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VALUE BASED HEALTHCARE

Opportunities to improve patient outcomes

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VALUE BASED HEALTHCARE (VBH)

- What is Value-Based Healthcare?
- Why is it worth pursuing?
- What are the ‘ingredients’ of VBH?
- Transitioning to VBH
- What should be different under a VBH approach?

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VALUE BASED HEALTHCARE (VBH)

VBH is:

Outcomes (or benefits) that matter to patients, relative to the cost of achieving those outcomes.

It is both
Value to the individual patient and
Value to the system

- VBH goes to the issues of clinical practice and models of care, 'linked up' care, and greater internal accountability for patient outcomes and costs.

- VBH is a **potential game changer**. It's worth the investment of time and energy.

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WHY IS IT WORTH PURSUING?

- The current service delivery system provides (mostly) piecemeal and fragmented care.
- ABF funding is an effective instrument to achieve many positive objectives, including technical efficiency, ***but not value***, either for the patient or for the system.

There continues to be sub-optimal outcomes, unrelated to cost.

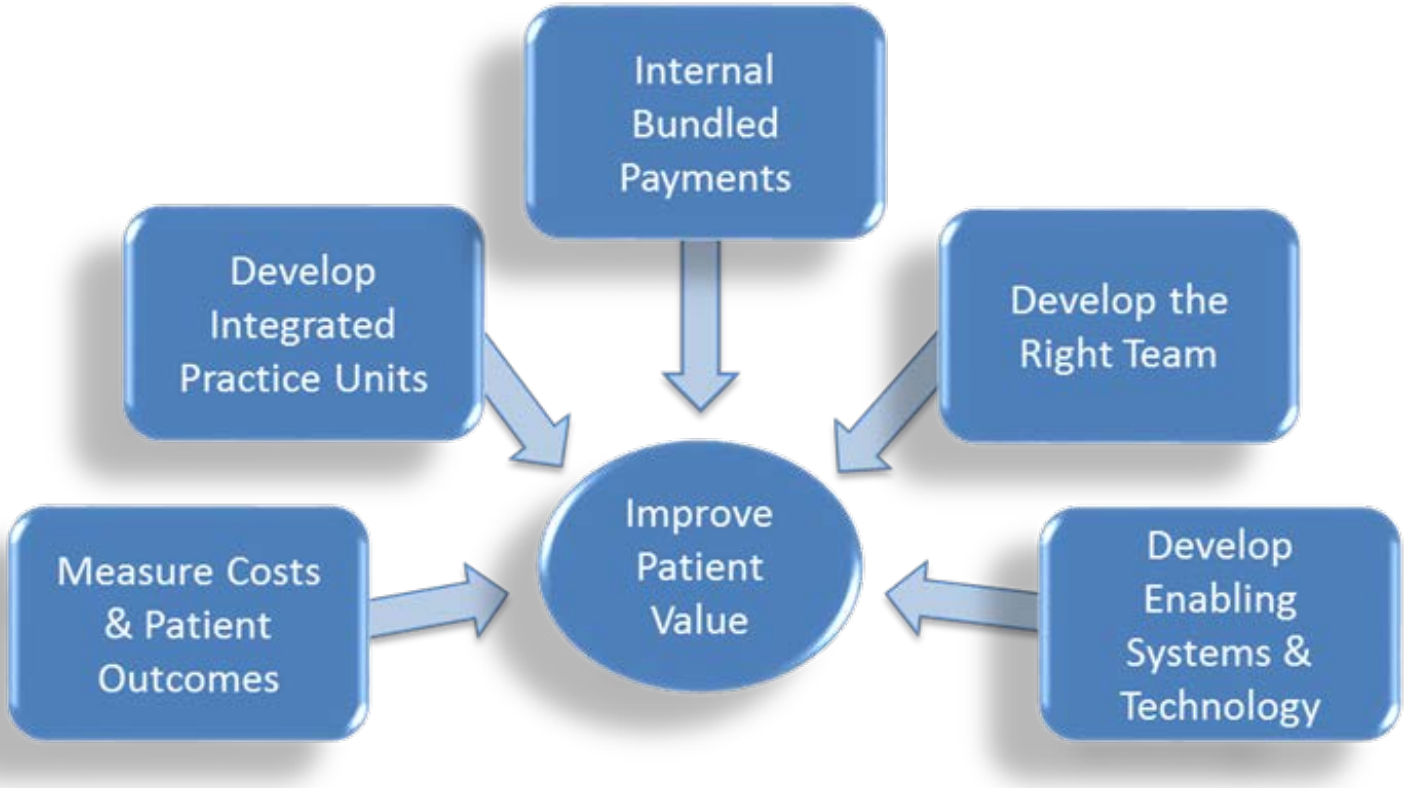
Why? Because:

- Models of care are not structured (or incentivised) to deliver holistic patient outcomes.
- Hospitals are not structured to deliver value.
- There are no effective measures of patient outcomes, or measures of what constitutes ‘value’.

VBH HAS FIVE CORE ELEMENTS

VBH is in its infancy in Australia but it's not a new concept.

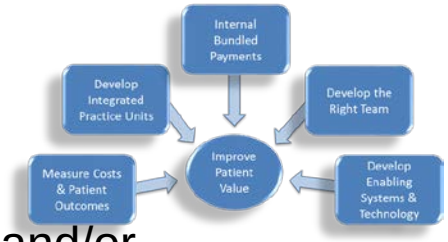
(Extensively developed by Harvard Business School amongst others)



These components are not new, but it is a new way of thinking

A NEW APPROACH TO VBH

- It's not hard to see why VBH has not gained much traction. Often seen as:
  - Too idealistic;
  - An 'All or Nothing' approach;
  - 'Too complicated' to introduce;
  - The necessary support systems are 'too immature'; and/or
  - Very difficult to deliver by 'top-down' or system-wide approaches. *'Top-down approaches by themselves are necessary but insufficient to enable VBH to succeed*.



This presentation seeks to challenge these assertions.

- It is true that you need an over-arching vision and a well-developed strategy to achieve VBH that is owned by stakeholders, but it can be delivered:
  - In bite-sized chunks that suit each individual health service. It is necessarily, a multi-step transition;
  - Benefits accrue even from incremental change; and
  - There is no single one-sized fits all transition 'blueprint'.

WHERE MIGHT YOU START?

The answer is …. Anywhere. *Don't be daunted.*

- You could start with your 'biggest problem'. That's how the international case studies started.

- You can tackle – in only one clinical stream - efficiency; Or quality; Or clinical practice; Or patient flow…….

INTEGRATED PRACTICE UNITS

This is about aligning patient and clinician interests.

- The IPU (multidisciplinary) team takes responsibility for the full extended episode of care; that is:
  - All stages of care;
  - All related clinical conditions, circumstances or complications of care, secondary consultations etc;
  - Patient and carer education, engagement and follow-up are integrated into care.
- Holistic care with clear patient pathways, planned from the outset.

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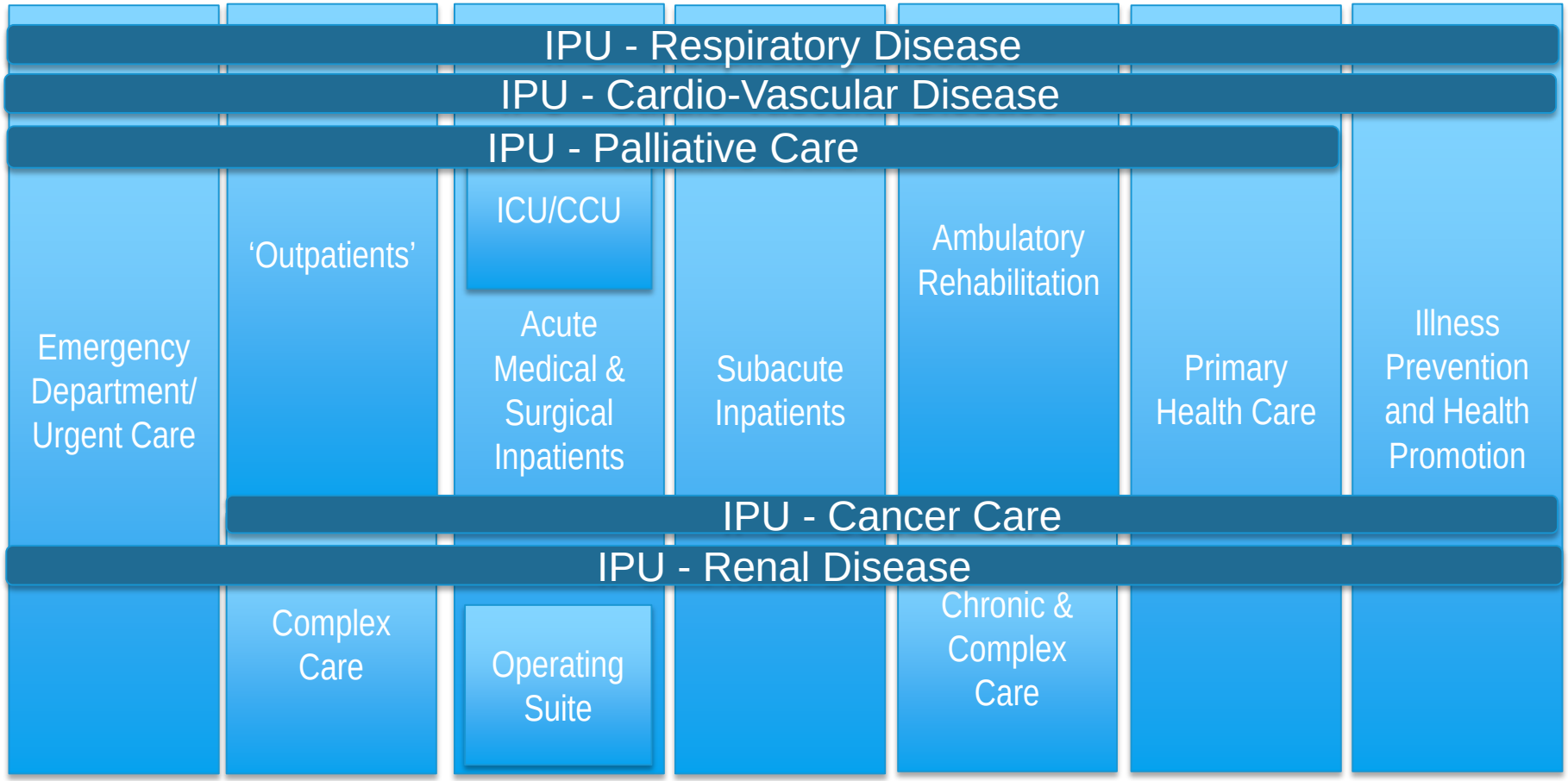
INTEGRATED PRACTICE UNITS

Traditional Hospital Silos



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MEASURING COSTS AND PATIENT OUTCOMES

- The IPU team measures outcomes, costs, and processes *for each patient* using a common measurement (balanced scorecard) platform. (Not all measures need to be in place at the start. These evolve.)
- 'Borrow heavily' (and unashamedly) from internationally accepted **patient outcome measures**, which are accepted by clinicians. Supplemented by other measures that matter to patients.
- Progressively enhance **cost measures** at the patient level.
- All measures need to be **'owned'** by clinicians and management.
- IPU teams track progress over time and compare their performance to that of peers inside and outside their organisation. Makes results **transparent**.

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CREATE INTERNAL BUNDLED PAYMENTS

- ABF is a top-down driven system. Not surprisingly:
  - Clinicians who make the decisions are not engaged (and don't want to be engaged) in costs, and
  - ABF funding is too blunt an instrument to focus on patient value.

- **An alternative approach is to establish your own internal 'funding bundles'.**

- **The IPU team is responsible for delivering all care and treatment within the agreed funding bundle.**

- Funding Bundles vary with 'span of control' and may differentially apply to segments of the continuum of care. May require formal arrangements with co-providers.

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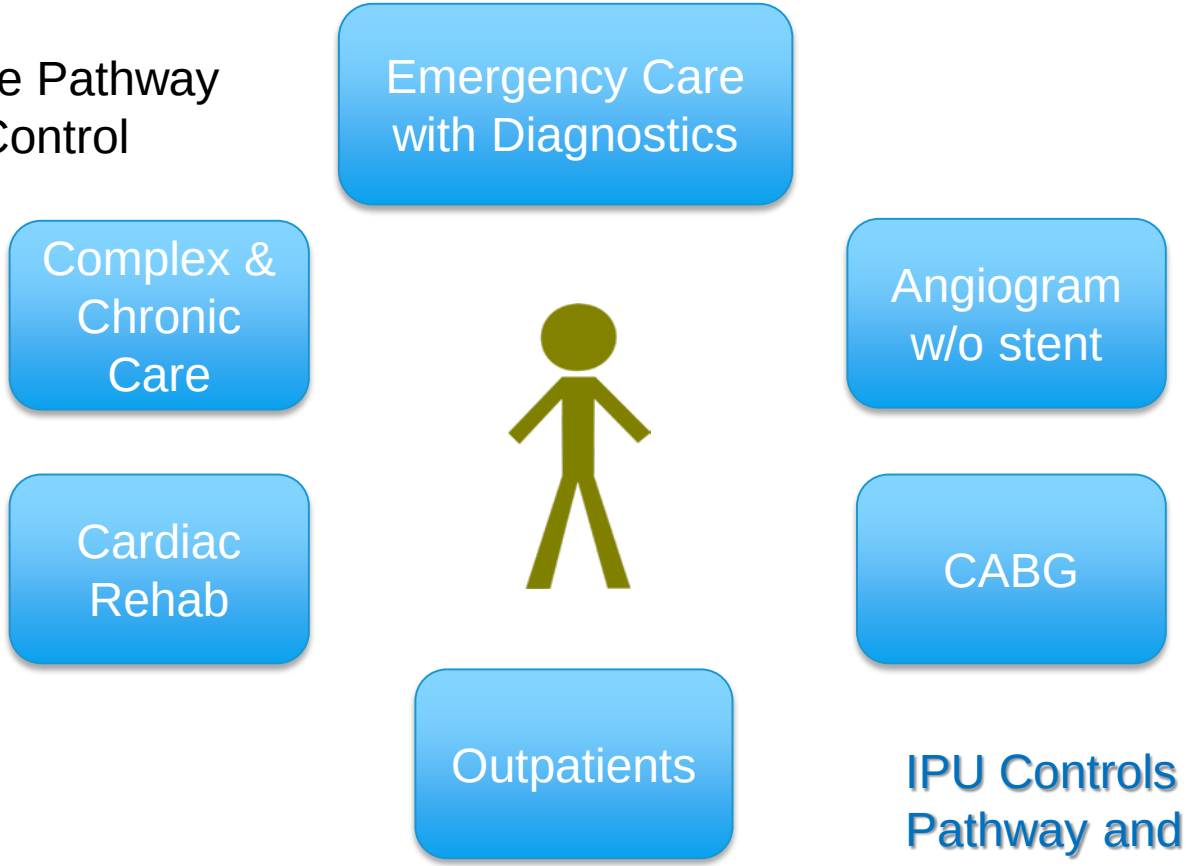
INTERNAL BUNDLED PAYMENTS FOR CORONARY ARTERY DISEASE (CAD)

Indicative Care Pathway and Span of Control



IPU Controls the Patient Pathway and the Funding

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CAD EXAMPLE – INDICATIVE BUNDLED PAYMENT

Service	Funded Item (Indicative)	Cost Weight	Full Service Payment	Payment Per Patient
ED Presentation & Diagnostic tests	ED funding ± MBS funding (e.g. ROPP)	na	na	$480
Interventional investigation (w/o stent)	Interventional Coronary Procedure F16B (WIES24)	1.4032	$4,732	$6,640
Outpatient & Pre-admission	Angiography/Angioplasty Tier 2 Clinic 10.05 Tier 2 Clinic 20.02	0.86 0.73	$275	$437
CABG	Coronary Bypass Procedure F06B (WIES24)	4.3759	$4,732	$20,706
Cardiac Rehabilitation	Subacute Inpatient 4A33 Subacute Ambulatory (HIP)	na	na	$10,401
Review	Cardiac Rehabilitation Tier 2 Clinic 40.21	0.376 x 3	$275	$310
Complex Care for 24 mths	Chronic Condition	na	na	$350
Primary Care - GP	MBS	na	na	$250
			Notional Internal Bundle	$39,325

BUDGET CONTROL

- The IPU has **resource control**, including:
  - Budget control of their cohort of patients, within an annual ceiling (volume x weight x price)
  - Theatre and bed capacity, etc
  - Budget control may be supplemented by ROPP income or other grants

- This approach also lends itself to **normative pricing** within the health service.

- The IPU has clinical and financial incentives to review models of care that are more **effective** and more **efficient**.

- **Internal bundled payments push down the decision-making for patient outcomes and costs to the people most able to impact both; creating the environment for Value-Based Healthcare to take root**.

DEVELOP THE RIGHT TEAM

- A team leader or clinical care manager oversees each patient's care process. You need a clinical **champion**
- **Team accountability** is accepted for patient outcomes and costs
- The unit structure is not prescribed
- A 'tight team' that meets formally and informally on a regular basis to discuss patients, processes and results

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DEVELOP ENABLING SYSTEMS AND TECHNOLOGY

- Siloed IT systems make cost and outcome measurement virtually impossible.
- Tailor to capture costs and patient outcomes. (This is an anathema to most).
- The team generates the initiatives for IT and automated practices that yield benefits.
- Enables seamless connectivity internally and across external partner providers.
- Patient data is shareable and accessible longitudinally.
- Doesn’t necessarily require entire new systems.

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WHAT WOULD BE DIFFERENT WITH VBH?

Now

- Fragmented/Siloed Care
- Limited Clinician Engagement, or owning patient outcomes beyond their direct role
- Limited Clinician Engagement with organisational issues
- Disengaged workforce from funding/budget
- KPIs unrelated to patient outcomes and value
- Sub-Optimal patient Outcomes

With VBH

- Integrated ‘End-to-End’ Care
- Enhanced clinician buy-in, and control
- Bottom-Up driven model of care changes
- IPU (devolved) budget controls
- Bottom up efficiencies (and even lower costs)
- ‘Better’ data providing direct relationships between patient outcomes and Value
- Enhanced Patient Outcomes

KEY MESSAGES

- The proposed approach to Value Based Healthcare is NOT for the purists
- Bottom-up solutions are likely to be more enduring
- Supported by top-down initiatives. Top-down approaches by themselves are likely to be less successful
- For health care organisations, it means developing a longer term vision and a well thought through plan (and system design), and then bite-off as much as you can chew

It is a brave new world for the early adopters