Value-Based Healthcare
The way forward

Prof.ssa Sabina Nuti
Laboratorio Management e Sanità
Istituto di Management
Scuola Superiore Sant’Anna
VALUE...

✓ Quality of care
✓ Financial sustainability
✓ Equity
Equity?

**Vertical**: “no equal parts for disequal”  
(don Lorenzo Milani)

**Orizontal**: «same needs... same answers».....  
Avoid “Post code medicine”!
People who received care services

People who could benefit more from care

POPULATION VALUE
The Italian healthcare system

It's a *Beveridge-like model*: Universal, Comprehensive (almost), Free, Financed by general taxation.

It is organized in three levels:

- The **national** level is responsible for national health planning, including general aims and annual financial resources and for ensuring a uniform level of services, care and assistance (LEA).

- The **regional** level has the responsibility for planning, organizing and managing its health care system through LHA’s activities in order to meet the needs of their population.

- The **local** level (Local Health Authorities): provides care through public and/or private hospitals, primary care and prevention services.
The national level duty is granting that **essentials levels** of care are uniformly guaranteed across the country.

It should therefore monitor that each Region reaches **minimum thresholds** in terms of quality and appropriateness.

The regional level is responsible for organizing healthcare provision in order to maximize value for money.

Performance evaluation is therefore aimed at detecting **best practices**, in order to spread the most effective organizational solutions, through **target setting, public disclosure, reward system**, working on **employees motivation and communication** to assure system improvement.
Performance evaluation at the Italian national level

• National Healthcare Monitoring System (Nuovo Sistema di Garanzia PDTA by MoH)
  → STANDARDS FOR ESSENCIAL LEVELS OF CARE (30 national indicators):
  80% national goal for femur fracture operated within 48 hours, minimum level 55%

• National Program Outcomes (Piano Nazionale Esiti promoted by AGENAS http://pne2017.agenas.it/)
  → OUTCOME MEASURES FOR SINGLE PROCEDURES
Reputations count: why benchmarking performance is improving health care across the world

GWYN BEVAN
Professor of Policy Analysis, Department of Management, London School of Economics and Political Science, London, UK

ALICE EVANS
Lecturer in the Social Science of Development, Department of International Development, King's College London, London, UK

SABINA NUTI
Professor of Health Management, Laboratorio Management e Sanità, Institute of Management, Scuola Superiore Sant'Anna, Pisa, Italy
Performance evaluation at the regional level: IRPES
Inter Regional Performance Evaluation System

http://performance.sssup.it/netval
1. Measuring and benchmarking performance among Regions...
   • on a voluntary basis ...

2. With data public disclosure...
   with a Public University guaranteeing the benchmarking process...

3. Engaging health professionals in the process...
   • setting targets and priorities...
   • Improving quality and reducing avoidable variation...
Managerial tools and techniques to support decision making

- Setting challenging goals
- Coping with waiting times
- Priority setting
- Best practices
Some examples:

Avoidable hospitalizations for chronic diseases
Quality indicators on primary care

6.11. Diabetes hospital admission in adults, 2010 and 2015 (or nearest year)

Age-sex standardised rates per 100 000 population

1. Three-year average.

StatLink  http://dx.doi.org/10.1787/888933603545
Diabetes hospitalization rate (35-74 years) 2017
Major amputation rate for diabetes, 2017
Chronic Heart Failure hospitalization rate (50-74 years) 2017
COPD hospitalization rate (50-74 years), 2017
Percentage of patients leaving hospital against medical advice (PLHAMA), 2017
Average waiting times for breast cancer surgery, 2017
In order to describe the performance evaluation system, **seven** areas have been identified to highlight the core results of the regional healthcare system.
Valutazione dello stato di salute della popolazione (anni 2013-2015)

Bersaglio 2017
Veneto

Regione: Veneto

Andamento indicatori / Trend 2016-2017

Numero indicatori: 94

- Indicatori migliorati: trend positivo
- Indicatori stazionari
- Indicatori peggiorati: trend negativo

21.3% - 17.0% - 61.7%
Valutazione dello stato di salute della popolazione (anni 2013-2015)

Bersaglio 2017
Puglia

Regione: Puglia

Andamento indicatori / Trend 2016-2017

Numero indicatori: 77

- 24.7% Indicatori migliorati: trend positivo
- 13.0% Indicatori stabili
- 62.3% Indicatori peggiorati: trend negativo
Valutazione dello stato di salute della popolazione (anni 2013-2015)

Bersaglio 2017
Lombardia

Regione: Lombardia

Andamento indicatori / Trend 2016-2017

Numero indicatori: 67

- Indicatori migliorati: trend positivo
- Indicatori stabili: trend neutro
- Indicatori peggiorati: trend negativo

24.9% 20.9% 52.2%
Valutazione dello stato di salute della popolazione (anni 2013-2015)

Bersaglio 2017
Toscana

Regione: Toscana

Andamento indicatori / Trend 2016-2017

Numeri indicatori: 99

- Indicatori migliorati: trend positivo
- Indicatori stazionari
- Indicatori peggiorati: trend negativo

32.3% 14.2% 51.8%
THE PERFORMANCE EVALUATION SYSTEM MUST OVERCOME THE SILOS PERSPECTIVE....
Let’s play the patient’s music….

The stave, as well as the dartboard, relies on the five colour bands (from red to dark-green). These bands are now displayed horizontally and are framed to represent the different phases of care pathways. This view allows users to focus on strengths and weaknesses characterizing the healthcare service delivery in the different pathway phases.
From Siloes to Pathways

<table>
<thead>
<tr>
<th>Experience</th>
<th>Outcome</th>
<th>Adherence</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREMs</td>
<td>PROMs</td>
<td>...</td>
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<td>...</td>
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</tr>
</tbody>
</table>
PROMs & PREMs

**Before Surgery**

- T0 – baseline
- Patients’ characteristics
- Clinical info; surgery info

**Surgery**

- Date of surgery
- PROMs
- Diagnostic phase
- Hospital stay experience
- Use of services
- Role of family physician

**Follow-up**

- t1 - 30 days
- t3 - 3 months
- t12 - 12 months
- PREMs
- Follow-up

**Clinician reported**
The Questionnaire Follows the **Patient Experience Journey**

The diagram illustrates the following stages:

- **Access**
- **Hospital Stay**
- **Discharge**

Each stage includes the following components:

- **Communication, interactions and relationship with the health care staff**
- **Care**
  - Team work,
  - Collaboration,
  - Coordination,
  - Comfort
- **Overall evaluation**

Closed-ended questions:

- **Access (reception)**
- **Patient-staff relationship**
- **Comfort**
- **General / Overall feedback**
- **Valuing of health care workers**
The «Next Generation» Surveys

Systematic, open and continuous survey

Automatic invitation 24 hrs after the discharge

Online questionnaire

Real time web platform
The «Next Generation» Surveys

New questionnaire, more narrative and briefer

Patient satisfaction
A broad and multi-dimensional concept influenced by personal preferences, expectations, personal characteristics. No consensus about exactly which domains should be included.

Patient experience
Patient are asked to report about their experiences on what actually occurred.

Patient reported outcome measures
Standardized validated instruments to measure patients’ perceptions of their health status (impairment), their functional status (disability), and their health-related quality of life (well-being).

Patients’ Narratives – Storytelling
Acknowledgement that patient stories – the illness and experience narrative – that arise from personal encounters of patients with health and social care, should be the dominant voice.
Listening to patients’ stories is important, but the challenge for health professionals is to find ways of using these narratives to improve practice and the patient experience.

Sometimes a picture is worth a thousand words — or even a few sentences. So it appears for the public reporting of patients’ experiences with doctors and clinics. Millions of dollars have been invested in the collection of standardized, quantitative measures of patient experience and in reporting them with the use of colorful icons that highlight the best and worst performers. However, consumers’ use of these measures remains limited because of a lack of timely exposure, doubts about the trustworthiness and relevance of metrics, and the complexity of reports and websites that incorporate multiple ratings. By contrast, websites like Yelp and Angie’s List, which present volunteered comments about service providers, including clinicians, have burgeoned over the past 5 years. By 2013, 37% of Americans had read patients’ comments online, and 34% used them when selecting a clinician — half again as many patients as report using numbers from standardized patient experience surveys when making a selection. A parallel pattern is evident among clinicians. Written comments, in settings where they are currently available, are often sought by physicians as the most useful and meaningful form of patient feedback.

The proliferation of patient comments about clinical encounters, described in their own words, was greeted skeptically by some clinicians, who worried that they would be little more than a library of grievances. Because most volunteered comments (hereafter “comments”) are unattributed, these concerns were largely unfounded. Our own research, however, reveals a different potential downside: comments can divert attention from other vital measures of clinician performance.

At the same time, qualitative reports from patients about health care represent an essential missing link both for patients seeking to understand the experience of other patients and for physicians seeking to learn from patients to improve quality. The incorporation of narrative feedback into public reporting can highlight aspects of quality that are missing from conventional surveys. In addition, elicitation of narrative feedback can encourage participation in patient experience surveys by allowing consumers to report what matters most to them.

Including carefully elicited patient accounts (hereafter “narratives”) as a core component of the assessment of patients’ experiences would enhance the value of patients’ comments. Patient narratives would be especially valuable if they were elicited and reported with the same scientific rigor already accorded to closed-ended surveys. We make the case here for this approach by exploring the opportunities and challenges associated with eliciting patient narratives and by considering what type of data would be used in this qualitative account.

Patient narratives can improve health care quality beyond what conventional report cards accomplish, by better informing consumers choices and by enhancing clinicians understanding of encounters that are considered by their patients to be problematic. A growing number of report cards present consumers with standardized metrics of patient experience along with multiple measures of clinical performance and patient safety. However, many consumers feel overwhelmed by this plethora of information. Report designers have responded with simplified presentations, but this does not make the actual choice process simple: consumers still must decide how to weight different aspects of physician performance.

Consumers approach complex choices in vari-

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PROMs in real-time feedback
Individual Care & Quality Improvement

PREMs in real-time feedback
Quality Improvement

PROMs in long-term perspective
Performance Evaluation

PREMs in long-term perspective
Performance Evaluation
Orthopedic Surgery PROMs

In the last 6 months, do you think that the various doctors who have followed your care were coordinated (i.e. they were informed about your health status or therapies)?

How would you describe today the results of your knee surgery of 6 months ago?
Reconstruction Surgery for Breast Cancer PROMs

Percorso Ch. ricostruttiva post-mastectomia: Regione Toscana

How long has it been between the mammography screening and the first diagnostic test/investigation?

How long did it take between the decision of the surgery and the day of the surgery?
Did your family physician follow your pathway after the discharge?

How do you describe today the results of your surgery of 3 months ago?

Globally, how is your health problem today in respect to 3 months ago?
In the last 6 months, was your family physician in contact with the cardiologist to follow your pathway?
<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage of improved indicators</th>
<th>Percentage of stable indicators</th>
<th>Percentage of worsened indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medium and large Regions (&gt;2M inhabitants)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Puglia</td>
<td>62.3%</td>
<td>13.0%</td>
<td>24.7%</td>
</tr>
<tr>
<td>Toscana</td>
<td>51.5%</td>
<td>16.2%</td>
<td>32.3%</td>
</tr>
<tr>
<td>Lombardia</td>
<td>52.2%</td>
<td>20.3%</td>
<td>27.5%</td>
</tr>
<tr>
<td>Veneto</td>
<td>61.7%</td>
<td>17.0%</td>
<td>21.3%</td>
</tr>
<tr>
<td>Average</td>
<td>56.9%</td>
<td>16.6%</td>
<td>26.5%</td>
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<tr>
<td><strong>Medium Regions (1-2M inhabitants)</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>FVG</td>
<td>51.6%</td>
<td>18.3%</td>
<td>30.1%</td>
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<tr>
<td>Umbria</td>
<td>49.5%</td>
<td>15.1%</td>
<td>35.5%</td>
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<td>Liguria</td>
<td>51.6%</td>
<td>16.8%</td>
<td>31.6%</td>
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<td>Marche</td>
<td>50.0%</td>
<td>19.5%</td>
<td>30.5%</td>
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<tr>
<td>Average</td>
<td>50.7%</td>
<td>17.4%</td>
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<td><strong>Small Regions (&lt;1M inhabitants)</strong></td>
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<td>Basilicata</td>
<td>46.2%</td>
<td>15.4%</td>
<td>38.5%</td>
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<tr>
<td>Bolzano</td>
<td>51.7%</td>
<td>14.6%</td>
<td>33.7%</td>
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<td>Trento</td>
<td>50.6%</td>
<td>11.8%</td>
<td>37.6%</td>
</tr>
<tr>
<td>Average</td>
<td>49.5%</td>
<td>13.9%</td>
<td>36.6%</td>
</tr>
</tbody>
</table>

Improving value for population....
Making governance work in the health care sector: evidence from a ‘natural experiment’ in Italy

SABINA NUTI*
Laboratorio Management e Sanità, Institute of Management, Scuola Superiore Sant’Anna, Pisa, Italy
FEDERICO VOLA
Laboratorio Management e Sanità, Institute of Management, Scuola Superiore Sant’Anna, Pisa, Italy
ANNA BONINI
Laboratorio Management e Sanità, Institute of Management, Scuola Superiore Sant’Anna, Pisa, Italy
MILENA VAINIERI
Laboratorio Management e Sanità, Institute of Management, Scuola Superiore Sant’Anna, Pisa, Italy

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