IDENTIFYING THE MOST PROMISING OPPORTUNITIES FOR VALUE-BASED HEALTHCARE

August 16, 2018 Design Day Strategic Outcomes Summary

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Prepared on behalf of the
Canadian Foundation for Healthcare Improvement

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Acknowledgements

This report was prepared by Jennifer Zelmer, PhD (formerly, President, Azimuth Health Group, now President and CEO of the Canadian Foundation for Healthcare Improvement, Twitter: @jenzelmer) for the Canadian Foundation for Healthcare Improvement (CFHI). The author thanks key informants for their insights on Canadian value-based healthcare initiatives, as well as external reviewers and CFHI staff for their insightful comments and helpful suggestions.

About the Canadian Foundation for Healthcare Improvement

The Canadian Foundation for Healthcare Improvement (CFHI) is a not-for-profit organization funded by Health Canada. CFHI identifies proven healthcare innovations and accelerates their spread across Canada by helping organizations adapt, implement and measure solutions that improve the patient experience and healthcare outcomes. We unleash innovations that have been co-designed with patients and families and work shoulder-to-shoulder with organizations, system leaders, providers, patients, families and Indigenous communities to improve healthcare for all Canadians. Based in Ottawa with a staff of more than 65 people, CFHI creates collaboratives to spread evidence-informed improvement.

The views expressed herein do not necessarily represent the views of Health Canada.

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DESIGN DAY OVERVIEW

On August 16, 2018 CFHI hosted a Design Day bringing together a diverse group of people with experience related to value-based healthcare.

Through a co-design process, the 25 participants shared learnings regarding identifying promising opportunities for value-based healthcare (VBHC) in Canada's health sector. Their insights will be used to inform development of a screening tool to assist with review of potential opportunities.

Discussions focused on:

- Key success factors for VBHC initiatives
- Minimum specifications for identifying promising VBHC initiatives in a Canadian context
- Identifying leading opportunities for capacity-building to support VBHC and for implementation of this approach
- Advice to CFHI regarding how to advance VBHC efforts
- Next steps for participants in furthering the outcomes of the Design Day discussions

Participants

Design Day participants came from six jurisdictions and brought a wide range of perspectives.

- **Owen Adams** – Canadian Medical Association
- **David Barrett** – Ivey International Centre for Health Innovation
- **Shahira Bhimani** – MaRS EXCITE
- **Gavin Brown** – Health Canada
- **Lauren Bell & Dov Klein** – Plexxus
- **Jenny Buckley, Bill Callery & Maria Judd** – CFHI
- **Anderson Chuck** – Alberta Health Services
- **Neil Fraser & Jason Vanderheyden** – Medtronic Canada
- **Alan Forster** – The Ottawa Hospital
- **Fred Horne** – Horne & Associates
- **Hameed Khan** – Institute for Reconstructive Sciences in Medicine, University of Alberta
- **Paul L'Archevêque** – Ministry of Health and Social Services, Quebec
- **Brian Lewis** – MEDEC
- **Kathleen Morris** – Canadian Institute for Health Information
- **Tammy Clifford** – Canadian Agency for Drugs and Technologies in Health
- **Erik Sande** – Medavie Health Services
- **Adriana Milito** – Ministry of Health and Long-Term Care, Ontario
- **Gabriel Seidman** – Boston Consulting Group
- **Heather Sherrard** – University of Ottawa Heart Institute
- **John Sproule** – Institute of Health Economics
- **Jason Sutherland** – University of British Columbia

Facilitator

- **Jennifer Zelmer** – formerly, President, Azimuth Health Group, now President and CEO of CFHI

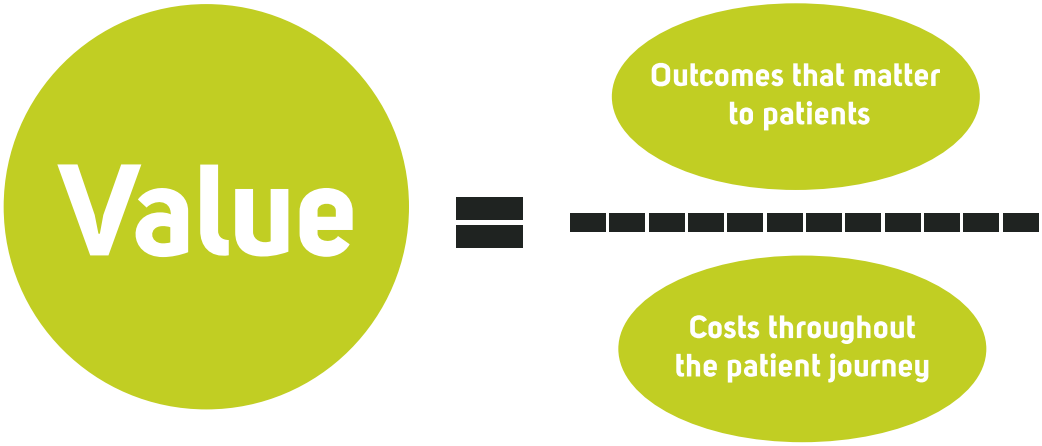
OVERVIEW OF VALUE-BASED HEALTHCARE

WHAT IS VALUE-BASED HEALTHCARE?

Participants noted that the concept of VBHC builds on decades of work in areas such as cost-effectiveness, outcomes measurement, patient preferences and adoption of innovations.[1]

For the purposes of the meeting, they noted that, while there are various ways of defining value,[2] at its core VBHC is about linking dollars spent to outcomes that matter to patients, rather than to volumes of services or to specific processes or products that may or may not achieve those outcomes.[3]

This conceptualization of VBHC focuses on goals that align with the intrinsic motivation of key stakeholders and can extend to embrace the interests of citizens broadly, not just particular groups of patients.



What works best for whom in different contexts varies and may evolve over time. As a result, VBHC aims to avoid over-specifying how outcomes will be achieved.

"Value-based healthcare is a genuinely patient-centric way to design and manage health systems. Compared to what health systems currently provide, it has the potential to deliver substantially improved health outcomes at significantly lower cost."

World Economic Forum[6]

WHAT VBHC IS NOT

The focus of VBHC is not cost-containment.

Both overuse and underuse can affect value. Rather, the aim is to encourage services that deliver high value, scale back or drop those that do not, and/or re-balance the mix of services to improve the ratio of outcomes to overall costs. Better outcomes at the same or lower total cost is the goal.[2]

Equally, evidence-informed practice can facilitate more appropriate care and improved outcomes, but it is not the ultimate goal of VBHC.

Providers should and will use evidence regarding the effectiveness of interventions to design and continuously adapt models of care to optimize value. However, VBHC is not the same as pay-for-performance models that reward delivery of specific care processes, e.g. prescribing of medications recommended in clinical guidelines. Such approaches have had mixed results.[4] Design features and context appear to have a strong influence on both direct results and broader effects on health sector governance and strategic purchasing. Neither is it only focused on comparative performance measurement.

VBHC also does not reward cost reductions in isolation.

Instead, it targets improvement in outcomes experienced by patients relative to resources used. Specific operational improvements may – or may not – deliver value for patients in this context. In some cases, this increased value may come from options outside the health sector that improve health outcomes, not just services offered by traditional healthcare providers.[5] How we learn, live, work and play can all affect our health. Value-based care can also include a broader focus with interventions addressing the social determinants of health.

VBHC focuses on the whole, not the parts.

It does not aim to optimize individual components of an episode of care in isolation. Rather, it seeks to understand and promote improvement in outcomes and costs that span an episode of care or population group, not just those delivered by a specific healthcare provider or at a particular time. Any targeted improvements must contribute to this overall goal, which often cuts across organizational and budgetary boundaries.

EXAMPLES OF VBHC IN CANADA

Canadian VBHC initiatives are diverse. They cover a range of health services, use a variety of funding and procurement models, and are at varying stages of implementation.

Building on a model for accountable care units originally developed at Emory University, **health regions in Saskatchewan are transforming the model of care on inpatient medical units.** Target outcomes include improved clinical outcomes, patient flow, patient satisfaction, and staff satisfaction, retention, and recruitment.	From acquisition of medical devices to renovation and replacement of a hospital's biochemistry and hematology lab technology, value-based procurement has been used in a variety of contexts in Canada. For instance, under the terms of a provincial procurement for cardiac devices, **if a device had to be replaced before seven years, the supplier had to pay the cost of the replacement surgery.**
New Brunswick's 'Primary Health-Care Integration Initiative' aims to i**mprove coordination and collaboration among several types of services provided outside of hospitals, including ambulance services and home care** (extra-mural program). Payment under a 10-year $74 million incentive-based contract depends on results for indicators such as increased homecare visits and reduced emergency department visits by homecare patients.	Ontario has introduced **bundled payment models to align incentives for integrated care** in areas such as hip and knee replacement surgery, dialysis care, and selected chronic diseases. Early adopters, such as St. Joseph's Health System, have shown improved patient experience and outcomes, more satisfied providers and engaged teams, and overall cost savings.
Open innovation challenges specify a desired outcome and reward innovators who best meet it, rather than selecting those who will be supported in advance and specifying how a goal is to be achieved. The ImagineNation Challenges targeted innovations to improve the **quality of care and the patient experience with emerging digital solutions.**	Varying approaches to **outcome-linked financing** have also been introduced. For instance, with partners in five provinces, Canada Health Infoway co-invested using an outcome-linked model in improving chronic disease management with telehomecare. Likewise, the Heart and Stroke Foundation and its partners aim to incent improved blood pressure control using a "pay for success" social impact bond investment model.

IDENTIFYING PROMISING INTERVENTIONS

DESIGN DAY STARTING POINTS

In addition to a background executive brief on VBHC, there were two main starting points for Design Day deliberations.

Health system leaders, healthcare providers, patient organizations, governments, industry and other stakeholders gathered in March 2018 to share experiences and perspectives with respect to developing and implementing VBHC at a VBHC Summit.

Summit participants highlighted a number of factors that could be helpful in identifying promising potential VBHC initiatives and assessing readiness (see page 12).

In addition, Design Day participants began the day with a structured brainstorming exercise to identify key success factors for VBHC initiatives and potential early steps (see pages 13-14).

VBHC SUMMIT: LEARNING FROM EARLY ADOPTERS

Context matters

Discussions at the Summit made it clear that there are many paths to VBHC. Context matters, and delivering real results requires teamwork and heavy-lifting. In a learning health system, continuous improvement means on-going efforts to deliver more value and to reduce and/or eliminate that which does not generate value.

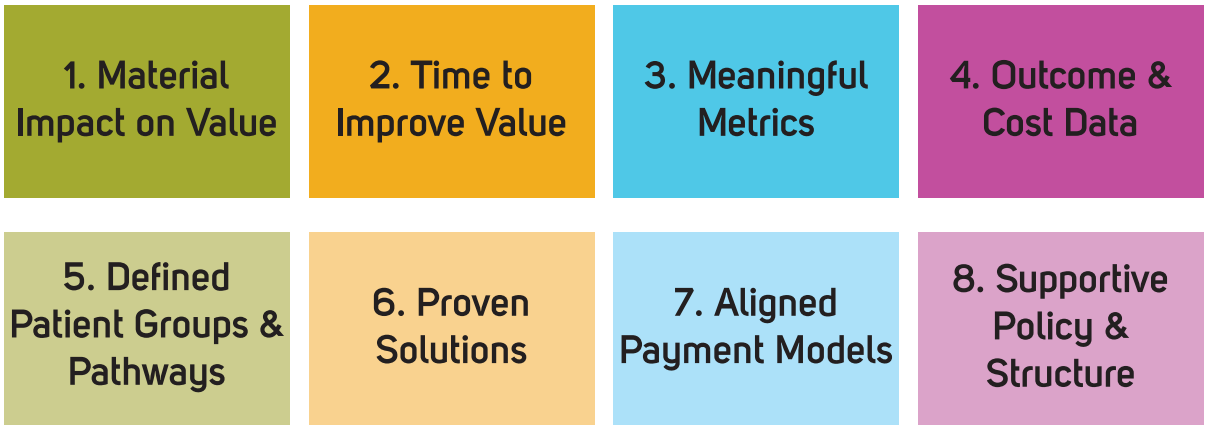
Various initiatives have incorporated novel approaches to financing and procurement, risk/gain sharing, data and measurement enhancements including patient-reported experience and outcome measures, and other innovations.

> **Many speakers at the Summit urged those interested in improving value to 'just do it,' getting started and evolving based on on-going learnings.**

To this end, several suggested pathways to refine care delivery. Others offered complementary suggestions for pragmatic approaches to identify promising opportunities to apply VBHC. Experiences of early adopters confirm the promise and potential of the approach, as well as the need for thoughtful implementation.

What could help to identify promising potential initiatives and how to assess readiness?

Reflections from the Value-Based Healthcare Summit.



BRAINSTORMING KEY SUCCESS FACTORS

Design Day participants worked through a structured exercise to identify key success factors for VBHC (in no particular order):

- System-level commitment that enables defined risk/accountability mechanisms that align incentives and rewards
- Clear population/scope for VBHC initiative, e.g. who is included and who is not
- Follow change management good practices
- Appropriate clinical leadership
- Recognize that VBHC approaches are only one element required for transformational change
- Bridge health (and sometimes social) system silos
- Plan for and develop skills to scale initiatives once proven
- Keep it simple (don't overcomplicate)
- Ensure improving outcomes for the defined population is the central motivator
- Seek alignment of workflows and stakeholders
- Take current policy agendas into account
- Ensure a balance of ground up and top down innovation and drivers
- Consult and include key stakeholders, recognizing the many bright, committed, and powerful people in the health sector
- Reinforce intrinsic motivation to improve health and healthcare

FIRST STEPS TO VBHC: IDEAS FROM DESIGN DAY

Design Day participants brainstormed initial steps that would accelerate VBHC initiatives and their value. Participants were specifically asked to consider what we could/should stop doing.

- Stop pursuing perfect cost/outcomes data. Where possible repurpose existing data/structures.
- Stop pursuing conceptual perfection.
- Stop/decrease funding of pilot projects. Instead consider paths to scale.
- Stop excluding other industries. Seek their lessons learned.
- Work together earlier, particularly with patients.
- Strengthen value-based procurement capacity.
- Identify priority problems to solve.

"Stop writing reports and do it!"

MINIMUM VBHC CRITERIA

What are the minimum criteria for identifying promising VBHC initiatives in a Canadian context?

Design Day participants were then invited to vote on the most important criteria to identify promising VBHC initiatives in a Canadian context, e.g. to assess the relative potential and risk of different initiatives.

VALIDATING THE RESULTS

To test the validity of initial results, an empathy mapping exercise was undertaken to ensure that the perspectives of several key stakeholders were considered.

ANA

Lives with several chronic conditions and has high healthcare needs.

JIM

Health region CEO facing tight budgets and growing demand for services.

VEENA

Start-up CEO. Has a cardiac innovation that they wish to market based on the value that accrues to the health system.

JOHN

Senior leader in the Ministry of Health, with responsibility for funding for a range of health services.

JASON

Endocrinologist with diverse specialty practice.

Questions posed:

- What would be different for this person if the criteria were used broadly?
- What would be changed/improved?
- What would be worse?

VOTING RESULTS: MINIMUM VBHC CRITERIA

Criteria for identifying promising VBHC initiatives in a Canadian context.

Participants indicated that a given criteria was important to consider by "up voting" it, indicated that a criteria was a lower priority by "down voting", or remained neutral.

Response	Up Votes	Down Votes	Net Votes
Meaningful metrics	22	1	21
Outcome and cost data	22	1	21
Defined patient groups and pathways	19	1	18
Material impact on value	15	6	9
Clinical leadership	8	1	7
Clear description of issue trying to address	8	1	7
Dedicated resources ($ and people) assigned to initiative	9	2	7
Permeability between silos	11	4	7
Supportive policy and structures	12	5	7
Aligned payment models	13	6	7
Availability or opportunity to build capacity/skill to undertake VBHC	5	1	4
Build VBP capacity skill set in BPS health sector (system process)	4	1	3
Proven solutions	8	9	-1
Time to improve value	6	11	-5

Interpreting the Criteria

Following voting, Design Day participants discussed the interpretation of the top-rated criteria. They also reviewed descriptions of markers of low, medium, and higher risk. In doing so, they noted that the intention was that these markers would provide information to decision-makers, not that a higher risk rating for a particular category would automatically disqualify a potential initiative or that all criteria ought to be pursued. Sometimes focusing on select criteria is the only way to begin the journey to VBHC. In addition, the criteria should not be interpreted to be in competition with each other, and should not necessarily be pursued to perfection but need to be purpose fit, all while leveraging the existing system.

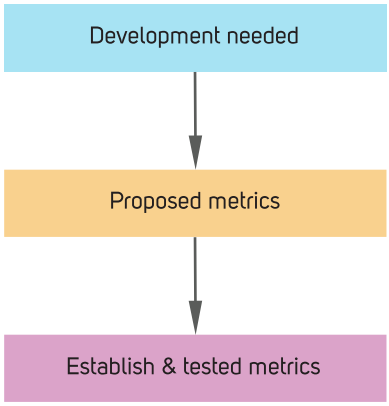
Outcomes of the discussion are shown on the following pages.

IDENTIFYING PROMISING POTENTIAL INITIATIVES AND ASSESSING READINESS: TOP 4 FACTORS

Reflections from Design Day

1 Meaningful Metrics

WHAT WOULD THIS LOOK LIKE?



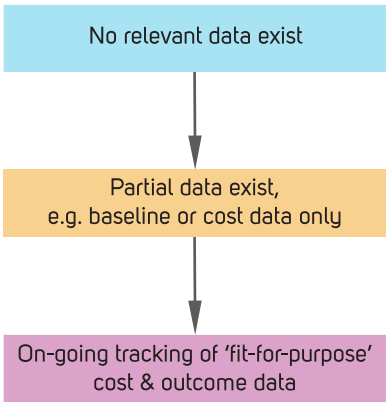
Clearly defined metrics of value, including both costs and outcomes. May include leading and lagging outcomes, as well as balancing measures.

Ideally, metrics will have validated psychometric properties, be able to capture improvement, have been tested through prior use, and be harmonized with those used by others, e.g. via national or international standards.

This does not mean that metrics have to be 'perfect' on all dimensions, but rather 'fit-for-purpose' for the VBHC initiative in question.

2 Outcome & Cost Data

WHAT WOULD THIS LOOK LIKE?



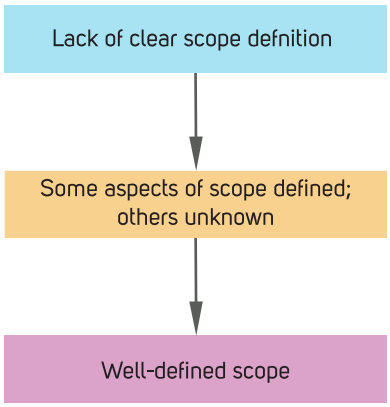
Fit-for-purpose outcome and cost data are both important for VBHC initiatives.

Ideally, the data would be patient-based, captured at a level that aligns well with the scope (e.g. patient characteristics or geography) of the specific VBHC initiative, and be of suitable quality and timeliness.

Where possible, it is preferable to leverage existing data systems to align with broader quality improvement efforts and minimize respondent burden.

3 Clear Scope

WHAT WOULD THIS LOOK LIKE?

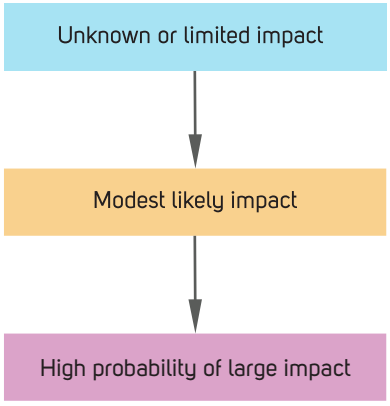


Clarity of scope matters in VBHC initiatives. Considerations include clearly-defined target populations (with sufficient scale and homogeneity to demonstrate value) and sufficient information about care pathways for the defined scope to shape and evaluate improvement efforts, e.g. across healthcare settings as well as social services settings.

Design Day participants noted that time can be a factor in scope definition, e.g. particular individuals may move into or out of the target scope over time, if they move or if their health status changes.

4 Material Impact

WHAT WOULD THIS LOOK LIKE?



Design Day participants suggested that it was important to consider up front the probability of a VBHC initiative influencing value and the potential magnitude of gains in value.

They noted that it is important to consider to whom value is likely to accrue (including those investing in the change) and to ensure that the assessment of potential change in value is aligned with the scope of the VBHC initiative.

IDENTIFYING PROMISING POTENTIAL INITIATIVES AND ASSESSING READINESS: OTHER FACTORS

Reflections from Design Day

FACTOR	5. Clinical Leadership	6. Dedicated Resources, e.g. $, people	7. Permeability Between Silos	8. Supportive Policy & Structures
WHAT WOULD THIS LOOK LIKE?	Not identified	Sufficient resources not confirmed	Existing silos create barriers	Barriers outside team's authority to influence
	Potential champion identified	Short-term resources in place	Plan for addressing silos	Workarounds possible
	Active clinical leadership in place	Sustainable resources identified	Health system well-aligned for VBHC scope	Well-aligned policy & structures

FACTOR	9. Aligned Payment Models	10. Capacity/Skill for VBHC	11. Proven Solutions*	12. Time to Achieve Value
WHAT WOULD THIS LOOK LIKE?	Existing models create barriers	Limited or no capacity/experience	Mechanisms to grow value unclear	Extended or unknown period
	Workable or one-time payment models	Plan to secure capacity/skills	Proven solutions	Value gains will only come in longer term
	Well-aligned models	Required capacity & skills in place	Solutions proven in similar context	Value can be achieved soon & sustained

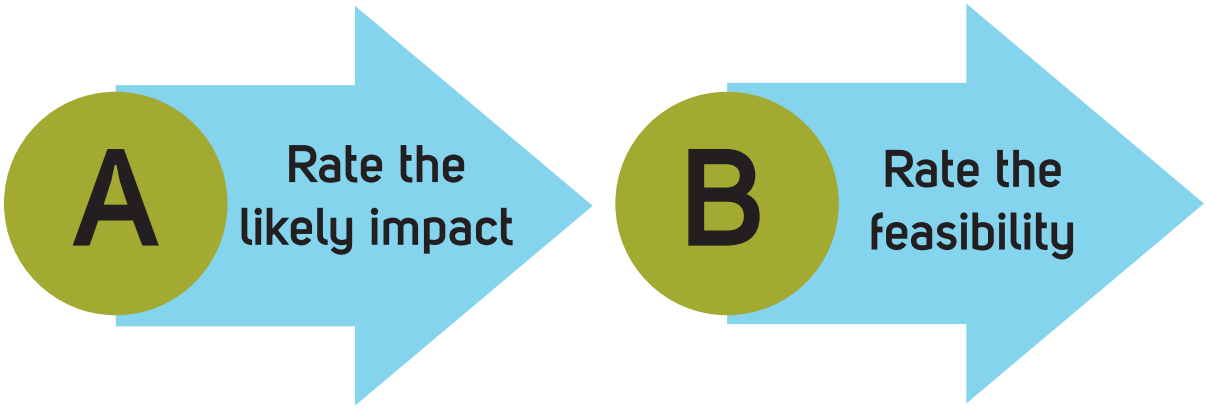
* May include both investment and disinvestment solutions

WHERE'S THE VALUE

WHAT'S NEXT?

Top enablers of VBHC and opportunities to improve value in Canada's health sector

Participants were asked to identify the largest opportunities from their perspectives, as well as the first step that would move us in this direction. Ideas were then circulated for group voting using the scale below.



1 = Not my cup of tea
5 = Could solve everything

1 = Not in my lifetime
5 = Ready, willing, able

LEADING IDEAS TO ENABLE VBHC IN CANADA

The list below includes ideas that received an average rating of at least 4/5 (based on ratings by 5 participants) on impact, feasibility, or both.

- Trusted source of outcome/cost data
- Moving physicians from independent contractor status to become employees of the system, which would include a change in compensation structure
- Align objectives of patients/clinical/system outcomes in a meaningful language for decision-makers
- Systems approach/integrated care
- Align incentives to deliver VBHC, beginning with eliminating fee-for-service payment
- Integrated budgets across the continuum of care
- Begin to measure patient outcomes
- Harmonize outcomes measurement and transparency around reporting
- Align payment models to follow patients across care sectors, reducing the impact of siloed budgets
- Establish common outcome measures in priority/high-demand areas, begin by reviewing and adopting established measures (e.g. ICHOM)
- Start by implementing VBHC in orthopedics, building on global experience
- Build capacity/skill to create VBHC knowledge as a foundation for future healthcare decisions
- Integrate value-based funding around chronic disease management (e.g. INSPIRED approach to COPD care)
- Type 2 diabetes, e.g. transition to bundled payment
- Enhance home and community care to delay/prevent admission to longterm care, including shared budgets/ management in one region
- Shift significant resources from acute to community care, building a granular understanding of VBHC for chronic illness to make a compelling case
- Indigenous health and remote populations, e.g. mental health and addiction, type 2 diabetes and obesity
- Accountable care organization shared savings program, including coordinated high-quality care for patients
- Focus on complex patients, have a single point of accountability to manage the top 5% (chronic, comorbid)
- Improve efficiency and effectiveness of chronic care management and prevention by coordination of silos
- Reduce risk of chronic disease among children, adolescents, and young adults
- Reduce the incidence and length of stay of post-operative atrial fibrillation in cardiac surgery patients

NEXT STEPS

LOOKING AHEAD

The Design Day closed by asking participants to consider actions that they themselves could take to advance value in the health sector, as well as their advice to CFHI regarding how the organization could advance VBHC. Suggestions are listed below (in no particular order).

- Identify, share, and celebrate leading practices in VBHC
- With partners, promote culture of value and outcomes that matter to patients
- Champion and help support framework for implementation of VBHC in a Canadian context
- Convene Canadians interested in VBHC (consider framing as value in healthcare rather than value-based healthcare)
- Explore opportunities for use of VBHC approaches in conjunction with successful CFHI collaboratives or other proven quality improvement interventions, e.g. accountable care organization models
- Feed concepts into broader policy discussions, e.g. support provinces/ territories in "writing in" VBHC in policy and planning; discussions about implementation of Fit for Purpose report
- Clarify focus and define role/scope of activity
- Experiment with and develop approaches to support VBHC risk management (including across silos)

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