Delivering value based health care: An introduction

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Dr James Mountford, Director of Clinical Quality, UCLPartners
Dr Emma Stanton, Beacon UK
Outline

- What is “value”, why can it be helpful to our current challenges, and whose job is it to deliver it
- Some factors which hold back progress
- Some practical tools
- The unique role of the FD/CFO, and things FDs can do to lead for value across the whole system, as well as their own organisations
We are living in a golden age of medical progress …

Decline in Deaths from Cardiovascular Disease in Relation to Scientific Advances

Source: Nabel & Braunwald E, NEJM 2012
... but is this enough to meet Edna’s needs?

Edna is 58 years old. She lives at home with her husband. She is a smoker. For several months she has been more breathlessness. GP started inhalers. The GP does spirometry, and diagnoses COPD. Recently Edna’s been to the GP more often; inhalers have been upped

Edna gets breathless one evening. She rings the on-call GP. The doctor sends her to hospital, where she stays for a week. She leaves hospital & has some questions (such as: “how do I use my new inhaler”). She makes an appointment to see her own GP

Edna’s GP knew nothing about the admission, changes to treatment or planned follow-up. But Edna & the GP have a useful conversation about inhaler technique. Edna agrees to go on a smoking cessation programme

Eventually, the letter arrives from the hospital with the management plan, including pulmonary rehab. Community services start the paperwork, and Edna waits to be called

The next evening, Edna gets breathless and anxious once again. She calls the on-call GP. A doctor she has never met advises her over the phone to go to hospital. She goes to the same hospital. They can’t find her notes ...

...how could we organise care to improve Edna’s Quality of Care (and Quality of Life…and save money?)

Note: Patient example, developed for illustration only
In USA, no obvious relationship between cost and quality at hospital level

Variation in hospital mortality and cost per patient (sample of US acute care hospitals)

Note: Data are based on 10 HCUP states. Mortality is a weighted composite of 10 risk-adjusted inpatient mortality rates. Cost adjusted for wage index, case mix, and severity of illness

SOURCE: Joanna Jiang, Ph.D.; Center for Delivery, Organization and Markets, AHRQ
Why are we getting stuck?

What, fundamentally, are we trying to accomplish?

- Clinicians and other stakeholders need shared overarching goal
- Otherwise, interactions devolve into gamesmanship. Each group tries to protect its interests

Additionally, unlike most industries, generally

- We don’t have clarity and consensus on what we are trying to accomplish
- We don’t have an overarching performance framework
- We don’t have data on outcomes that matter or on costs
- We are not organized into functional teams
- Organizations (and individuals) are not paid to improve value

Traditional concepts of quality focus on clinicians’ reliability in performing processes. A value framework focuses on patients’ outcomes, and motivates problem-solving, learning, and improvement through collaboration

Source: adapted from Tom Lee, Partners Health Care System, Boston
Value as the overarching, unifying goal

Outcomes
- Defined by patient from patient’s perspective
- Measured for patient’s condition over entire episode of care

Cost
- Resources used, NOT price
- Measured for patient’s condition over entire episode of care

VALUE FOR PATIENTS

Health Outcomes
- Cost of delivering those outcomes

“Improving value for patients may be the only thing that all key stakeholders can agree upon”

Tom Lee, CEO Partners Network, Boston

Source: adapted from Tom Lee, Partners Health Care System, Boston
An over-arching objective for everyone …

Our shared goal should be *improving value* as defined by the outcomes that matter to patients and costs over meaningful cycles of care

Source: Tom Lee, NEJM 2010
Maureen Bisognano’s “Four crucial questions” for leaders

1. Do you know how good you are?
2. Do you know where you stand relative to the best?
3. Do you know where the variation exists?
4. Do you know your rate of improvement over time?
Value = \frac{\text{Clinical Outcomes + PROMS + Patient Experience}}{\text{Cost to provide}}

Determine and measure the most important measures of quality …

… relevant to each patient pathway over the whole pathway of care
CREATING A VALUE-BASED SYSTEM

Value-based healthcare encompasses a number of reinforcing themes, the most important of which is outcomes measurement.

1. Organise into Integrated Practice Units (IPUs) Around Patient Medical Conditions
   - Organise primary and preventive care to serve distinct patient populations

2. Establish Universal Measurement of Outcomes and Cost for every patient

3. Move to Bundled Prices for Care Cycles

4. Integrate Care Delivery Across Separate Facilities

5. Expand Excellent IPUs Across Geography

6. Create an Enabling Information Technology Platform.
DEFINING A ‘MEDICAL CONDITION’

Value in healthcare is frequently created by concentrating on doing a few things well, not trying to do everything for all patient groups

• Healthcare providers that concentrate their effort and learn from experience in addressing a medical condition usually deliver the most value

• A medical condition should be designed from the patient’s perspective – i.e., designed around symptoms or common sets of needs, NOT necessarily diseases, diagnoses. And definitely not medical specialty

• It should encompass the set of illnesses or injuries that are best addressed with a dedicated and integrated care delivery process

• A value-based system is designed around patients’ medical condition needs, rather than the way clinicians do things.
MEASURING OUTCOMES AND COST FOR PATIENTS

What actually are outcomes? Process compliance alone leaves out crucial influences on value.

Source: Michael Porter, VBHCD Course 2012, Harvard Business School
Outcome Hierarchy:

Tier 1
Health Status Achieved or Retained

Survival

Tier 2
Process of Recovery

Degree of recovery / health

Time to recovery or return to normal activities

Disutility of care or treatment process (e.g., treatment-related discomfort, complications, adverse effects, diagnostic errors, treatment errors)

Tier 3
Sustainability of Health

Sustainability of recovery or health over time

Long-term consequences of therapy (e.g., care-induced illnesses)
## Measuring Quality across a whole pathway – stroke example

<table>
<thead>
<tr>
<th>Element of pathway</th>
<th>Whole-pathway outcome measure</th>
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| 1. Stroke education and public awareness                     | • Population awareness of risk factors  
• Population awareness of FAST                                                                       |
| 2. Primary prevention and population risk factors             | • Population incidence of stroke                                                                |
| 3. Stroke and TIA hospital admissions (acute management and treatment) | • Acute mortality  
• %discharges direct to home from (H)ASU  
• Readmissions                                                                                      |
| 4. Rehabilitation/ access to services/ PROMS/ Mortality       | • Functional status  
  • Return to pre-stroke life role  
  • SF36                                                                                               |
| 5. Follow-up/ secondary prevention and hospital readmissions  | • Secondary incidence  
• Population mortality                                                                                         |
| 6. Measurement of patient experience                          | • Was care well-connected?  
• Did you get understand care plan & have chance to make choices?                                            |

Clinical performance

It gives me great pleasure to introduce our clinical performance metrics.

Over the last two years we have been working with our clinical specialties to develop a set of metrics (measurements). There are three reasons for doing this. First, we believe it will act as an incentive to improve quality. Second, it will let patients and others to see how we are doing. And finally it will enable the trust board, through its clinical performance committee, to monitor performance.

During the next six months we will be publishing metrics for all our specialties. You can find the metrics by using the tabs on the left hand side of this page. If the metric you are interested is not yet available, you will be able to see when we plan to publish it.

At present there are three metrics for each specialty, but over time we aim to add to this. We will also replace metrics if we identify ones which would we believe are more appropriate.

If you wish, you can read about how we developed our metrics in more detail. We have also provided a short description of how the metrics are laid out.

I do hope you will find our metrics interesting and a useful way of evaluating the quality of our clinical services.

Professor Stephen Powis
Medical director

page last reviewed: 17 August 2012
Waste through different peoples’ eyes

Patient
- Unnecessary repetition (exams, histories, tests)
- Longer stays
- Avoidable complications
- Ever greater spending on healthcare

Nurse
- Time away from the bedside
- Searching for equipment
- Repetitive documenting
- Chasing down notes and results

Doctor
- Chasing down notes and results
- Time and unpredictability
  - Unable to start clinic or operations on time
  - Operating/procedure list over-runs

Finance director
- Continuous financial pressure, and need to make “cuts”
- Reduced autonomy and headroom
- Constant firefighting; fear of failure
If you have one long-term condition you likely have several.
1. Annual review
You should see your doctor or nurse at least once a year for a COPD review. During your review, you should be asked how well your medicines are helping with your symptoms and whether you have had any side effects.

2. Spirometry test
Your diagnosis of COPD should be confirmed by a post-bronchodilator spirometry, also known as a ‘blow-test’. This test checks how well your lungs work by measuring the amount of air you can blow out. This helps to decide upon the treatment your doctor should offer.

3. Stopping smoking
Giving up smoking and sticking to it is extremely important if you have COPD. Your doctor should encourage and help you to do this.

4. Inhaler technique
If you have an inhaler you should have been shown how to use it. The medicines you use depend on how severe your COPD is, how it is affecting your everyday life, and what side effects you may experience. You should only be given an inhaler once you’ve been shown how to use it and you are confident that you can use it properly. Your technique should be checked annually. If you need a refresher, please contact your surgery.

5. Pulmonary rehabilitation
Certain patients could benefit from a pulmonary rehabilitation course. It is a programme of care designed for your individual needs. During the twice weekly session, for 6-8 weeks, you work with a healthcare professional in your local area to help you to make the most of your physical abilities and to become as independent as possible.

6. Support with self-management
Contact your GP to talk about getting a self-management plan with a rescue pack. Sometimes your symptoms may become particularly severe. These are called “exacerbations or flare-ups”. You should be given advice about how to spot these early and prevent them from getting worse. You may be given a rescue pack to keep at home to help prevent exacerbations.

1. Book next appointment for April 2012.
- Last Review (10th April)

2. What is a spirometry test?
- It is when you take an inhaler to open up your airways, before taking a deep breath and blowing as hard as you can into a sensor.

3. Stopping smoking
- Have you tried stopping before but couldn’t? Your surgery should be the first point of contact for deciding which method of quitting would most help you. They can direct you to the appropriate service.

4. Inhaler technique
- You may consider:
  - Should you breathe out before use?
  - How hard should you be breathing in?
  - How long should you hold your breath?

5. Pulmonary rehabilitation
- What is a pulmonary rehabilitation programme?
  - Ask your GP if you are suitable for a pulmonary rehabilitation programme
  - If you are suitable your GP will refer you

6. Support with self-management
- What’s a rescue pack?
  - It contains antibiotics and steroid tablets so that you can start these as soon as possible when your COPD starts getting worse.
  - Bad breathing: Rescue pack
  - Talk with your GP
Bundled payments for whole pathways of care

Example: Hip & Knee replacement bundle in Stockholm

Components

| - Pre-op evaluation | - All doctor and other and staff fees |
| - Lab tests         | - 1 follow-up visit within 3 months |
| - Radiology         | - Any additional surgery to the joint within 2 years |
| - Surgery & related admissions | - If post-op infection requiring antibiotics occurs, guarantee extends to 5 years |
| - Prosthesis        |                                           |
| - Drugs             |                                           |
| - Inpatient rehab, up to 6 days |                                           |

- Applies to all relatively healthy patients (i.e. ASA scores of 1 or 2)
- Mandatory reporting of results by providers to the joint registry
- Provider participation is voluntary (but all providers are participating)

Current bundled tariff ~£5,000
"Value in any field must be defined around the customer, not the supplier. Value must also be measured by outputs, not inputs. Hence it is patient health results that matter, not the volume of services delivered. But results are achieved at some cost. Therefore the proper objective is the value of health care delivery, or the patient health outcomes relative to the total cost (inputs) of attaining those outcomes. Efficiency, then, is subsumed in the concept of value. So are other objectives like safety, which is one aspect of outcomes."
7 things FDs can do to lead on value for patient benefit

**Lead within your organisation**

1. Be a driving force for measurement of quality paired to resource use
2. Champion the quality dimension of CIPs (and shift to “VIPs”)
3. Show progress possible: Highlight waste; build and tell stories of successful value improvement
4. Build capacity for improvement (and get finance onto every QI team)

**Lead within your system**

5. Focus work to organise care better for the 1%/5% patients who drive 20%/50% of total system cost
6. Use your collective voice, e.g., changing payments to bundled pricing; be intolerant of low-value-add interventions

**Listen to the customer**

7. Let patients guide the solutions
Roy Lilly on value

“If you were a member of my own family I would be doing it like this.

If I were spending my own money I would be spending it like this.

If our roles were reversed, this how I would want to be treated”
Thank you

james.mountford@uclpartners.com
Emma.stanton@beaconhs.com