Improving Programme Implementation through Embedded Research (iPIER)
Hospital performance contracting - improving implementation
Lebanon

Final Report

I. PART I: Reporting on the study outcomes

A. Section 1: Background on the context in which you are working

In November 2014 the Lebanese Ministry of Public Health (MoPH) implemented mixed-model performance contracting (PC) with hospitals, whose purpose is to reimburse hospitals based on their performance. This replaced the previous system which relied solely on accreditation (since 2001).

The previous system had functioned under the assumption that better equipped and higher accredited hospitals receive more complex (and thus costly) cases, and should be reimbursed at a higher rate. However, while accreditation likely contributed to healthcare quality, the link between accreditation and reimbursement was found to be not appropriate by research conducted at the MoPH (Ammar et al. 2013). Importantly, many hospitals were eager to include performance measures beyond accreditation.

Under the new contracting system, hospital performance will be measured every year and the results reflected in the reimbursement rate contracted hospitals receive from the MoPH. The current contracting score includes hospital case-mix index, patient satisfaction, intensive care unit case proportion, surgical case proportion, auditing deduction and accreditation. In the 2015-2016 contracting cycle it is anticipated that this will also include readmissions for specific conditions.

The MoPH covers hospitalization for all citizens with no formal insurance coverage, amounting to about 52% of the population, and 240,000 annual hospitalizations at 26 public and 105 private hospitals.

B. Section 2: What was the implementation challenge that you were trying to address with this research

1. What is the implementation barrier you were facing?

Concurrently with the evaluation of the previous system, the MoPH had been developing measures for performance contracting. In several public events during 2013-2014 the MoPH took the opportunity to share with hospitals the concept of performance contracting, as well as detailed methodology. Documentation was developed and shared through the Syndicate of Private Hospitals, who also hosted a stakeholders session on the new contracting system.

However during the two-month notice period after performance results were disseminated (August 2014) the MoPH received numerous visits and requests by hospital representatives seeking to understand how performance was measured and to share concerns. It became apparent that, with the exception of a handful, hospitals had a **weak understanding of performance contracting**, including the general concept and indicators used.

This represents an important barrier for the MoPH policy on performance contracting in Lebanon, as the support of hospitals for this initiative may waver. If this is left unaddressed,

in the long term this will affect the **commitment of hospitals** for performance contracting and possibly threaten the **sustainability** of this initiative by the MoPH.

2. What was your theory about the systems failure that caused the barrier?

From the outset there has been **limited participation** of hospitals in the development of performance contracting, followed by **weak engagement** of hospitals by the MoPH.

The MoPH **communication process** on performance contracting to hospitals using presentations at public events and subsequently disseminated documentation has allowed only limited opportunities for hospitals to provide feedback. Some hospitals were hesitant to address questions or share concerns at these events, however they were eager to do so in direct discussions with the MoPH during the notice period.

During these discussions it also became apparent that **different definitions** of terms and concepts such as 'case-mix', 'performance' and 'quality', both in the literature and among hospitals, has contributed to the weak understanding of this initiative. An additional factor contributing to this may be the **mixed evidence** in the literature regarding PC effectiveness in healthcare.

3. What was the research question and how did it relate to your theory about the system failure?

Our research question was: **How can the system processes for stakeholder engagement be strengthened to increase the buy-in of hospitals in performance contracting?**

Our research objectives were to:

a. Identify the **factors** that hindered the involvement of hospitals
b. Understand the **interaction/communication** among stakeholders
c. Understand how the lack of engagement influenced the **acceptability** of performance contracting
d. Assess the **alignment of definitions** among stakeholders regarding performance contracting
e. Identify the **mechanisms/options** that could be put in place to improve stakeholder engagement

a. Identify the **factors** that hindered the involvement of hospitals

We would like to identify such factors, whether at MoPH, syndicate or hospital level. In particular we would use these findings to increase hospital involvement by the performance contracting team at the MoPH, and facilitate sharing of annual results and regular developments in the PC initiative.

b. Understand the **interaction/communication** among stakeholders

Much of the communication held during the early stages involved MoPH and Syndicate representatives at the highest levels. We have limited insight into how much was communicated to hospitals by the Syndicate, and whether this was done in a timely manner. Understanding how such exchanges happened, and how it can be improved or formalized, would be very useful for increasing buy-in of hospitals.

c. Understand how the lack of engagement influenced the **acceptability** of performance contracting

One result of the limited involvement of hospitals was that there was a degree of doubt among some regarding the new contracting system and why they were not involved in its development. We would like to understand the perspective of hospitals and use this to develop a better approach for future engagement.

d. Assess the **alignment of definitions** among stakeholders regarding performance contracting

Though the literature provides varying definitions regarding certain concepts such as quality and performance, it is important that the MoPH, Syndicate and hospitals adopt a common understanding of these and other keywords. We will assess how hospitals and the Syndicate interpret such terms, and use this to inform future activities/documentation that will address any misalignment if definitions.

e. Identify the **mechanisms/options** that could be put in place to improve stakeholder engagement

We will map out the processes that were carried out and the contextual factors involved, and use this to understand the mechanism by which the performance contracting was initiated and offer the MoPH options for improving stakeholder engagement.

C. Section 3: What was the study design and what methods did you use to answer your research question?

1. What methods were used in the study?

Semi-structured interviews were held with senior managers at 8 hospitals in the Beirut and Mount Lebanon regions, and one unstructured interview was held with the president of the Syndicate of Private Hospitals.

2. What data were collected and analysed?

We used a qualitative content analysis conventional approach, whereby coding themes were directly derived from the text data. Two sources of data will be used in this research. These are: senior hospital management personnel (e.g. chief medical officer, chief accounting officer); and the president of the Syndicate of Private Hospitals. A discussion and brainstorming session was first be held with the MoPH team involved in performance contracting, to identify a list of themes/issues that are relevant to discuss with hospitals. This was then used to develop the question items for the semi-structured interviews with hospitals.

After initial contact by telephone with interviewees, and arrangement for interview time and date, we obtained informed consent from participants. Semi-structured interviews were conducted on site at each hospital. The interview questions used are listed below:

1. Can you describe the impact of the previous accreditation process for hospitals?
2. How do you see the relation between the Ministry of Public Health and hospitals today?
3. What do the following terms mean to you?
    a. Hospital Performance
    b. Quality
    c. Case-mix
    d. Patient satisfaction
4. Do you see the implementation of performance contracting last year as a positive or negative development?

5. Are there any factors/ challenges that you think may limit/face hospitals' involvement in the performance contracting process?
6. How do you think the communication and engagement between your hospital and the MoPH has been throughout the performance contracting process?
7. Can you describe the credibility of the current hospital contracting process?
8. Can patient outcomes be improved or not through performance contracting or other similar linkages to hospital reimbursement?

A similar exercise was conducted using unstructured interview format with the president of the Syndicate of Private Hospitals. This interview allowed us to probe with the Syndicate on similar issues as mentioned for hospitals, but also explore in greater detail implications regarding strategic development of performance contracting.

3. Who and how many people were included in the study?

A total of nine hospital managers were interviewed in this study, each in a different hospital. The head of the Syndicate of Private Hospitals was also the representative of his own hospital.

D. Section 4: Results & Interpretation

1. What were the outcomes of the analyses of the data?

All interviews were conducted in February 2016, with a median interview time of 1hr10minutes. Our analysis identified 19 primary themes and other minor themes, including performance, quality, methodology, patient satisfaction, communication/engagement, common language, local adaptation, credibility and public perception.

Accreditation	**Credibility**	**Methodology**	**Public perception**
Casemix	**Impact**	**MoPH as regulator**	**Quality**
Claims	**Interference**	**Other**	**Rates**
Common language	**Limitations**	**Patient satisfaction**	**Relations**
Communication /engagement	**Local adaptation**	**Performance**	**Transparency**

In more detail, the points elaborated on under some of the main themes are listed below.

Accreditation:

- *Positive development*
- *Improved understanding of quality*
- *One of the most successful MoPH projects*

- *Good progress for auditing and governance*
- *Successful but needs improvement*
- *No more 'bad' hospitals*
- *It had a great impact*
- *A tool to support hospitals*
- *Accreditation was good*
- *We had more support because of accreditation standards*
- *We could talk more with doctors about cases being admitted*
- *Positive, stimulating*
- *It had a good impact on quality*

Performance contracting:

- *Performance is linked to safety and care about the patient*
- *Performance should be linked to process and outcomes*
- *Performance is linked to safety, care quality, efficiency and staff knowledge*
- *Patient safety + outcome = performance*
- *Performance = complexity, deduction, ICU, surgical and medical proportions*
- *Performance: should be divided into departments of hospitals*
- *Performance should be on outcome: doctors, patients, nurses*
- *Efficiency-effectiveness-safety dimensions*
- *Local culture should be considered in standard setting*
- *Performance: fairness with patient and institution*
- *Efficiency*
- *Soft indicators of performance are ethics, availability and compassion*
- *PC should consider the % occupancy for MoPH in a hospital*
- *It was positive but it passed without a feeling (i.e. low-key)*
- *It is a positive development, but mal-implemented*
- *It is limping*
- *Change was beneficial to patients, overall very positive*
- *Overall for all hospitals it was serious and positive*
- *Hospitals saw it as financial issue*
- *Not understood by half of hospitals*
- *Performance is multidimensional*
- *I understand performance well, and agree with it*
- *Very scientific and good process*
- *Good scientific development*
- *Positive development*
- *Fair*
- *Performance contracting is better than accreditation, but needs to keep accreditation included*
- *It is a good process, and also did not affect reimbursement rates at our hospital*

Communication/engagement:

- *Will we need to invest more in this?*
- *Hospitals would like MoPH to visit/engage them more often*
- *Need broader spectrum of participants; financial, quality, medical, and administrative*
- *Broader engagement of hospital professionals at MoPH-hospital events, especially technical roles*
- *Communication between MoPH-hospitals was weak*
- *We were not involved in the project*
- *Only communication we received was to accept or not*
- *Need more communication between Hospitals and MOH*
- *More events or meetings*

- *As hospitals we do not completely understand our result in PC*
- *Consider having events inviting hospitals to discuss PC and understand the details*
- *Don't know, we had a good result, but need more involvement*
- *Need more seminars*
- *There should be seminars and conferences for any new implications and projects*
- *Need clear vision*
- *Need to know where to invest*
- *Need more information from MoPH on how to improve*
- *Need a simpler, clearer way to explain performance contracting process*
- *Deduction system is not clear*
- *Explain more details of methodology to hospitals*
- *Had to make a lot of effort to understand performance contracting*
- *Should be more detailed, but should be done*
- *Indicators should be more detailed*
- *Same-day surgery was misunderstood that it was not included*
- *Should use the term "Performance Indicators", not "Performance" alone*
- *Hospitals blamed the Syndicate of Hospitals of no openness regarding the performance contracting implementation*

2. What do these data tell you about the theory about the systems failure (section 1 part c) – does it confirm your theory or reject your theory?

The results obtained confirm to a large extent the theory about the systems failure hypothesized by this research.

We were able to confirm that hospitals did perceive a weak engagement in the performance contracting process by the MoPH, and coupled with the limited opportunities for interaction and weak communication further discouraged hospitals from being more active in the process. Although there was some level of coordination between the MoPH and the Syndicate of Private Hospitals, this was not sufficient to encourage increased engagement by hospitals. Ideas suggested by interviewees to help address this included having more seminars/meetings for both administrative and technical aspects, development/sharing a clear vision for hospital performance contracting by the MoPH, and defining/formalizing the communication channels between the MoPH and hospitals.

It was also confirmed that there was no common understanding of hospital performance, and the difference between this and healthcare quality. However interviewees shared what in their opinion are factors that should be included in evaluating hospital performance, and demonstrated an understanding of the concept of case-mix index. These findings underlined the importance of increased efforts for alignment of such definitions among stakeholders, including the dissemination of more detailed technical documentation and increased events for information-sharing.

After consideration of the above, the acceptability of performance contracting was strong among interviewees, and most still had a very favourable opinion regarding hospital performance contracting and the potential to improve patient outcomes, system efficiency, or both. Comparison with the previous accreditation process that began in 2001 was often used as an example of positive collaboration between the MoPH and hospitals, but this was subject to clear commitment and understanding of parties involved.

3. Based on your analysis, what is the new knowledge that you have generated about the implementation of your programme?

This research has helped us identify and understand the factors that limited hospital participation in the performance contracting process, the misalignment of definitions regarding hospital performance, the level of acceptability of performance contracting, the importance of effective interaction and communication among stakeholders, and the options/mechanisms that could be put in place to improve program implementation.

The primary change needed is to improve the engagement of hospitals through a comprehensive process, in addressing the issues of setting a representative committee, proper planning and organization, and follow-up.

E. Section 5: Conclusion

Hospitals have a strong support for performance contracting and its use as a general tool to set hospital reimbursement rates, however a wide variation was found for how hospital performance and quality were defined, and some differences on associating performance with patient satisfaction. The engagement and communication with hospitals by MoPH was weak, and some methodological details were not widely understood.

F. Section 6: Strategy for Implementation

1. **Identifying a stakeholder National PC Committee:**

First priority

- Develop terms of reference
- Identify participants
- Formalize official status of committee
- Host launching meeting
  Required for good representation of all hospitals; enhances sense of commitment and better compliance.

2. **Resources needed for implementation:**

High Priority

- Department of Projects and Programs at MoPH: additional personnel already existing in the department; recruit administrative assistant to support hospital engagement
- Department of Hospitals and contracts: 1 person working on this project
- Department of Statistics at MoPH: 1 person working on this project
  The team should be skilled and include credible people. Project should be institutionalized.

3. **Factors within the MoPH that need to be addressed/and political support:**

High Priority

- Decree signed by the Minister of Health whereby it sets an internal regulation and policy procedure making clear the role of the Ministry, the hospitals and the different human resources at MOH
- Revise MoPH-hospitals contracts to emphasize commitment and compliance needed on performance contracting

4. **Assessing the capacity of the hospitals to implement the required engagement:**

Medium Priority

- Improve their perception in buy-in the performance contracting process, by having more workshops and events
- Ensure that the hospitals have the appropriate implementation capacity: technical skills, logistics, alignment of definitions, etc.

- Develop and share documents detailing PC methodology, directly sent to hospitals by email and hosting on MOPH website.

5. **Monitoring and Evaluation**

Medium Priority

- Create indicators to tack the activities
- Use statistical analysis to monitor the impact and outcome

Action plan for implementation strategy – Lebanon Performance Contracting

Proposed Strategy	Key Implementation Steps	Key Players	Lead authorities	Timeline
Identifying a stakeholder National Performance Contracting Committee	- Develop terms of reference for committee - Identify participants - Formalize official status of committee - Host launching meeting	Syndicate of Private Hospitals, MoPH, Hospitals	MoPH leadership	June-August 2016
Resources needed for implementation	- Develop terms of reference for new recruitment - Recruit administrative assistant to support increased hospital engagement	MoPH	MoPH performance contracting team	May-July 2016
Factors within the MoPH that need to be addressed/and political support	- Develop and issue Ministerial decree setting internal regulation and policy regarding roles of MoPH and hospitals for the performance contracting process - Revise MoPH-hospitals contracts to emphasize commitment and compliance needed on performance contracting	Syndicate of Private Hospitals, MoPH	MoPH performance contracting team	September 2016 and December 2016
Assessing the capacity of the Hospitals to implement the required engagement	- Improve their perception in buy-in the performance contracting process, by having more workshops and events - Ensure that the hospitals have the appropriate implementation capacity: technical skills, logistics, alignment of definitions, etc. - Develop and share documents detailing PC methodology, directly sent to hospitals by email and hosting on MoPH website	Syndicate of Private Hospitals, MoPH, Hospitals	President of Syndicate of Private Hospitals, MoPH performance contracting team	July-December 2016

Monitoring and Evaluation	**- Create indicators to tack the activities** **- Use statistical analysis to monitor the impact and outcome**	**MoPH**	**MoPH performance contracting team**	**September 2016**

II. Part II: Reporting on the iPIER process

G. Section 1: Please describe how research findings helped inform changes in health policies and programs

The findings of this research have helped us identify how to improve the implementation of the hospital performance contracting program, in particular regarding the engagement of hospitals in this process. More specifically we have been able to identify and understand the factors that limited the participation of hospitals, how different definitions of hospital performance exist among stakeholders, and gauge the level of performance contracting acceptability, the importance of increased communication and interaction among them, and suggested ideas on activities and mechanisms to be considered for improving program implementation.

H. Section 2: Please describe the collaboration (positive and negative aspects) between the implementer (principal investigator) and the researcher(s)

The team involved in the implementation was that which is also involved in the implementation of performance contracting.

I. Section 3: Please describe the collaboration/support (positive and negative aspects) provided by Birzeit ICPH and EMRO?

The support and guidance received from both Birzeit ICPH and EMRO were valuable and very much appreciated by the research team. The regular communication with Birzeit ICPH was very helpful for ensuring some of the aspects of the research remained on track and to improve research quality, in particular regarding methodology, tool development and initial data analysis. We are thankful for their high professionalism and dedication. The workshops held by EMRO were extremely useful in increasing understanding regarding implementation research and formulating the research question and objectives. By nature of the grant setup the communication with EMRO was less regular than with Birzeit ICPH, but also very professional and helpful. One area for potential future improvement is to share implementation research material before the first workshop. More support in the contracting and reporting process would have also been helpful. We are thankful for both parties for the excellent support and guidance received, and the opportunity to conduct this research.

J. Section 4: What if any, challenges have you experienced during this period?

There were no major challenges to report regarding project implementation. The MoPH headquarters were moved to a new location in January 2016, which proved to be logistically challenging, and project personnel were more engaged with this process causing a delay in data collection from January to February 2016. One hospital had repeatedly re-scheduled interview time, as the senior manager identified was out of the country for several weeks. However due to data saturation being reached by previously interviewed hospitals, it was decided not to conduct this interview, which would otherwise have delayed completion of data collection beyond March 2016. It was also noted that some hospital managers sought to address issues with MoPH that were not related to performance contracting – discussion of these was conducted after the original interview and notes passed on to MoPH for follow-up.