Management Strategy

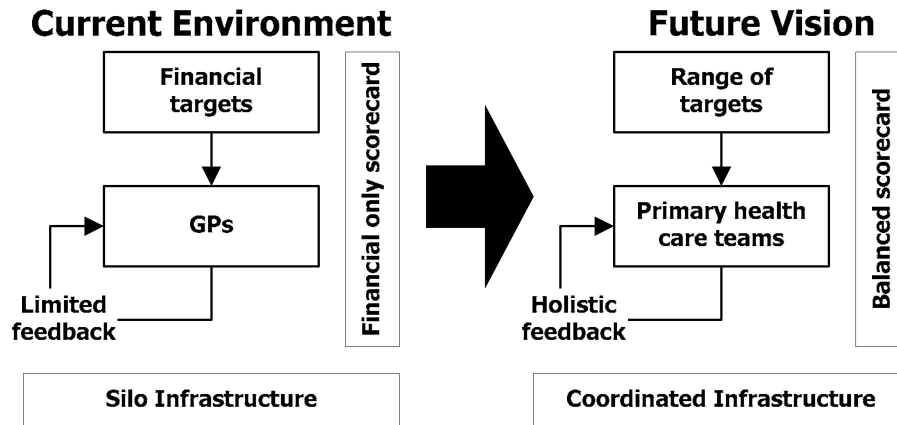
Over the next three to five years MidCentral District Health Board **will strive to achieve the following vision:**

> *The provision of referred services will be a shining example of our commitment to quality, our providers and our community. We will have confidence in the diagnostic ability of our services, utilised as best practice dictates. Our provision and use of pharmaceutical and pharmacy services will be second-to-none and the gains we have made will have been re-invested in proactive health protection of our community.*

The table below shows in high-level terms some of **the key differences between the majority of existing arrangements and those of the future vision:**

Old		New
Referred services as a series of uncoordinated contracts	➢	A co-ordinated approach to referred services
General practice focus	➢	Referred services management as a collaborative process
Financial performance rewarded	➢	Quality rewarded
Clinical governance as a maintenance function	➢	Clinical governance providing leadership
Information often unavailable or untimely	➢	Information when and where it is required
Fee for service/historical funding	➢	Needs based funding for population care
Radiology rationed by waiting lists	➢	Radiology prioritised on need
Limited feedback	➢	Holistic feedback

The diagram below depicts **the future vision for referred services contrasted with today's environment:**



The five key directions to achieve the vision are:

1. Establish a Clinical Governance Quality Council (CGQC)
2. Take a partnership approach to Referred Services Management
3. Focus on quality and removing inequalities
4. Continuously improve quality using quality information
5. Improve access to primary radiology.

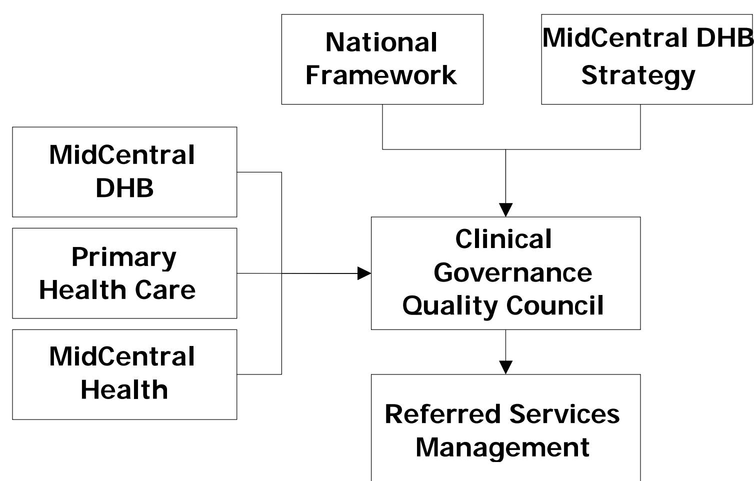
1 Establish a Clinical Governance Quality Council

The Clinical Governance Quality Council (CGQC) is a key aspect of this strategy. It is proposed that the Council will be a remunerated body consisting of a range of health professionals from the primary and secondary sectors and District Health Board. The Council will focus on referred services management in the primary health care setting and, in conjunction with its clinical governance role, will provide expert advice, guidance and monitoring.

Clinical governance

In relation to referred services management, clinical governance can be defined as:

> *Clinicians and managers leading and developing systems that result in improved clinical quality and safety in referred services management.*



Clinical governance includes:

- An integrated whole system strategy
- Clear lines of accountability and responsibility for quality of care
- A comprehensive programme of quality improvement initiatives

- Risk management policies
- Procedures to identify and remedy poor performance
- Strong leadership
- Cultural competency to address the needs of Maori and Pacific Peoples served.

A key aspect of clinical governance will be the utilisation review process. Reviews of literature suggest there is no one single effective method to support providers and that a multi-faceted approach will be the most successful. The national referred services project suggests nine activities should be included in a future referred services framework:

- A broadly based infrastructure
- Information systems, eg access to national utilisation data
- Peer review groups
- Implementation of national guidelines
- Personalised analysis feedback to members on utilisation
- Facilitator visits
- Bulletins to members on topics such as prescribing
- Incentives to encourage participation, eg Continuing Medical Education credits
- Electronic decision support.

MidCentral District Health Board recognises the immense value that personal relationships between facilitators and providers can add to this process.

Primary health organisations

The national referred services project noted that:

> *Primary Health Organisations will have the following referred services management function (either in-house or out-sourced) – a broadly based infrastructure including a clinical management committee.*

The Clinical Governance Quality Council fits well with the national approach and will provide a consistent approach to this area throughout MidCentral District.

Building capability

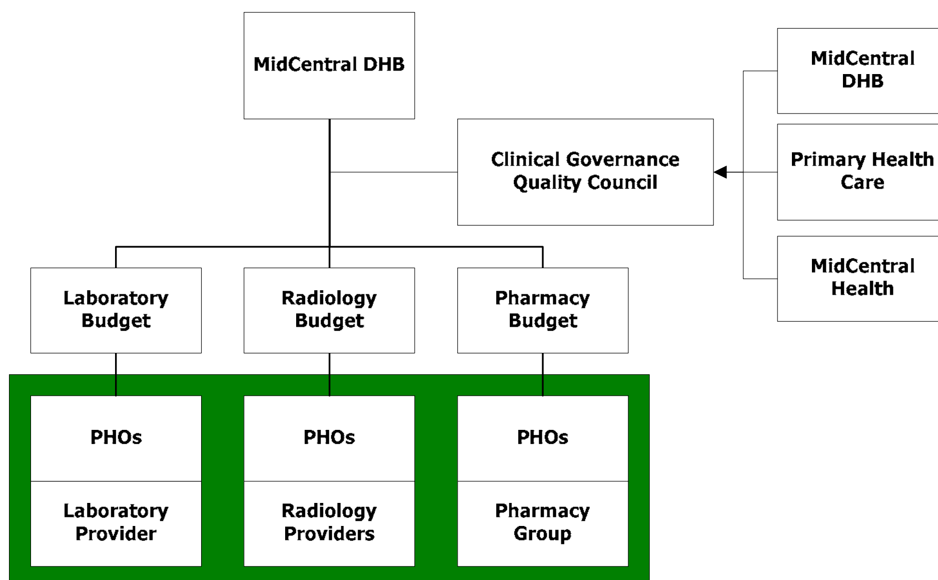
Over time there is potential to review the Council's scope and, as experience is gained and capability built, incorporate other areas such as:

- Assisting with review and prioritisation of new health initiatives
- Supporting coordination efforts between primary and secondary care
- The enhanced use of technology to support clinical practice.

2 Take a Partnership Approach to Referred Services Management

Traditionally the General Practitioner has been the focus of the majority of referred services initiatives. While it is recognised the General Practitioner plays the major part in prescribing and diagnostic ordering, the potential value able to be added by other health professionals has not yet been realised.

The partnership approach involves referred services management being performed by the parties directly involved in the referred services area, eg the laboratory budget managed in partnership with the General Practitioners and the laboratory provider.



The key features of this part of the strategy are:

- A partnership arrangement created for each referred services area
- General Practitioners (via a Primary Health Organisation or Independent Practice Association) involved in all referred service partnerships
- Quality focused targets and performance indicators to be used in conjunction with financial targets
- Savings to be invested in additional health related activities.

Expenditure Management

While the strategy is clearly focused on quality, maintaining the gains that have been achieved in cost containment is also an important part. Current budget focused schemes have led to improved management of pharmaceutical and diagnostic expenditure by focusing attention on quality and best practice.

Possible options for expenditure management include:

- Financial targets and performance indicators
- Budget management (notional budget holding)
- Budget holding (actual budget holding).

The national referred services framework, whilst still being finalised, is planning to move away from budgets based on historical utilisation to equity-based budgets based on the local population's health needs. This is congruent with the overall move to population based funding for District Health Boards. Future budget management or budget holding arrangements would be based on equity-based budgets.

3 Focus on Quality and Removing Inequalities

Traditional performance measurements focus on historical financial data and this is often insufficient to allow organisations to focus on what is important such as increasing quality, removing inequalities or improving population health indicators. Quality will be the driver of referred services management - that is, the best practice use of pharmaceuticals and diagnostic tests to improve health outcomes. To support this it is recognised the current financial monitoring measures need to be extended to incorporate other areas such as quality.

Performance indicators

Performance indicators will be created to identify and monitor key aspects in the referred services area. National indicators where appropriate will be used in conjunction with local indicators specifically developed to target areas in the MidCentral district.

The overall aims of the performance indicators are to:

- Encourage and reward improved referred services management utilisation in line with best practice
- Measure and reward progress in reducing health inequalities
- Promote the affordable use of resources.

Balanced scorecard[3]

An extension of the idea of a range of performance indicators is to use a “Balanced Scorecard” approach. This approach is consistent with the proposed national referred services framework which will be incorporating a balanced scorecard with measures covering the financial, clinical and process areas of referred services management. The actual measurements used for the MidCentral District will incorporate these three dimensions but also may cover other areas such as organisational health.

A key advantage of the balanced scorecard approach is the ability to set goals and targets based on the strategic direction and vision. Components in achieving the direction and vision can be targeted and monitored through the balanced scorecard. It

[3] See Appendix 2 for Balanced Scorecard Analogy

is recognised the accessibility and timeliness of data can create issues and these will need to be worked through to ensure the measurements used are the ones required.

Information requirements

The quality and timeliness of information in referred services have affected the efficacy of the system. The move to more varied performance indicators and ultimately a balanced scorecard will put even more pressure on the need for quality information. This aspect is dealt with in key direction number 4 - Continuously Improve Quality Using Quality Information.

4 Continuously Improve Quality Using Quality Information

The quality of information has caused many difficulties in referred services. Quality, robust and timely information are key ingredients in all aspects of this Referred Services Management Strategy.

In order to improve information quality and availability, the Board has commenced initiatives to address this area. Recent examples have been the Technology Best Practice Project and the current project to create an Information Strategic Systems Plan (ISSP). The ISSP is a district wide strategic plan that will help coordinate and guide expenditure in technology and infrastructure initiatives.

National and local focus

The issues with information have been known at a national level for some time. The current national referred services project has reiterated that quality information is essential to the effective running of referred service management, and proposes these issues be addressed through a central shared agency. The Board will keep in close touch with any national initiatives to address these issues.

In addition, the Board will look to facilitate initiatives to improve the quality and use of technology and information throughout MidCentral District.

Information management forum

A recommendation from the Technology Best Practice project was the establishment of an Information Management Forum (IMF) to create an overarching group focused on district-wide information and technology issues. The formation of this group would address the gaps that currently exist because information is stored in isolated systems. While there are organisations responsible for each individual system, there is no group active or responsible for the interface between these systems.

Some of the suggested roles this group could perform are:

- Promote an Information Management/Technology vision for MidCentral District in line with the ISSP Framework
- Support the implementation of the Referred Services Management Strategy
- Promote solutions for identified quick-wins

- Provide a forum for innovation and best practice
- Create a sense of urgency in regard to solving the issues
- Ensure a district wide view and approach is maintained
- Create an environment of mutual desire in the sector to achieve the vision
- Ensure quality thinking is applied to hard questions such as "is a single system possible?"

The IMF fits well with the goal of increasing collaboration between the primary and secondary sectors. The role and scope of the IMF also have a close fit with the role and scope of the Clinical Governance Quality Council.

5 Improve Access to Primary Radiology

Primary referred radiology services are a key component of the referred services management strategy. The ability of referrers to have access to radiology services for their patients based on need is important in the wider context of the New Zealand and MidCentral District Health Board primary health care strategies. The current rationing of radiology services based on waiting lists and a patient's ability to pay for private treatment are inconsistent with the goals of these strategies. However it is acknowledged that rationing is inevitable within a health care system that has limited funds.

A collaborative approach

It is recognised in the area of radiology there are critical interdependencies between primary and secondary health care and private radiology providers. To achieve the Referred Services Management Strategy goal, it will be important to understand these interdependencies and ensure any future plans to enhance access are not at the detriment of another service.

To this end, the Board plans to involve all stakeholders in the process of examining the service delivery options for primary referred radiology. Based on the findings of this process a plan for the provision of radiology services will be developed and implemented.

Implementing the Strategy

Implementing the referred services strategy will involve a period of change over the next three to five years. To ensure we build on the hard work that has already been expended in this area, the Board needs to ensure that it:

- Protects and build on the gains already made
- Maintains the collaborative process with the primary health care providers
- Understands that a stepwise approach to implementation may be necessary as other changes occur in primary health care.

The Board realises that primary health care is currently undergoing rapid change with the introduction of Primary Health Organisations and the Referred Services Management Strategy will be implemented with these changes in mind.

The following high-level Gantt chart details the logical steps that need to be taken to **commence** the implementation plan which is draft and will be finalised as other projects and processes are incorporated into the planning process. While it is acknowledged that buy-in to the change process needs to occur, the Board sees these changes as a key part of creating a strong primary health care system and will be creating the appropriate degree of urgency.

The MidCentral District Health Board is committed to achieving a strong primary health care environment with services targeted to the needs of the District's population. This strategy is a key piece in helping the Board achieve its overall goal that:

"the people of our district enjoy the best possible health and independence."

Conclusion

Our experiences working with the Technical Advisory Group demonstrated the great value able to be added when addressing issues with a multi-faceted team. The establishment of the Clinical Governance Quality Council will provide a solid vehicle for both understanding and tackling the issues that we have identified in the referred services area. The Council builds on the partnership approach, which is key not only to maximising health benefits in referred services, but also to tackling some of the wider macro issues around the co-ordination of services and information.

Considerable work will be needed to ensure the Strategy can be put into practice. Changes that are currently happening in the primary sector may mean that the implementation will need to be staged to ensure the steps can be completed with attention they require. It is important the focus is on the *effective* implementation of the strategy rather than the *speed* of implementation.

Appendix 1 – Technical Advisory Group

In order to commence the process of stakeholder involvement and buy-in, a Technical Advisory Group was formed to provide advice on the development of the referred services strategy in line with project objectives.

Members of the Group were:

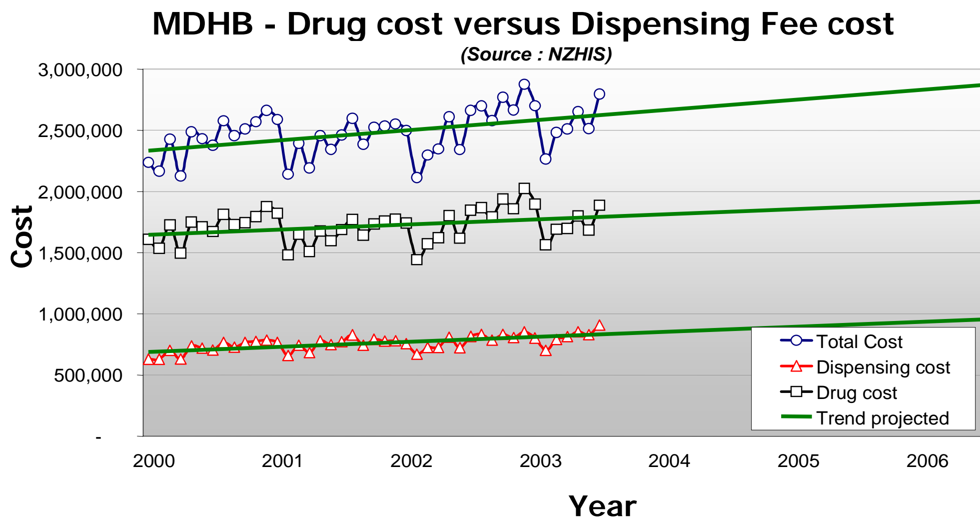
Alistair Whyte (Pharmacist, The Chemist Shop)
Clare Oliver (Pharmacist, Unichem Group)
Andrew Orange (Pharmacy Facilitator, MIPA)
Graham Jackson (General Manager, MIPA)
Dr Cynric Temple-Camp (CEO, Medlab Central Ltd)
Duncan Scott (General Manager, Broadway Radiology)
Lindsey Bates (Group Manager, MidCentral Health)
Dr Kevin Smidt (Clinical Director, MidCentral Health)
Dr John Goulden (Radiology Medical Head, MidCentral Health)
Dr Ralph Saxe (Medical Director, The Doctors)
Joanne Waayer (Practice Manager, The Doctors)
Mike Grant (General Manager, Funding Division, MidCentral DHB)
Rebecca Hanna (Performance Analyst, Funding Division, MidCentral DHB)
Roger McEwan (Project Manager, Funding Division, MidCentral DHB).

The Group proved to be an excellent forum for discussing the issues and possibilities in primary health care.

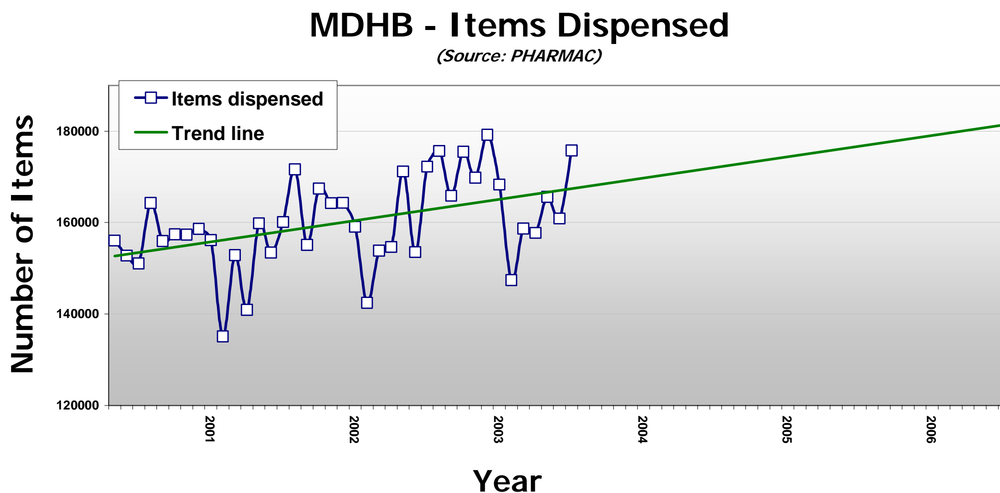
Appendix 2 – Referred Services Growth

PHARMACEUTICAL GROWTH

The following chart displays the historical pharmaceutical spend for the MidCentral District broken down into drug cost and cost of dispensing. Drug costs savings (by PHARMAC intervention) have been offset by the increase in volume and mix, and the result is a slight trend upwards of total drug cost. The cost of dispensing, which is a function of the increased volumes, is also trending upwards.



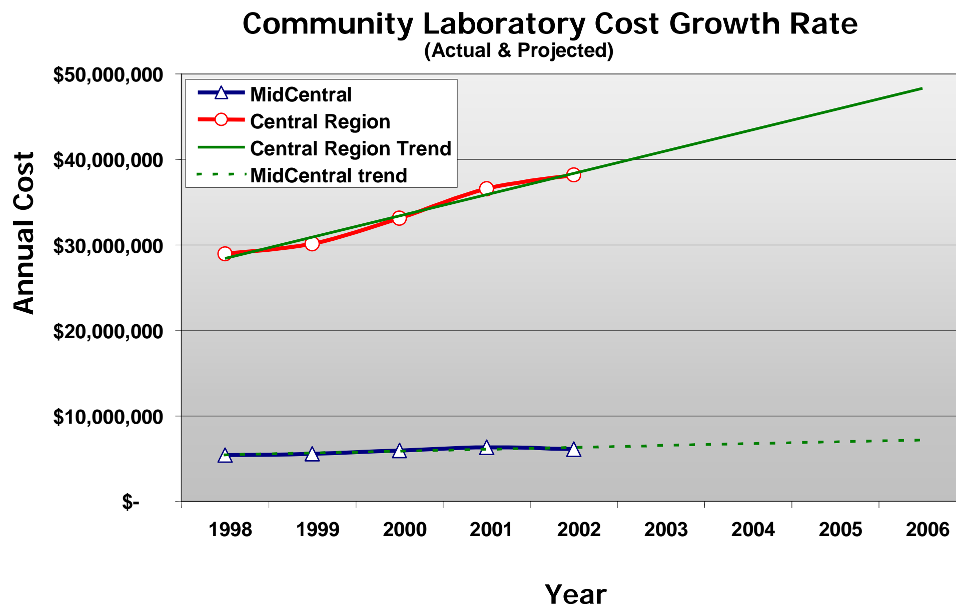
It is important to emphasise the key driver increasing the cost of pharmaceuticals is volume growth which affects both the drug cost and cost of dispensing. The dispensing fee paid per item dispensed has remained relatively unchanged during this period and PHARMAC interventions have reduced the cost of purchasing drugs therefore cost growth must be related to an increase in the volume of items being prescribed. A factor for which information is not currently available is the number of items prescribed but not dispensed which would both increase the items dispensed and the total cost.



LABORATORY GROWTH

The 2003 Review of Purchasing Options for Laboratory services noted the number of tests within the Central Region District Health Boards (DHBs) has achieved a compounded annual growth rate (CAGR) of 8% from 1998 to 2002. If this were projected at a similar rate to 2006, the number of tests would rise from 3 988 410 to 5 399 300. Under the current uncapped, fee-for-service arrangement this would equal greater cost without any benefits usually gained with economies of scale.

The MidCentral District volume and expenditure of community-referred laboratory tests compares very favourably with other District Health Boards. As shown in the table, the national CAGR was 7.4% compared to the Central Region DHBs at 8% and MidCentral, which experienced the lowest growth rate in the country, at 2.9%.



The relatively low volume growth has flowed through to reflect in the expenditure growth for the district. The CAGR for expenditure for the 1998 – 2002 period is 2.5% and this is displayed in chart below.

This information raises a key question: can we expect this rate of growth to continue or should we expect to see an increased growth rate similar to that experienced by other comparable DHBs?

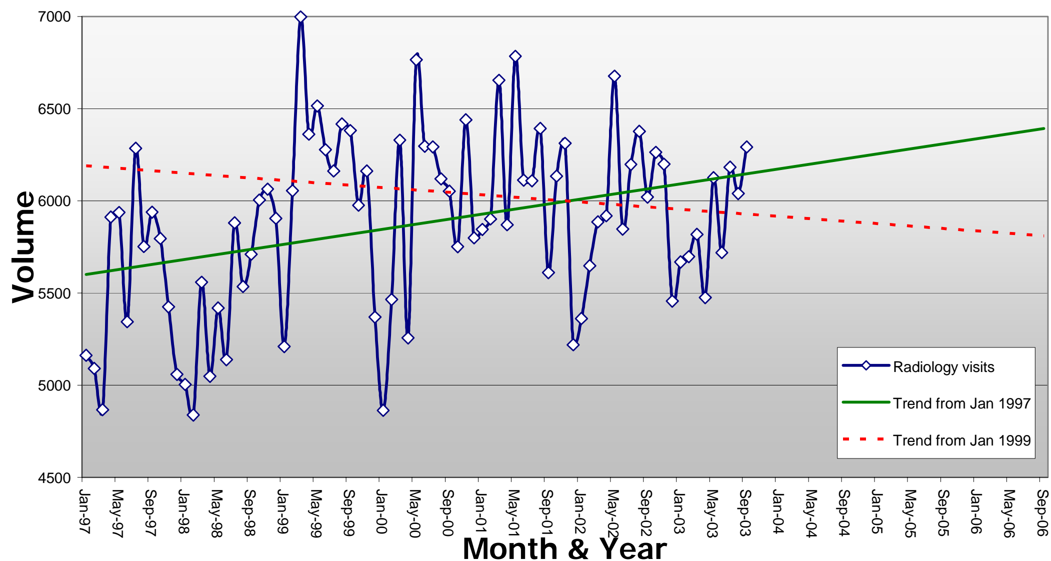
There are factors that indicate we can expect to see the current low growth rate continue. These are:

- The provision of community referred and hospital laboratory services from one provider means testing duplication is limited. The recent merger of the éclair and latte databases will continue to assist this process

- The focus on appropriate laboratory referring from MIPA, Tararua PHO and The Doctors
- The structure of the laboratory industry in MidCentral District and the arms-length relationship between General Practitioners and Medlab Central Ltd.

RADIOLOGY GROWTH

The trend of radiology tests within MidCentral District is somewhat more difficult to gauge. The chart displays the volume of community-referred radiology on a monthly basis. A trendline through the data from 1997 (solid trendline) shows a growth in volume. A trendline through the data from 1999 (dotted trendline) shows a decline in volume.



Complicating this analysis is the fact that there are waiting lists for a number of services and therefore true volume is difficult to gauge. The waiting lists at MidCentral Health as at 31 June 2004 are documented in the following table.

Procedure	Num	Wait time (weeks)	Num	Wait time (weeks)	Num	Wait time (weeks)
	30 Sept 2003		31 Jan 2004		31 Jun 2004	
Barium Meals	42	16	17	5	6	1
Barium Enemas	75	24	62	8	20	4
IVU	5	4	1	3	10	2
Digital Subtraction Angiography	20	2	15	3	24	4
Ultrasound general	237	12-14	282	12-14	521	24
Mammography Symptomatic	14	2-3	2	2-3	10	4
Mammography At Risk	38	4-6	24	12	11	6

Plain film, which accounts for 75% of procedures by volume, is done on a demand basis therefore there is no waiting list for plain film procedures. There is a delay, due to the staff shortages, in reading the films and reporting the results back to the requesting General Practitioner. Anecdotally this is on average a 1-2 week delay.

Community referred radiology is not paid on a fee-for-service basis but is primarily funded through a contract with MidCentral Health. Annually the Price:Volume schedule is set to determine the relative value units (RVUs) that will be purchased and the funding is a calculation of RVUs*Price. The price is set at a national level.

LATENT DEMAND

An important factor to consider when considering changes to the process for community referred radiology is latent demand. A discussion paper to the Board's Hospital Advisory Committee on the provision of radiology services noted "True demand is hard to capture as referral patterns change remarkably quickly in response to changes in availability. A case in point is the current temporary reduction in availability of fluoroscopy tests, the referral rates have dropped significantly, and will undoubtedly increase once the replacement unit is installed."

Also, the current practice when referring patients for radiology is to offer the patient the option of joining a hospital radiology waiting list at no cost to the patient or paying privately where they can be tested relatively quickly. The option for using a private provider is often preferred by General Practitioners due to the results being available sooner.

These two factors could see an increase in demand if the process for community referred radiology is altered.

Appendix 3 – Balanced Scorecard Analogy

The balanced scorecard approach has gained popularity in the commercial arena since its inception in the early 1990s. Traditional performance measurements focus on historical financial data and this is often insufficient to allow organisations to focus on what is really important such as quality or improving population health indicators.

The balanced scorecard concept can be difficult to grasp as it is often discussed at a technical level. A simple analogy using a cricket match is sometimes helpful to explain the effect the balanced scorecard is designed to have because cricket scoreboards are in fact balanced scorecards.

The purpose of a scoreboard is to give the cricket watcher ***an understanding of the current state of the match at a glance***. In cricket, the scoreboard has details such as: the current score, how many wickets have been lost, how many runs are needed to win, how many overs are left, and who is batting. These measures allow the cricket watcher to quickly understand the current state of the game they are watching.

On the scoreboard there are both historical and predicative measures. The number of runs scored details what has happened, but the number of wickets lost or overs to go gives us an indication of how many more runs are likely to be scored. So, not only does our scoreboard tell us the current state of the match it also gives us an insight into the future.

Imagine then if the scoreboard only focused on one aspect of the game - say batting (the analogy being of our current financial only view of referred services). Now the scoreboard would tell you who is batting and how many runs they had. It may even show the total, but without information such as the number of wickets and the runs required, the cricket watcher does not have a clue about the state of the match.

This is then what the Board want its referred services balanced scorecard to show. The Board wants to know - at a glance - what the current state of play is, how well it is doing against its key targets, and, importantly, how the Board is likely to be doing in the future.