ISTITUTO DI MANAGEMENT

Scuola Superiore Sant'Anna

Value-Based Healthcare
The way forward

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

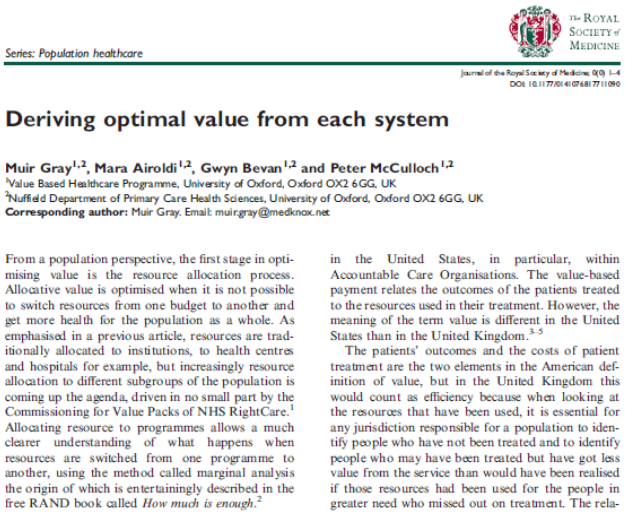
VALUE…

- ✓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"!



Series: Population healthcare

The Royal Society of Medicine

Journal of the Royal Society of Medicine; 0(0): 1–4
DOI: 10.1177/0141076817711090

Deriving optimal value from each system

Muir Gray[1,2], **Mara Airoldi**[1,2], **Gwyn Bevan**[1,2] **and Peter McCulloch**[1,2]
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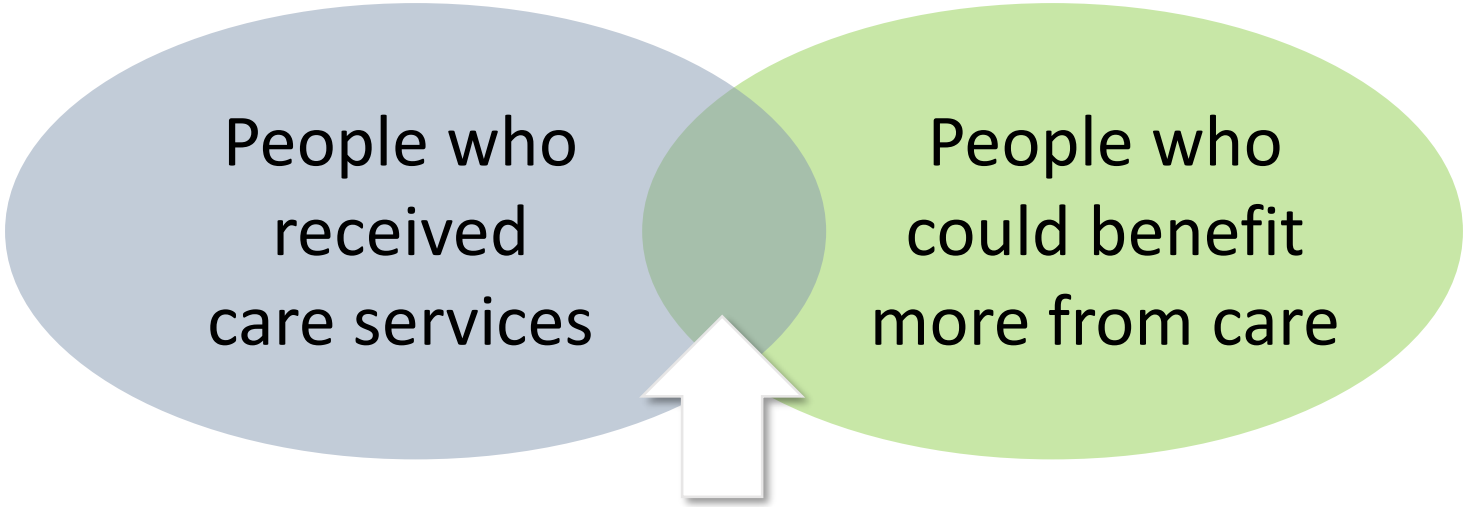
From a population perspective, the first stage in optimising value is the resource allocation process. Allocative value is optimised when it is not possible to switch resources from one budget to another and get more health for the population as a whole. As emphasised in a previous article, resources are traditionally allocated to institutions, to health centres and hospitals for example, but increasingly resource allocation to different subgroups of the population is coming up the agenda, driven in no small part by the Commissioning for Value Packs of NHS RightCare.[1] Allocating resource to programmes allows a much clearer understanding of what happens when resources are switched from one programme to another, using the method called marginal analysis the origin of which is entertainingly described in the free RAND book called *How much is enough*.[2]

in the United States, in particular, within Accountable Care Organisations. The value-based payment relates the outcomes of the patients treated to the resources used in their treatment. However, the meaning of the term value is different in the United States than in the United Kingdom.[3–5]

The patients' outcomes and the costs of patient treatment are the two elements in the American definition of value, but in the United Kingdom this would count as efficiency because when looking at the resources that have been used, it is essential for any jurisdiction responsible for a population to identify people who have not been treated and to identify people who may have been treated but have got less value from the service than would have been realised if those resources had been used for the people in greater need who missed out on treatment. The rela-



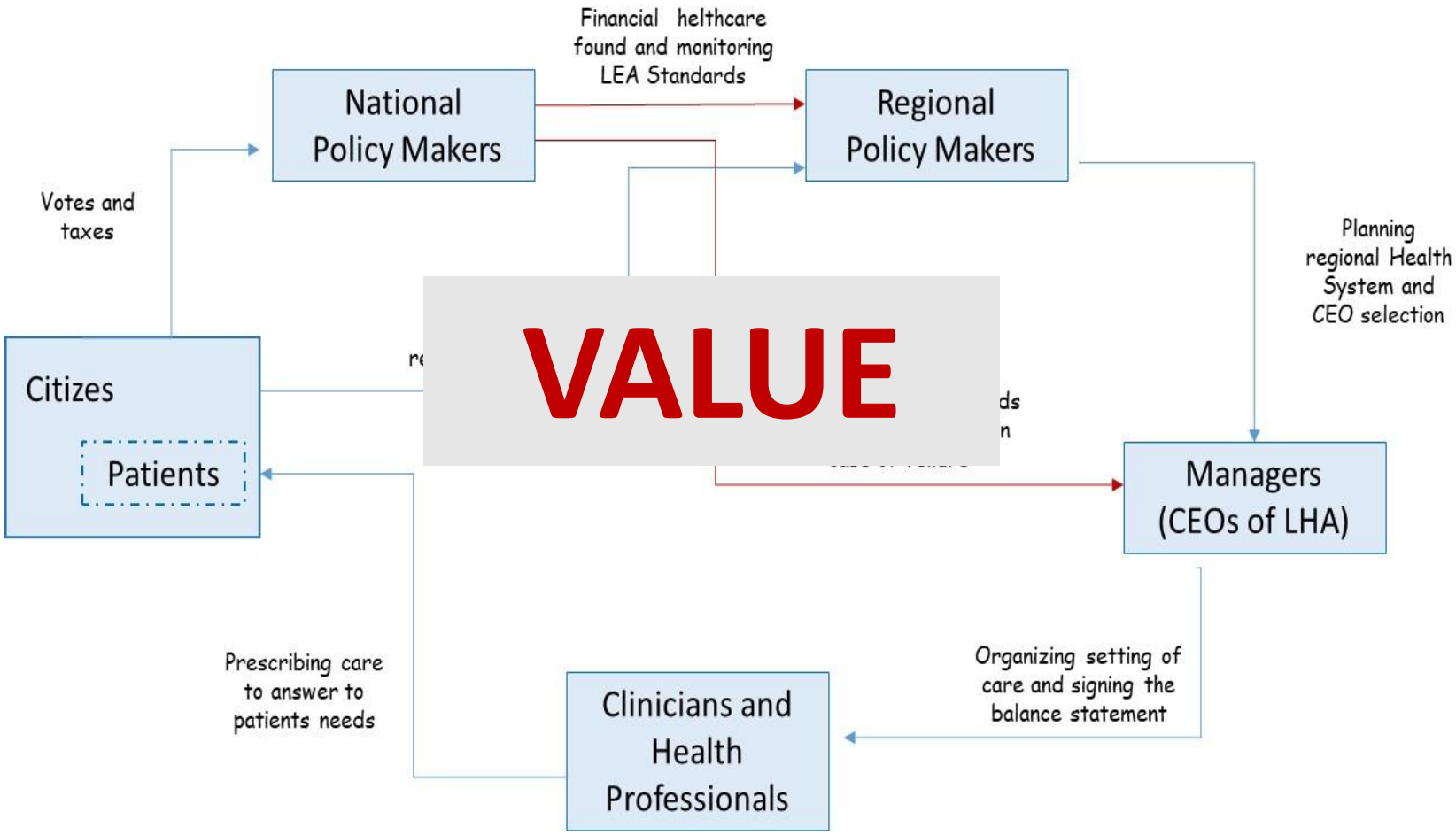
POPULATION VALUE

The Italian healthcare system

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

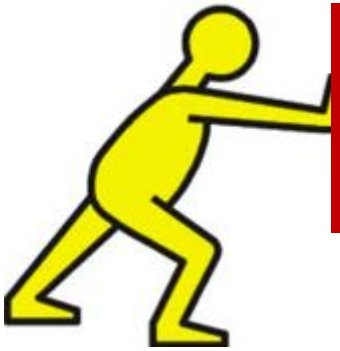
It is organized in three levels:

- 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.

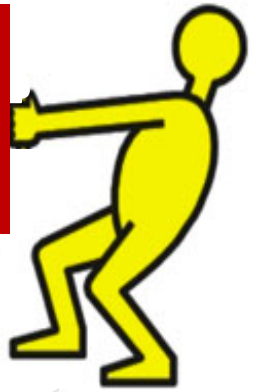

Financial helthcare found and monitoring LEA Standards
National Policy Makers
Regional Policy Makers
Votes and taxes
Planning regional Health System and CEO selection
VALUE
Citizes
Patients
Managers (CEOs of LHA)
Prescribing care to answer to patients needs
Clinicians and Health Professionals
Organizing setting of care and signing the balance statement

The national level duty is granting that **essentials levels** of care are uniformly guarateed across the country.

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

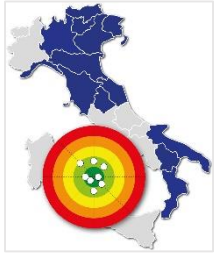


Performance



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, trought **target setting**, **public disclosure**, **reward system**, working on employees motivation and comunication 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):

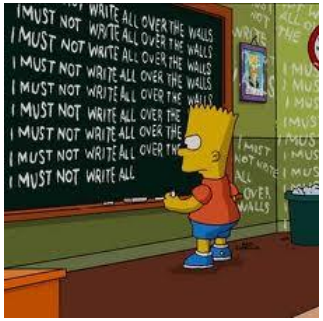
  80% national goal for femur fracture operated within 48 hours, minimum level 55%

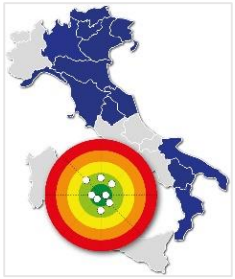
- National Program Outcomes (Piano Nazionale Esiti promoted by AGENAS http://pne2017.agenas.it/)

  → OUTCOME MEASURES FOR SINGLE PROCEDURES

Performance

Ministero della Salute





Health Economics, Policy and Law, page 1 of 21 © Cambridge University Press 2018
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Reputations count: why benchmarking performance is improving health care across the world☆

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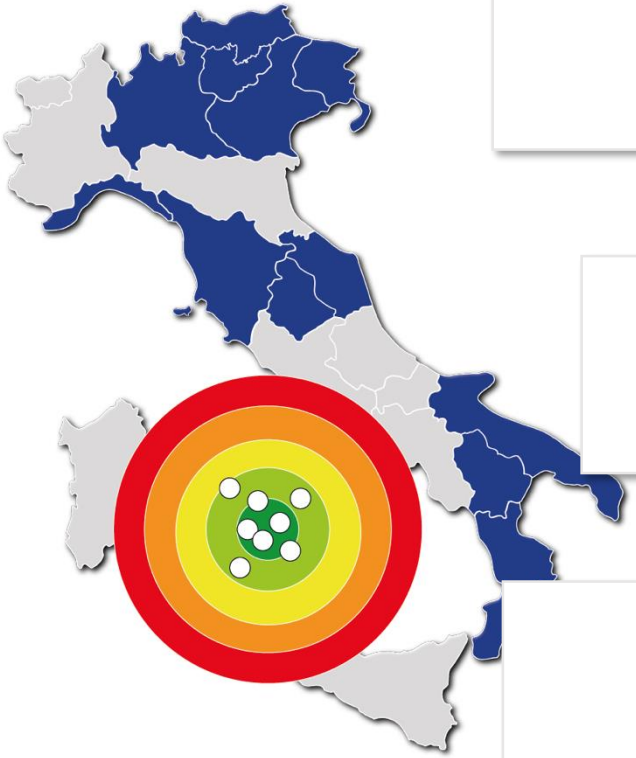
Performance evaluation at the regional level: IRPES Inter Regional Performance Evaluation System

http://performance.sssup.it/netval

The multidimensional reporting system shared by the network of the Italian regions



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**…

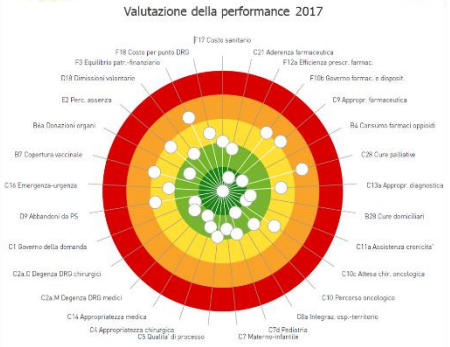
Managerial tools and techniques to support decision making

Setting challenging goals

Coping with waiting times

Priority setting

Best practices

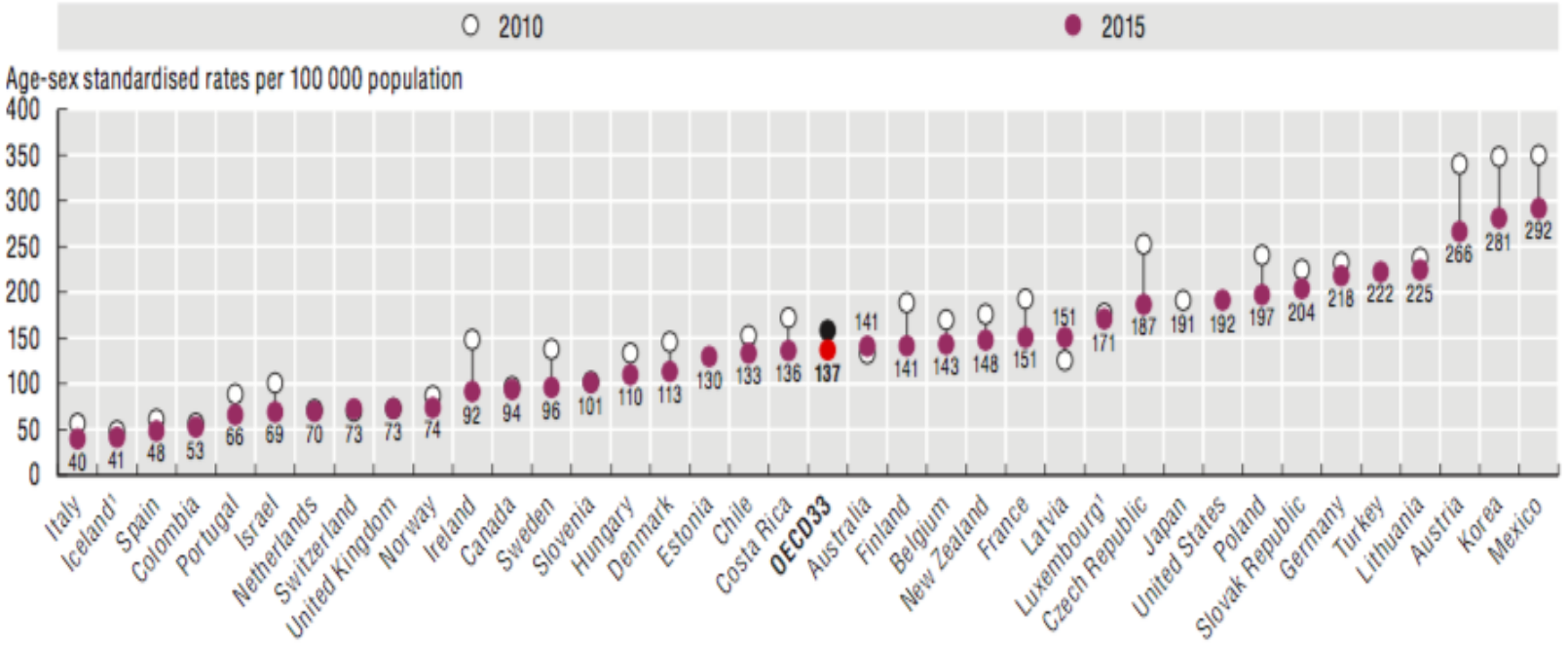


Some examples:

Avoidable hospitalizations for chronic diseases

Quality indicators on primary care

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

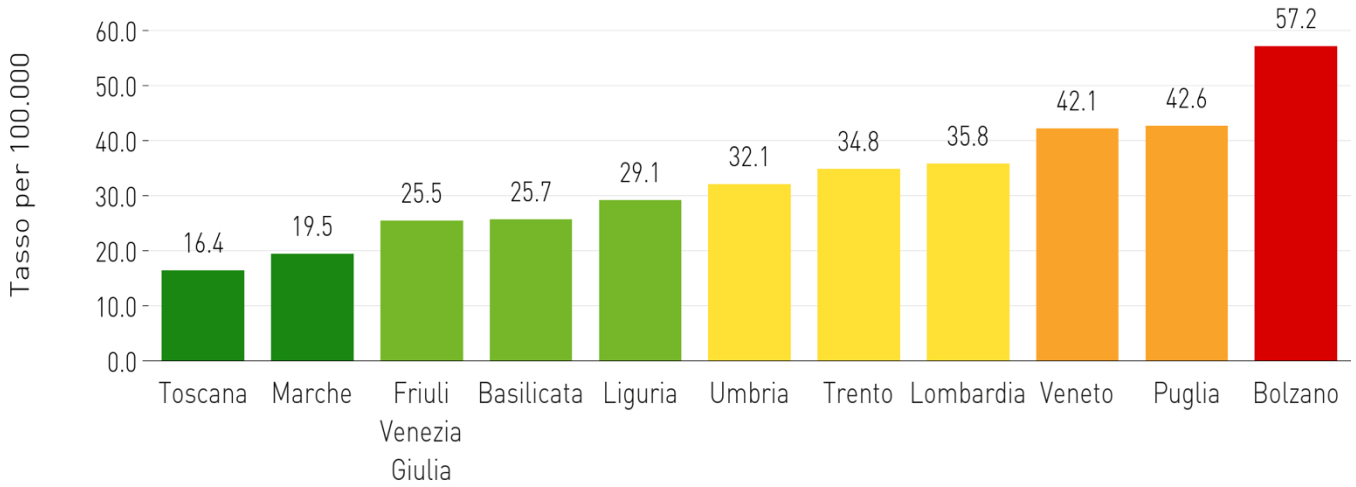


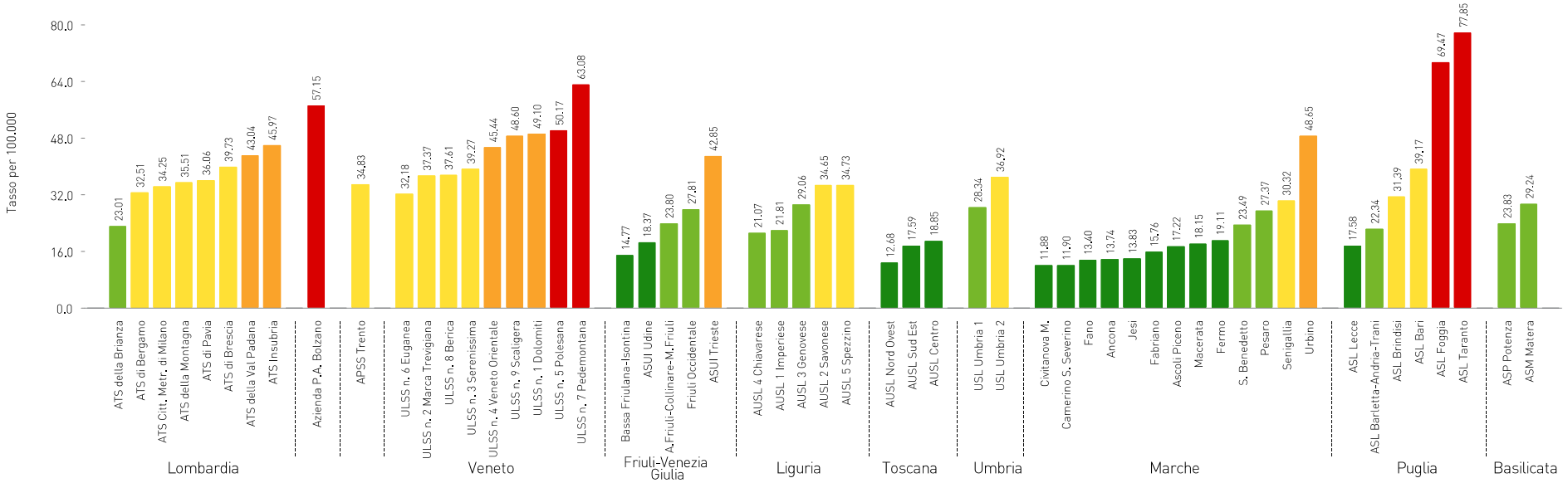
1. Three-year average.

Source: OECD Health Statistics 2017.

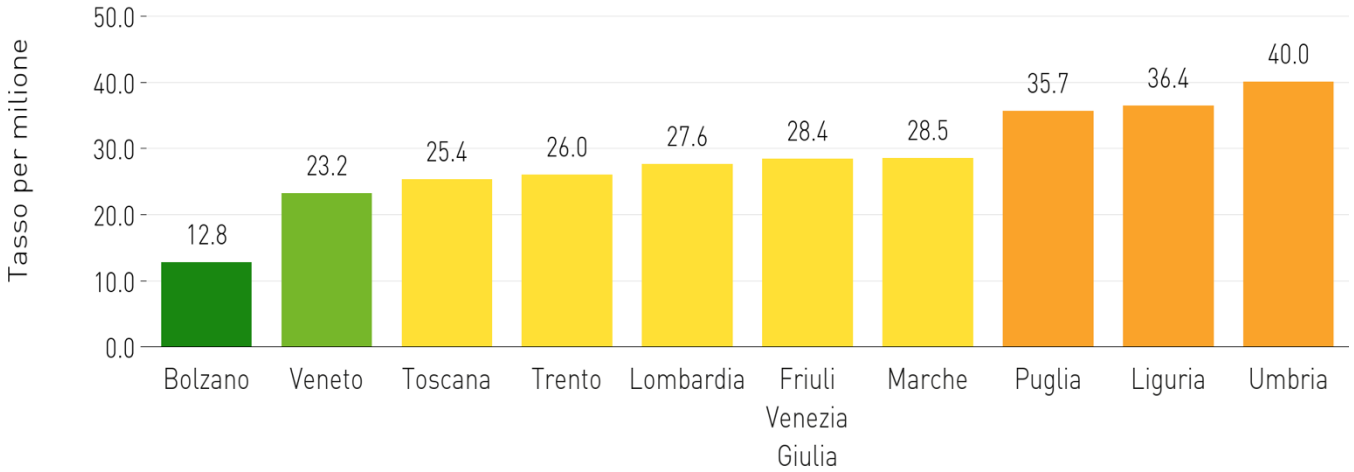
StatLink http://dx.doi.org/10.1787/888933603545

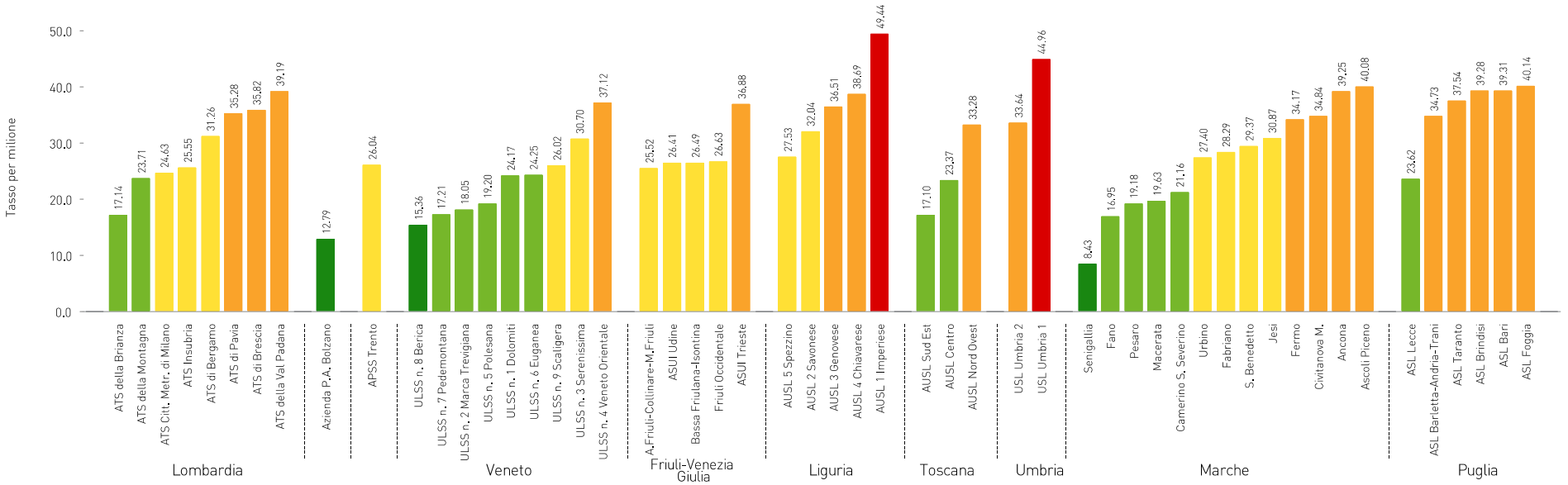
Diabetes hospitalization rate (35-74 years) 2017



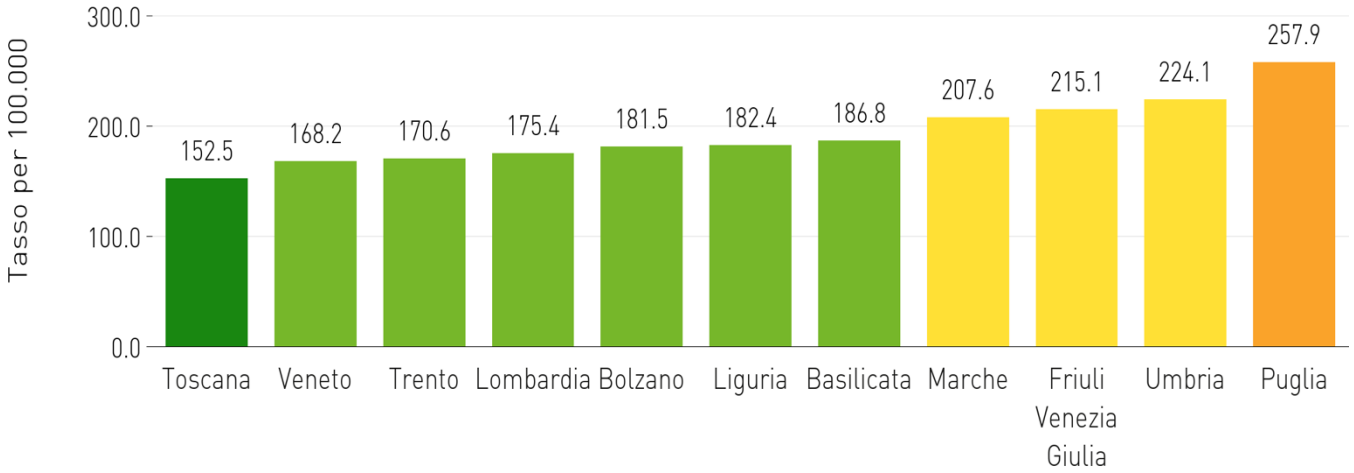


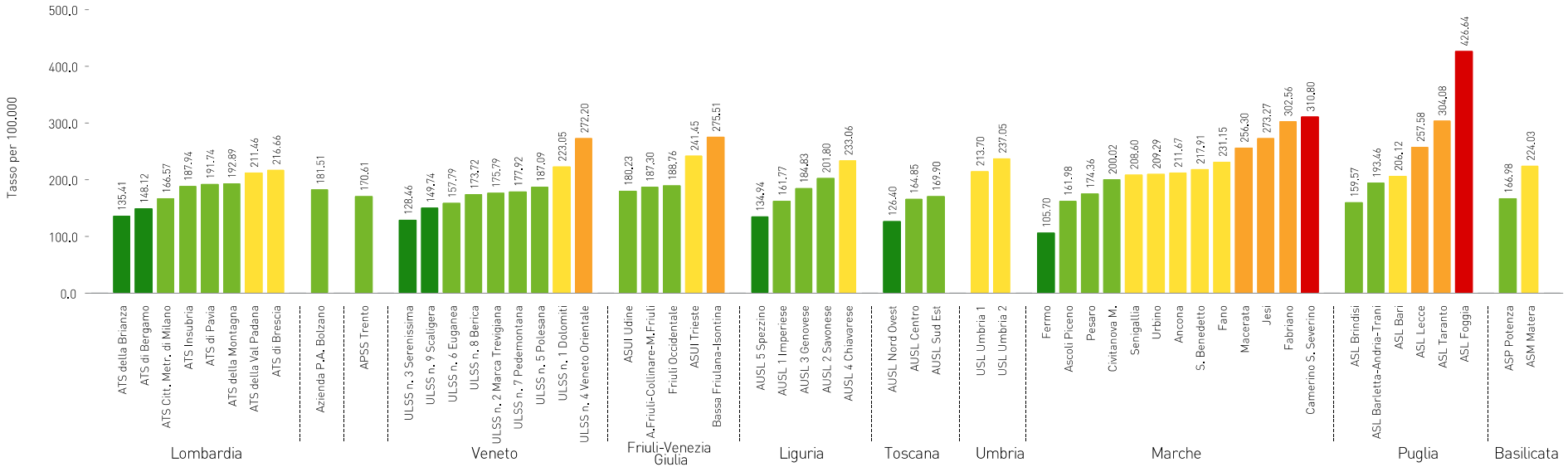
Major amputation rate for diabetes, 2017



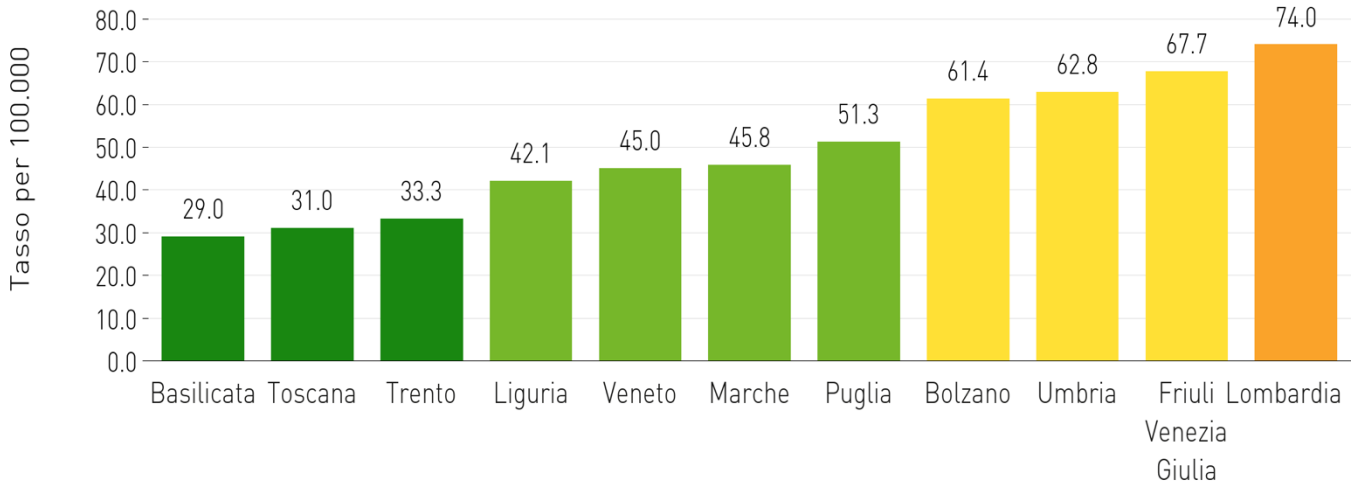


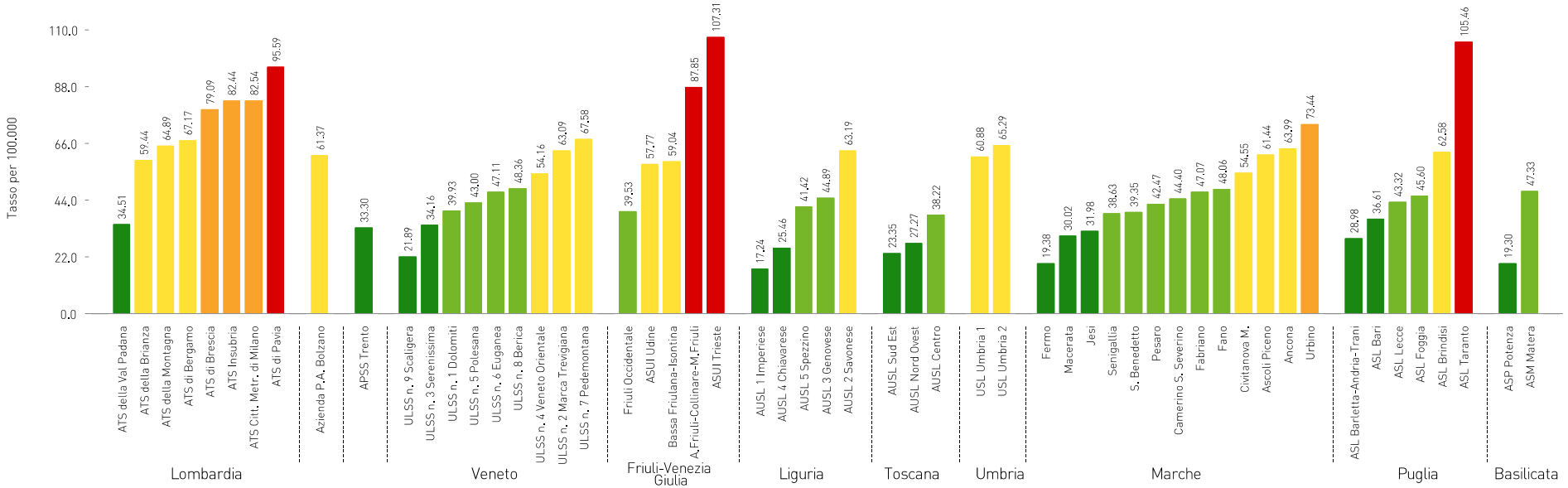
Chronic Heart Failure hospitalization rate (50-74 years) 2017



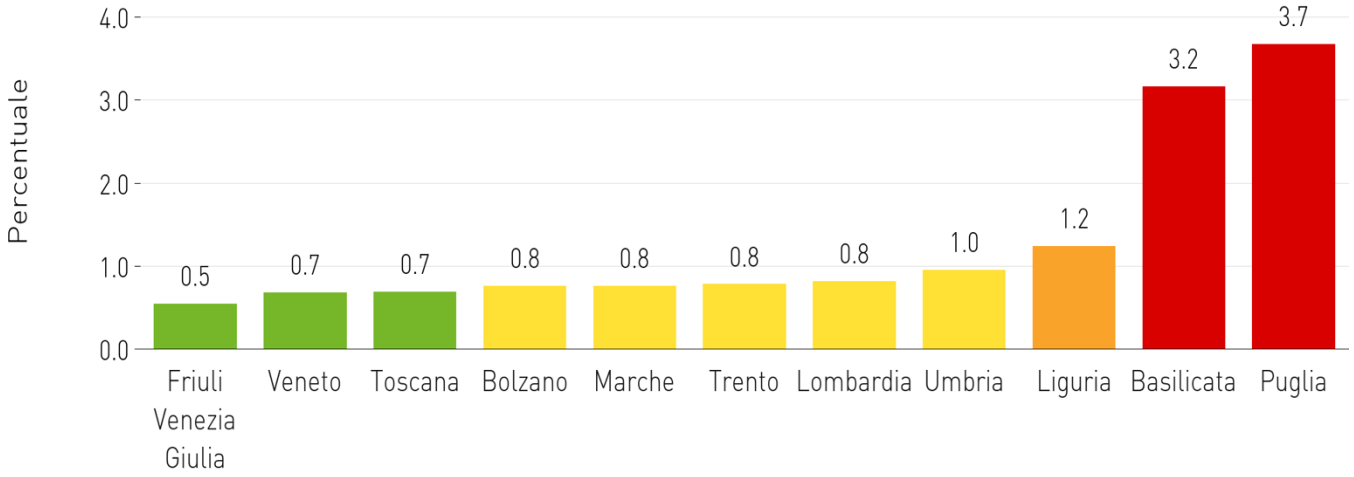


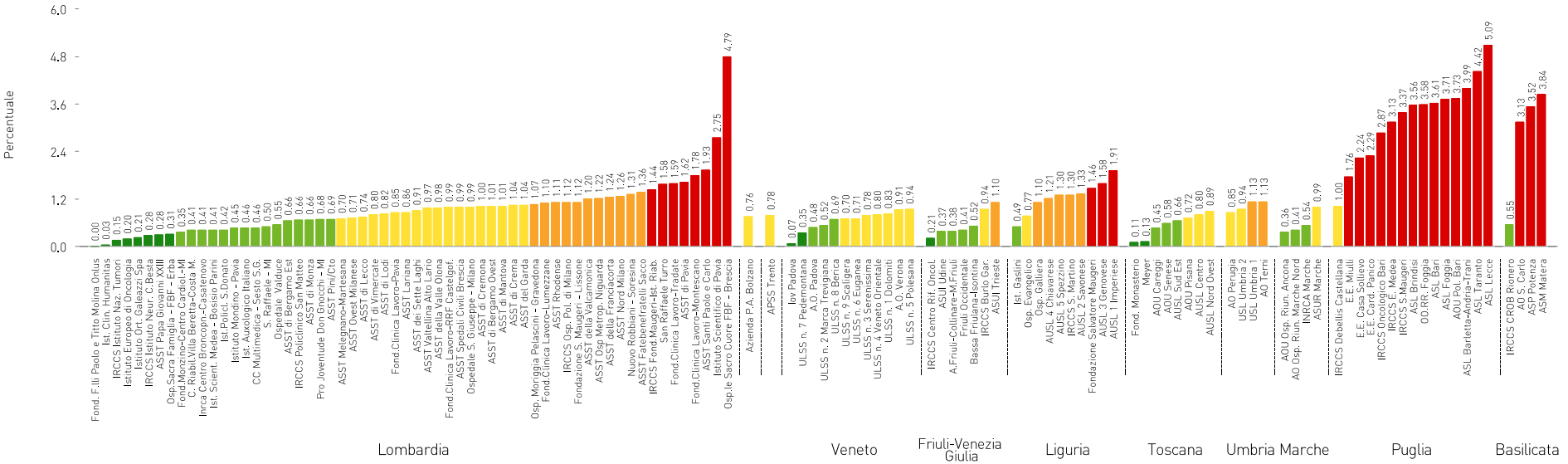
COPD hospitalization rate (50-74 years), 2017



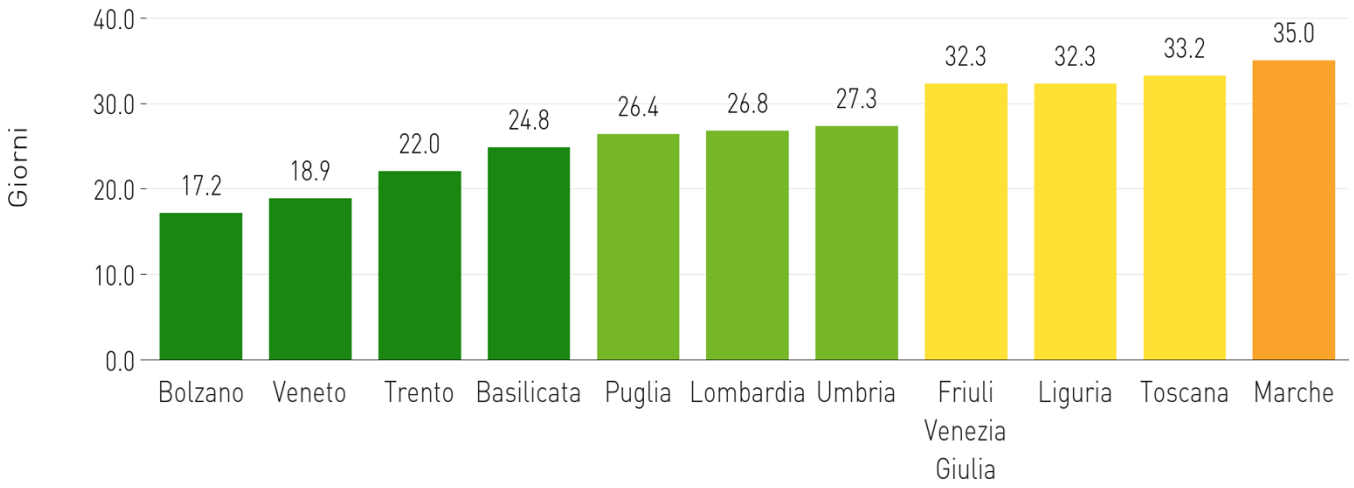


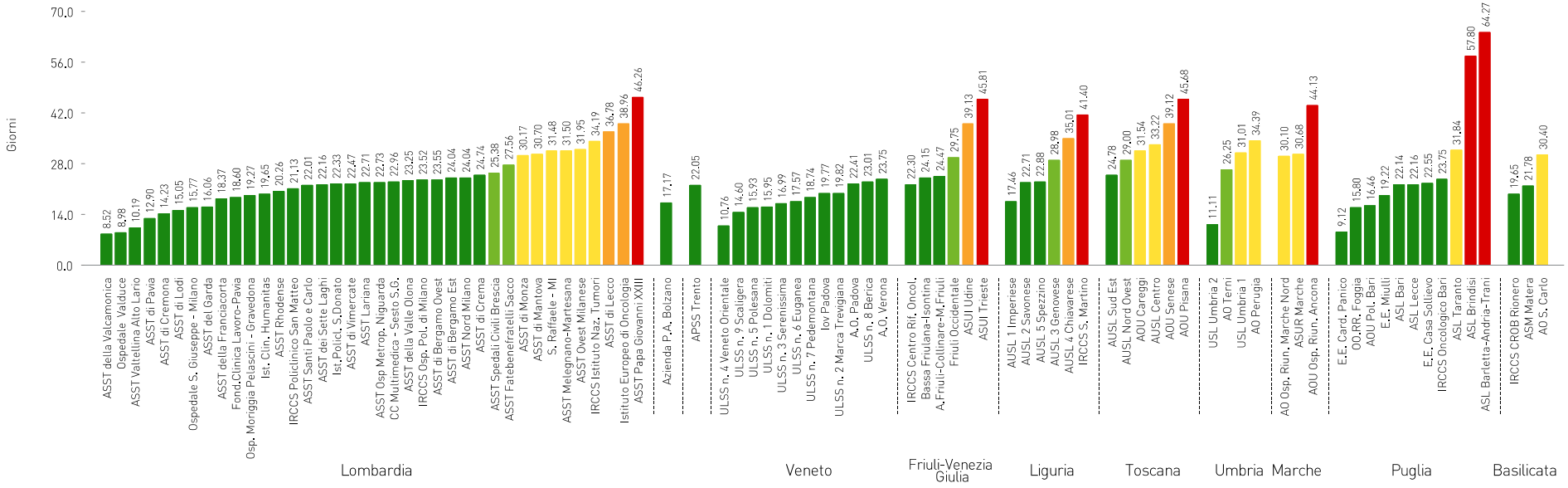
Percentage of patients leaving hospital against medical advice (PLHAMA), 2017





Average waiting times for breast cancer surgery, 2017





The multidimensional reporting system shared by the network of the Italian regions

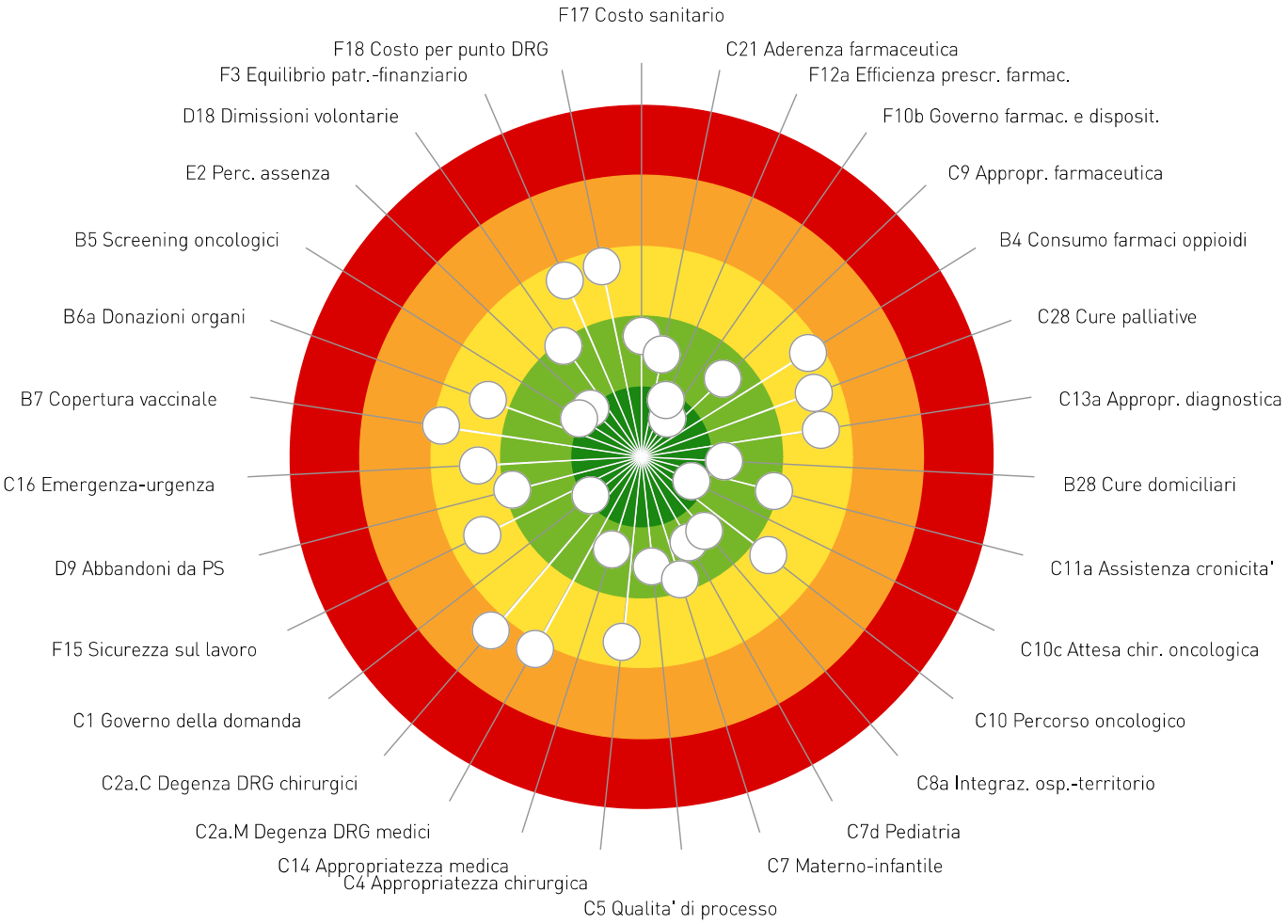
In order to describe the performance evaluation system, **seven** areas have been identified to highlight the core results of the regional healthcare system

SCORE	BAND COLOUR	PERFORMANCE
4 - 5	DARK GREEN	EXCELLENT
3 - 4	GREEN	GOOD
2 - 3	YELLOW	AVERAGE
1 - 2	ORANGE	POOR
0 - 1	RED	VERY POOR

Valutazione dello stato di salute della popolazione (anni 2013-2015)

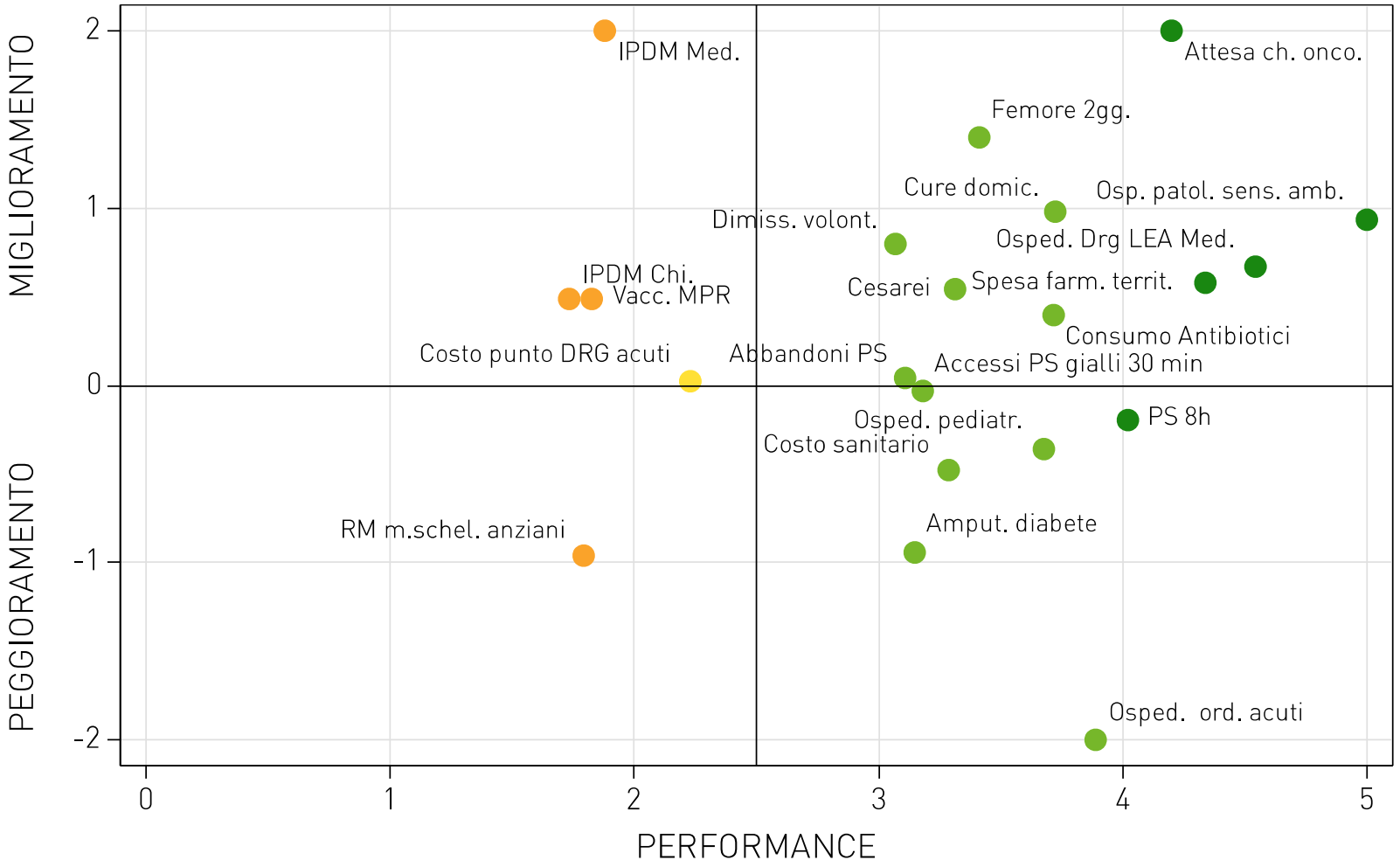
A1 Mortalita' infantile
A2 Mortalita' per tumori
A3 Mortalita' per malattie circolatorie
A4 Mortalita' per suicidi
A10 Stili di vita (PASSI)

Bersaglio 2017
Veneto



Mappe di performance e trend (2016-2017) – Selezione indicatori principali

Regione:Veneto



Andamento indicatori / Trend 2016-2017

Valutazione dello stato di salute della popolazione (anni 2013-2015)

A1 Mortalita' infantile

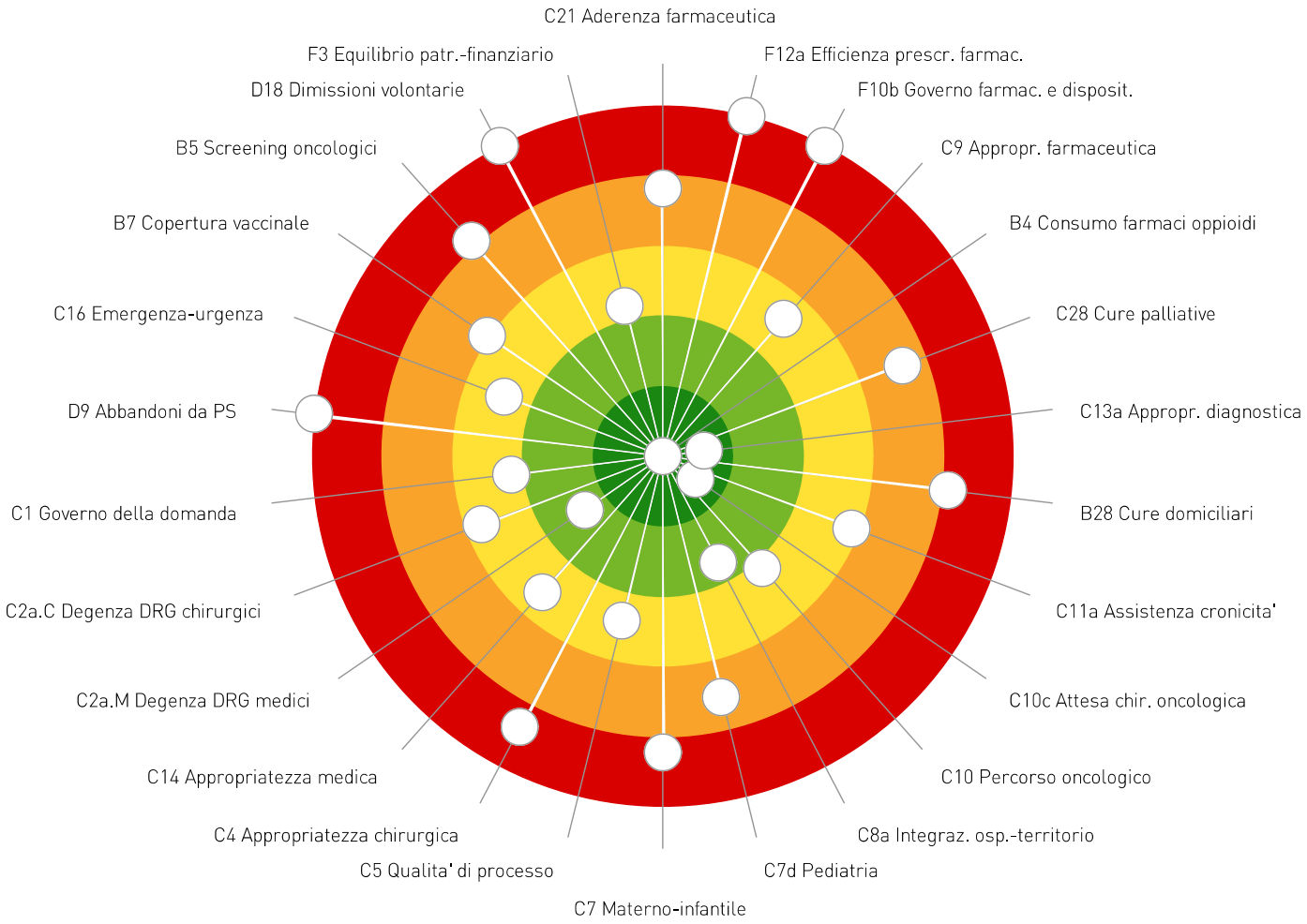
A2 Mortalita' per tumori

A3 Mortalita' per malattie circolatorie

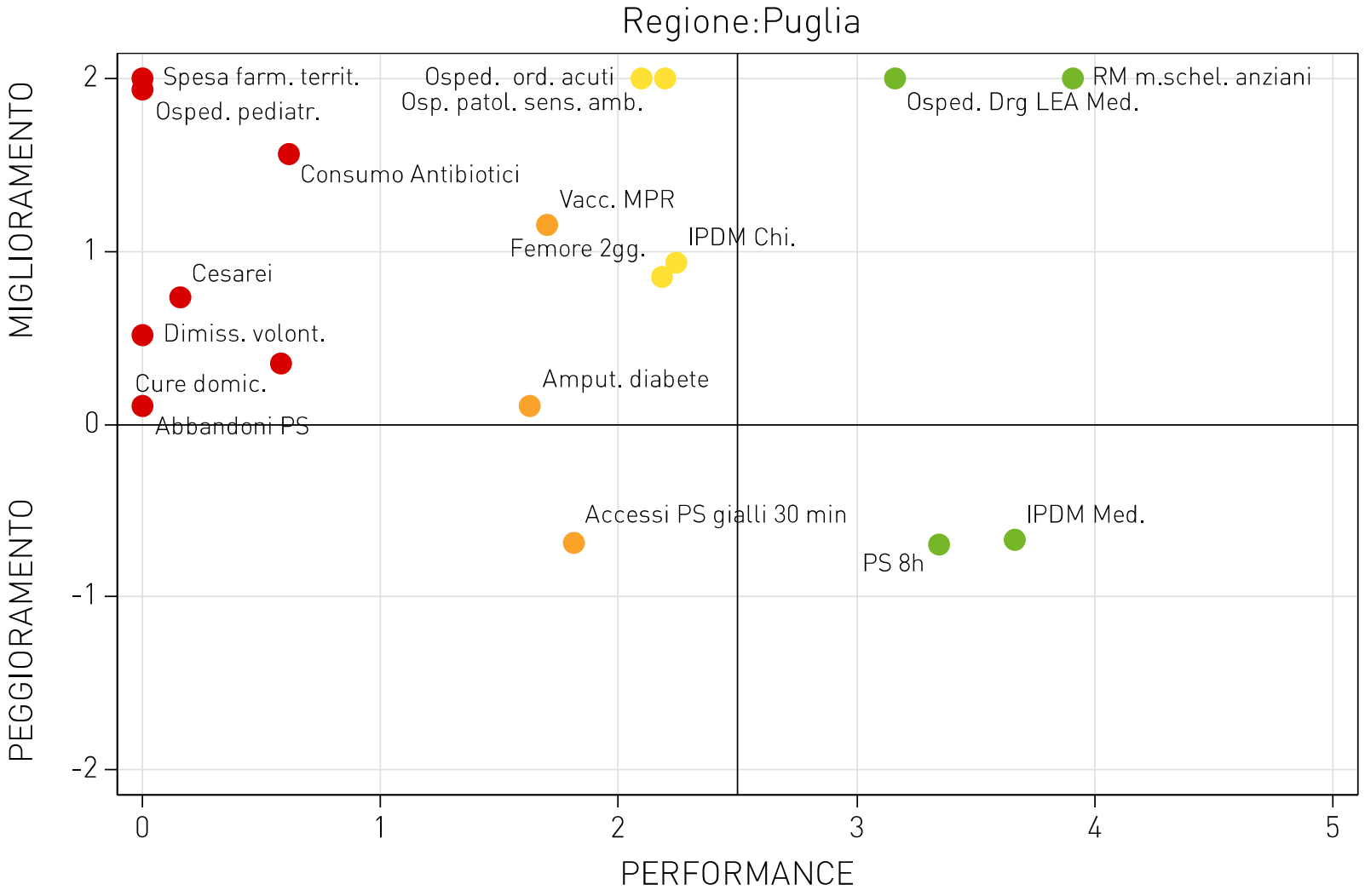
A4 Mortalita' per suicidi

A10 Stili di vita (PASSI)

Bersaglio 2017
Puglia



Mappe di performance e trend (2016-2017) – Selezione indicatori principali

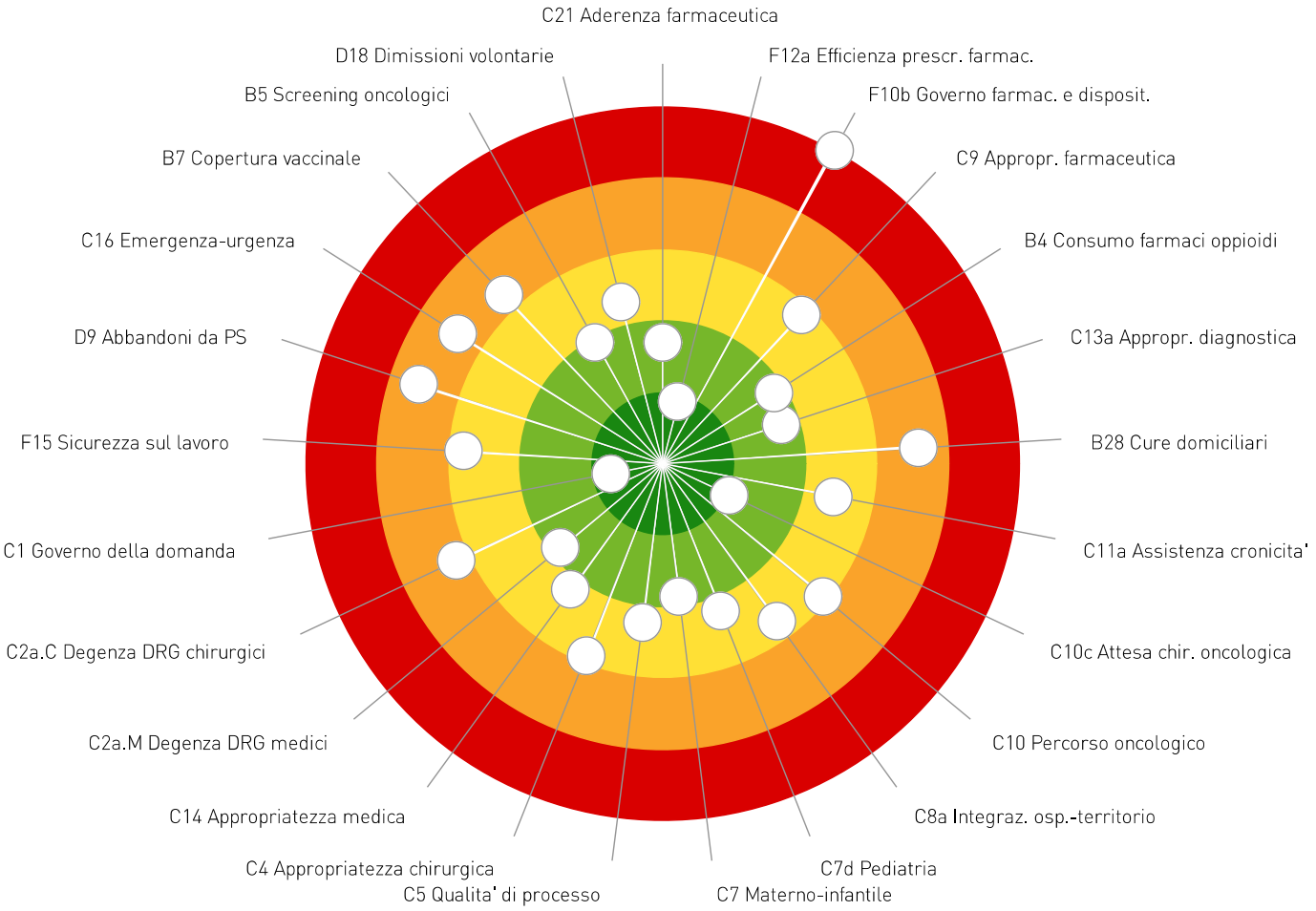


Andamento indicatori / Trend 2016-2017

Valutazione dello stato di salute della popolazione (anni 2013-2015)

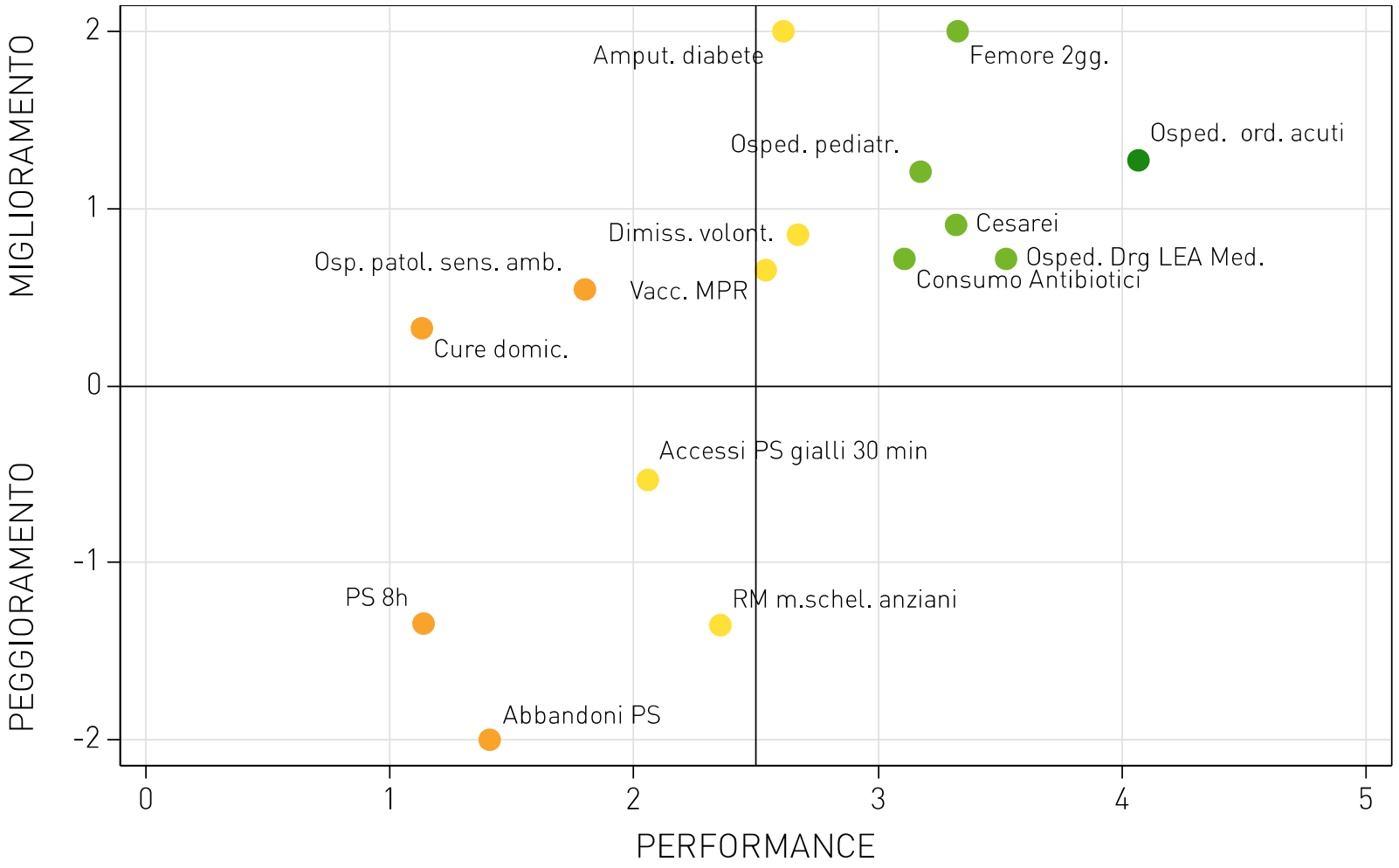
A1
Mortalita' infantile

Bersaglio 2017
Lombardia



Mappe di performance e trend (2016-2017) – Selezione indicatori principali

Regione:Lombardia



Andamento indicatori / Trend 2016-2017

Valutazione dello stato di salute della popolazione (anni 2013-2015)

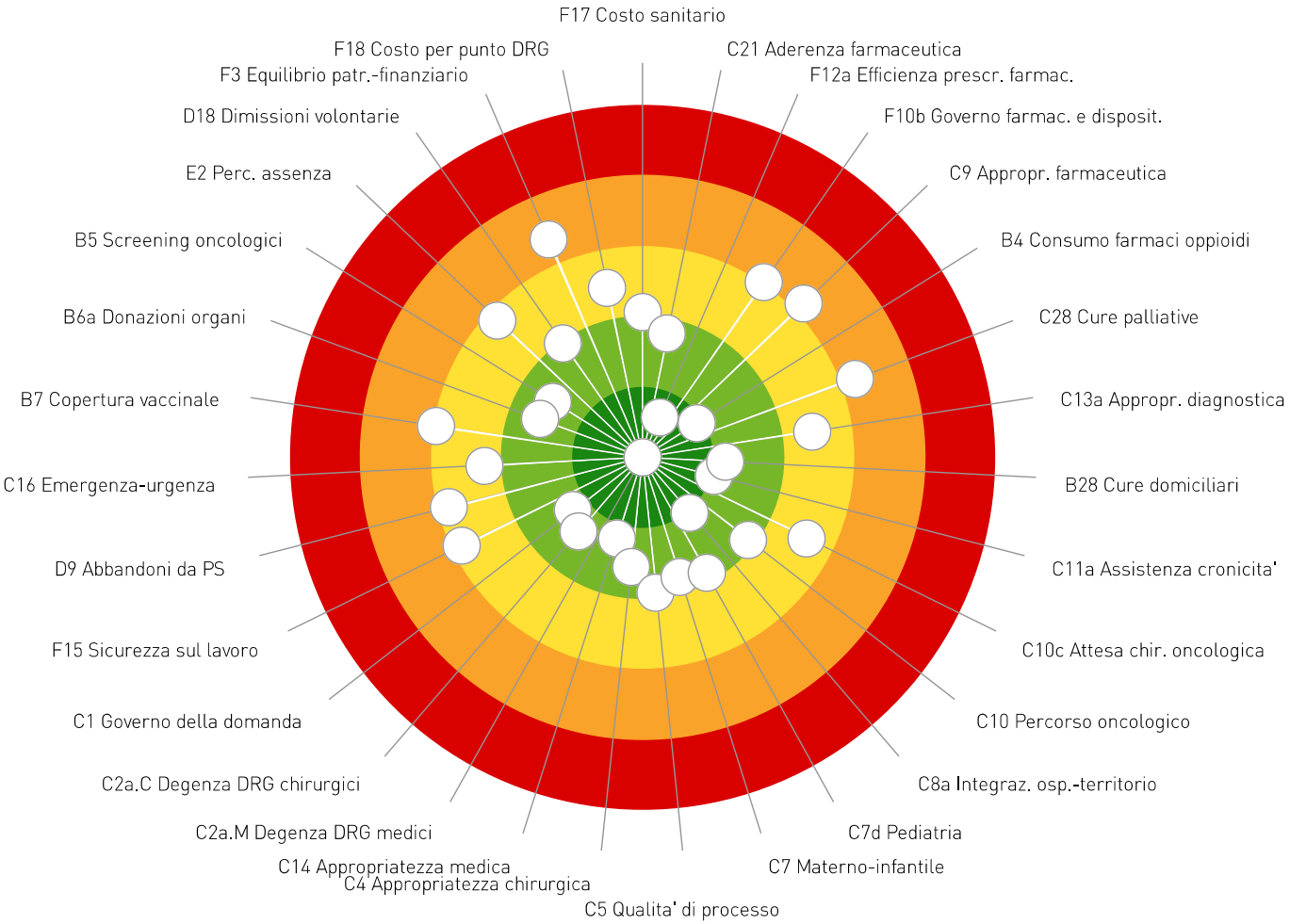
A1 Mortalita' infantile

A2 Mortalita' per tumori

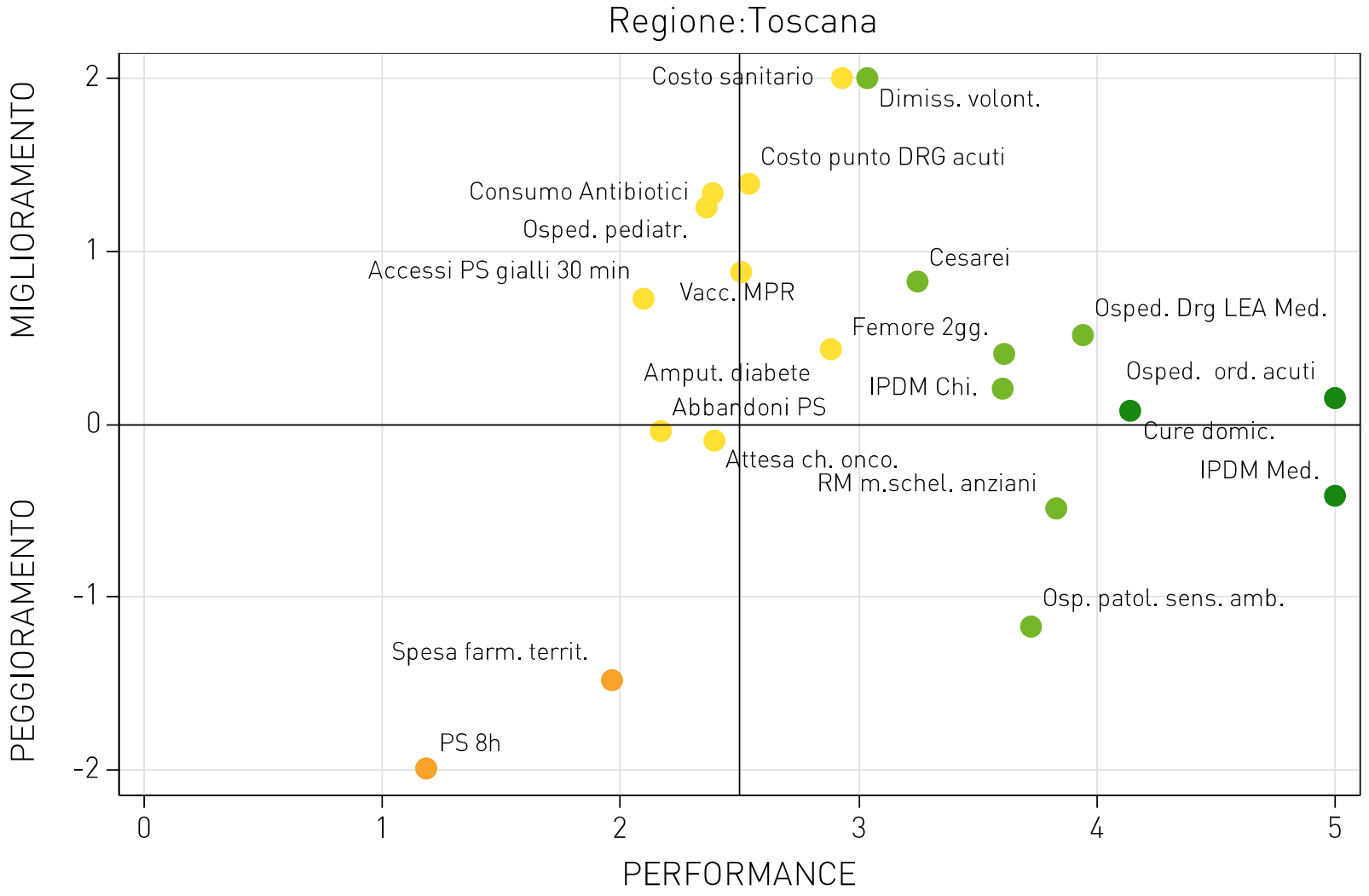
A3 Mortalita' per malattie circolatorie

A4 Mortalita' per suicidi

Bersaglio 2017
Toscana



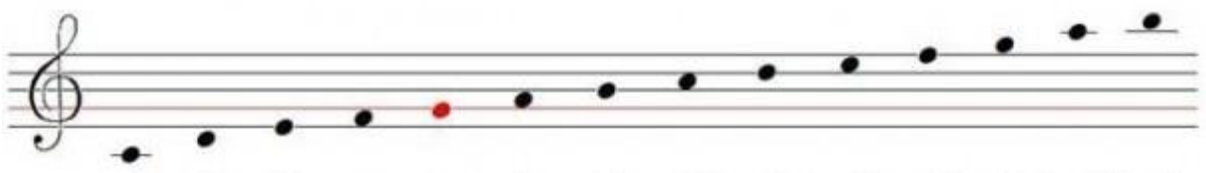
Mappe di performance e trend (2016-2017) – Selezione indicatori principali



Andamento indicatori / Trend 2016-2017

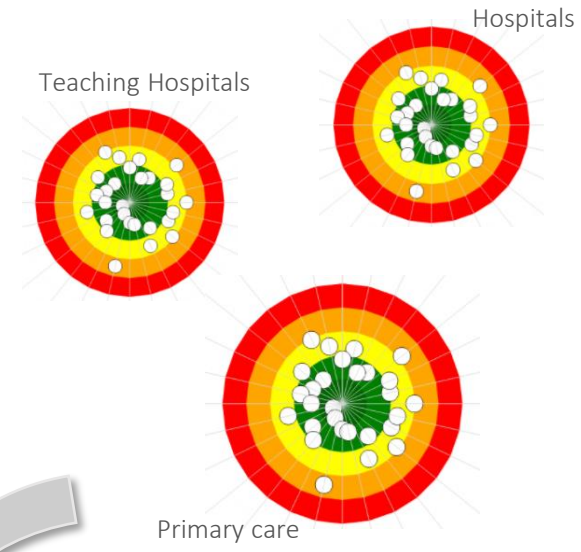
THE PERFORMANCE EVALUATION SYSTEM MUST OVERCOME THE SILOS PERSPECTIVE….

Let's play the patient's music….

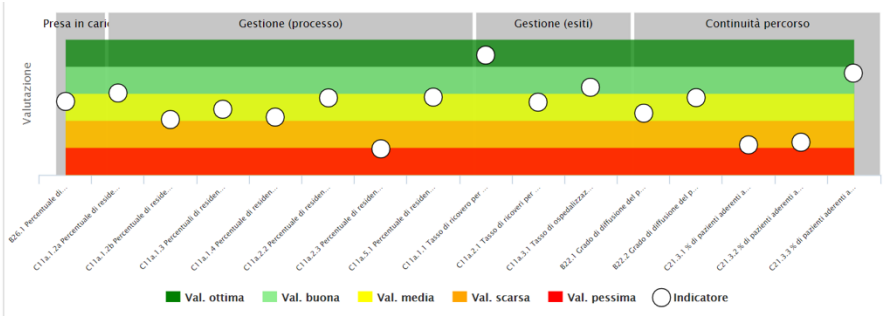


the positive metaphor of the "stave"

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



	Experience	Outcome	Adherence
Patients	PREMs	PROMs	…
Caregivers	…	…	…
Professionals	…	…	…

Scuola Superiore Sant'Anna

PROMs & PREMs

Before Surgery | Surgery | Follow-up | Follow-up | Follow-up

T0 – baseline | Date of surgery | **t1 - 30 days** | **t3 - 3 months** | **t12 - 12 months**

Clinician reported

Patients' characteristics

Clinical info; surgery info

PROMs

PROMs

PROMs

PREMs

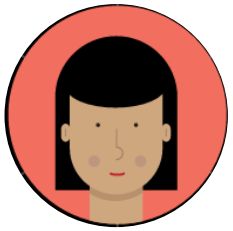
Diagnostic phase

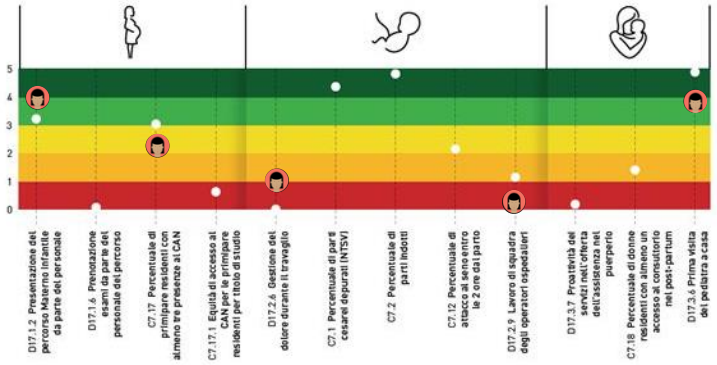
Hospital stay experience

Follow-up

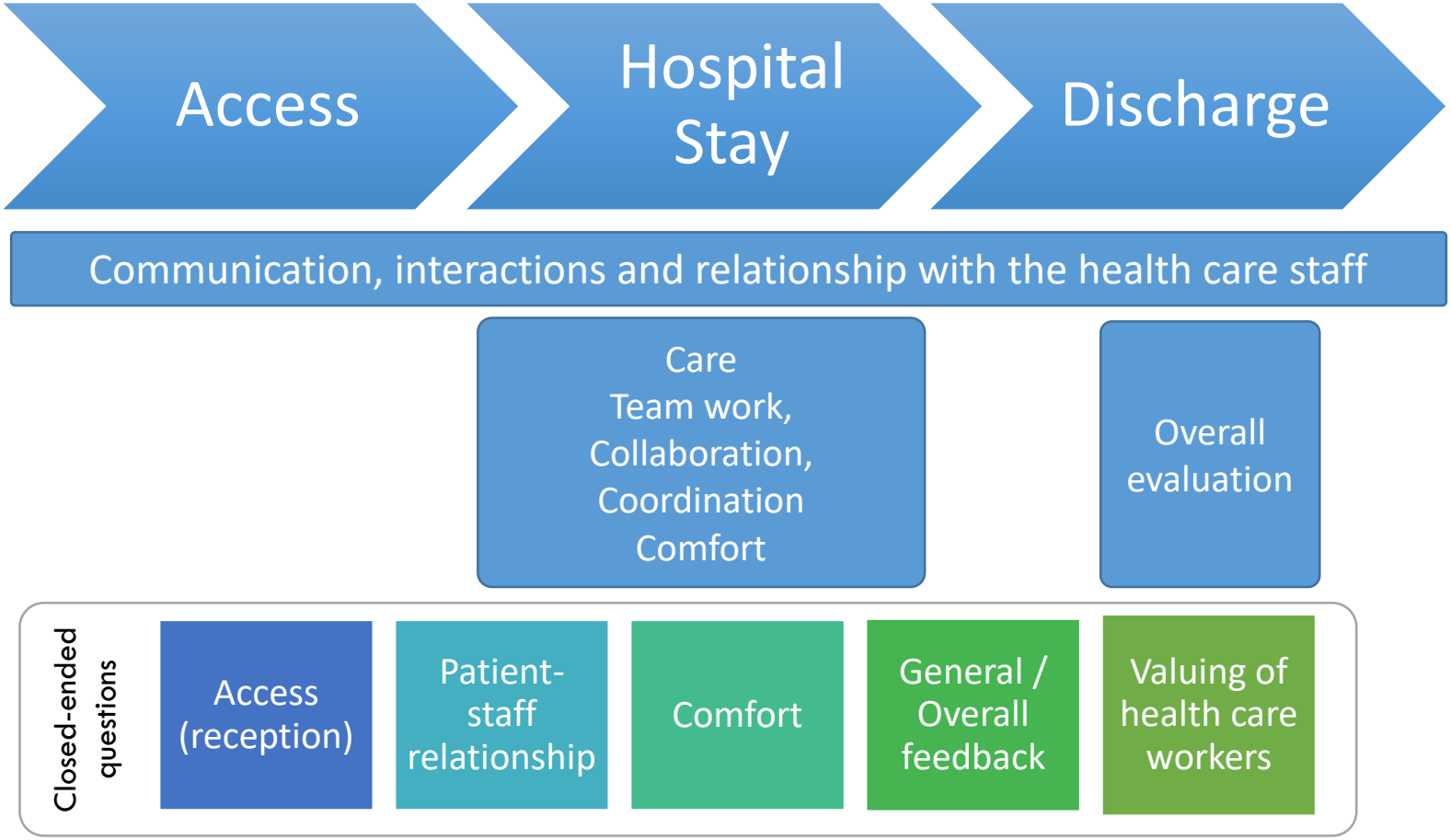
Use of services

Role of family phisician



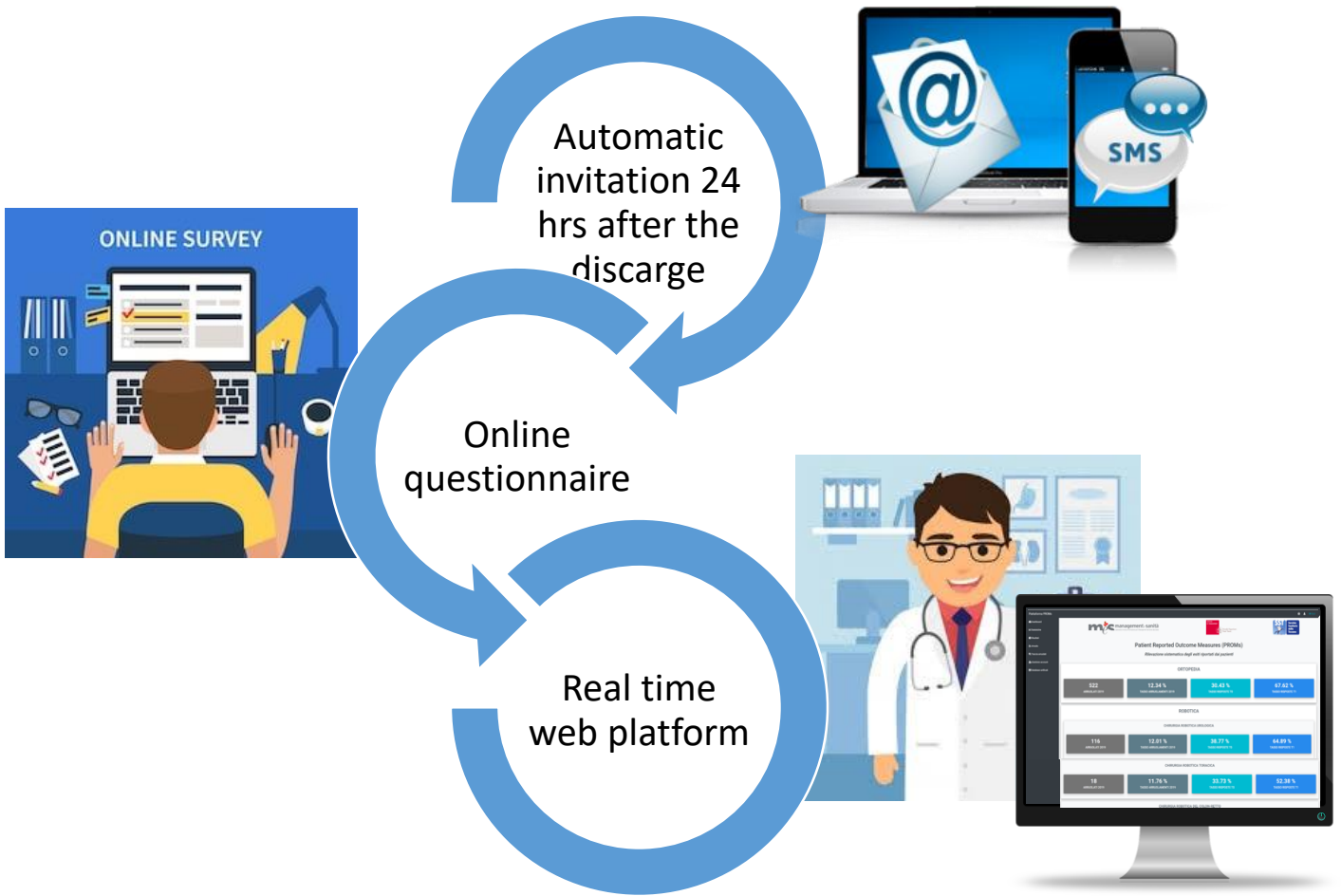


The Questionnaire Follows the **Patient Experience Journey**



The «Next Generation» Surveys

Systematic, open and continous survey



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

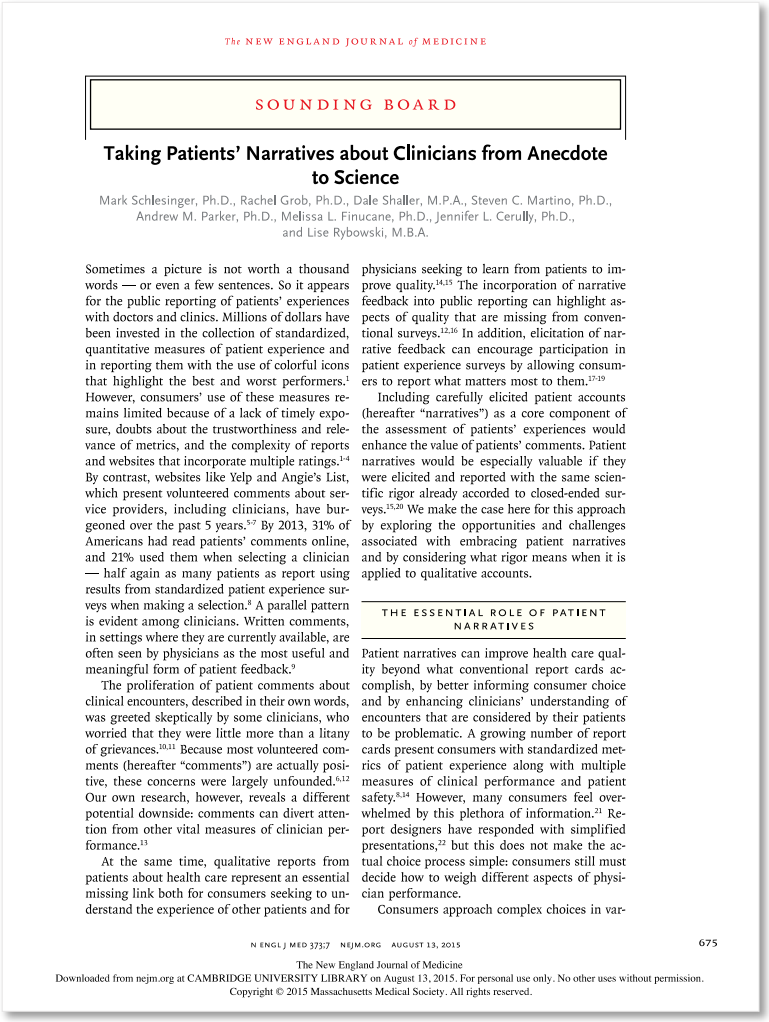
Patient reported outcome measures

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



The NEW ENGLAND JOURNAL of MEDICINE

SOUNDING BOARD

Taking Patients' Narratives about Clinicians from Anecdote to Science

Mark Schlesinger, Ph.D., Rachel Grob, Ph.D., Dale Shaller, M.P.A., Steven C. Martino, Ph.D., Andrew M. Parker, Ph.D., Melissa L. Finucane, Ph.D., Jennifer L. Cerully, Ph.D., and Lise Rybowski, M.B.A.

Sometimes a picture is not 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.[1] 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.[1-4] 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.[5-7] By 2013, 31% of Americans had read patients' comments online, and 21% used them when selecting a clinician — half again as many patients as report using results from standardized patient experience surveys when making a selection.[8] A parallel pattern is evident among clinicians. Written comments, in settings where they are currently available, are often seen by physicians as the most useful and meaningful form of patient feedback.[9]

The proliferation of patient comments about clinical encounters, described in their own words, was greeted skeptically by some clinicians, who worried that they were little more than a litany of grievances.[10,11] Because most volunteered comments (hereafter "comments") are actually positive, these concerns were largely unfounded.[6,12] Our own research, however, reveals a different potential downside: comments can divert attention from other vital measures of clinician performance.[13]

At the same time, qualitative reports from patients about health care represent an essential missing link both for consumers seeking to understand the experience of other patients and for physicians seeking to learn from patients to improve quality.[14,15] The incorporation of narrative feedback into public reporting can highlight aspects of quality that are missing from conventional surveys.[12,16] In addition, elicitation of narrative feedback can encourage participation in patient experience surveys by allowing consumers to report what matters most to them.[17-19]

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.[15,20] We make the case here for this approach by exploring the opportunities and challenges associated with embracing patient narratives and by considering what rigor means when it is applied to qualitative accounts.

THE ESSENTIAL ROLE OF PATIENT NARRATIVES

Patient narratives can improve health care quality beyond what conventional report cards accomplish, by better informing consumer choice 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.[8,14] However, many consumers feel overwhelmed by this plethora of information.[21] Report designers have responded with simplified presentations,[22] but this does not make the actual choice process simple: consumers still must decide how to weigh different aspects of physician performance.

Consumers approach complex choices in var-

(**Buckley A et al** (2016) Patient narratives 1: using patient stories to reflect on care. *Nursing Times*; 112: 10, 22-25.)

PROMs real time feedback

Individual Care & Quality Improvement

PROMs in long-term perspective

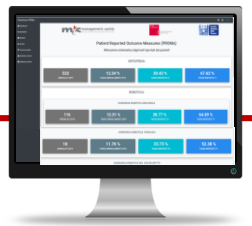
Performance Evaluation

PREMs real time feedback

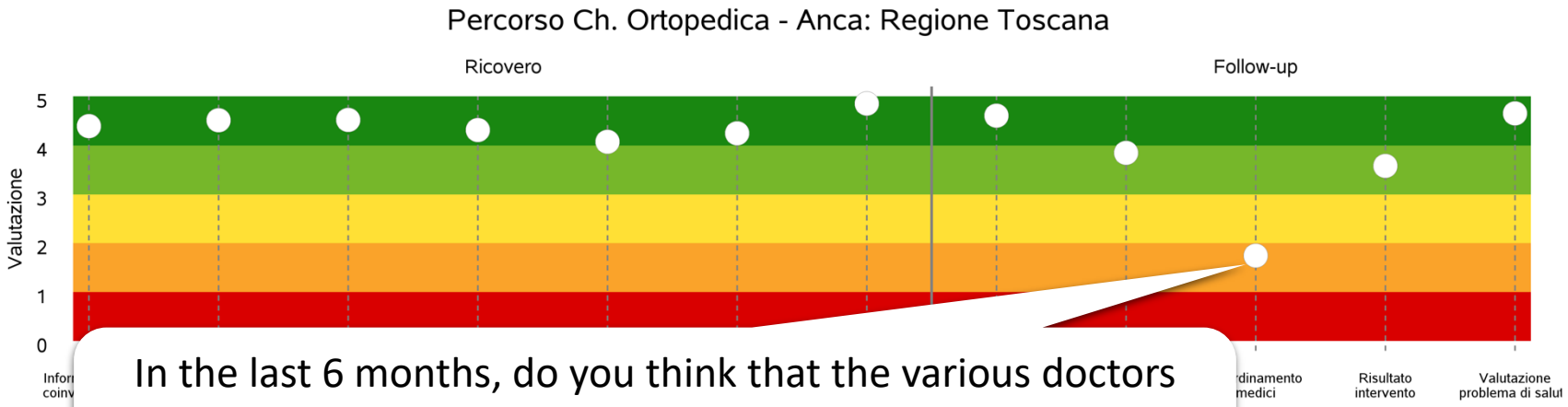
Quality Improvement

PREMs in long-term perspective

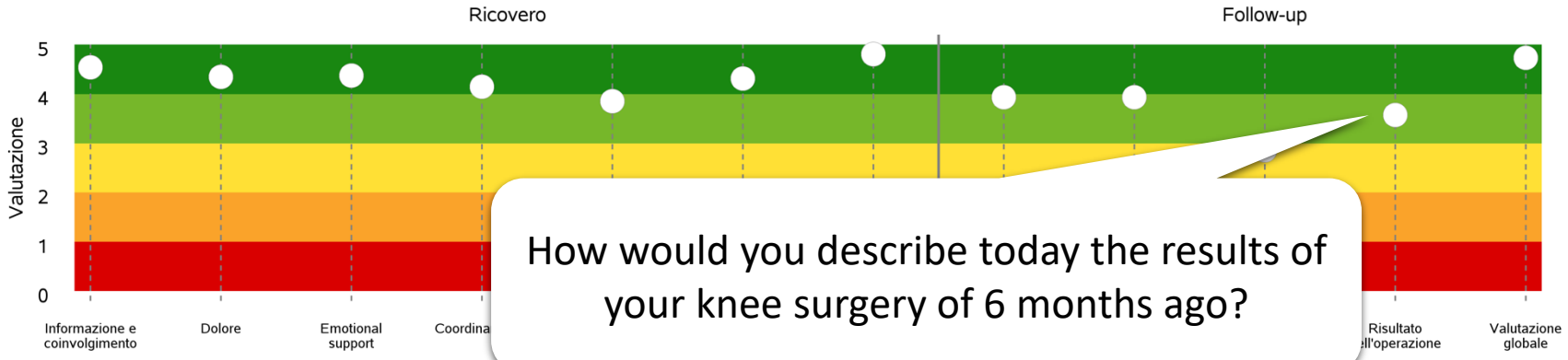
Performance Evaluation



Orthopedic Surgery PROMs

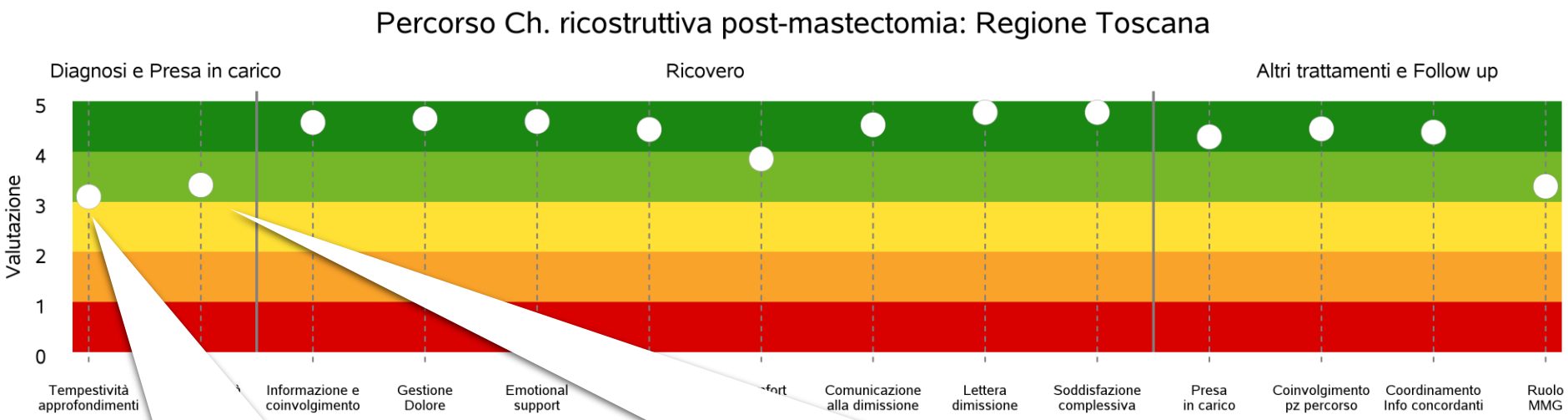


In the last 6 months, do you think that the various doctors who have followed your care were coordinated (i.e. they were informed about your health status or therapies)?



How would you describe today the results of your knee surgery of 6 months ago?

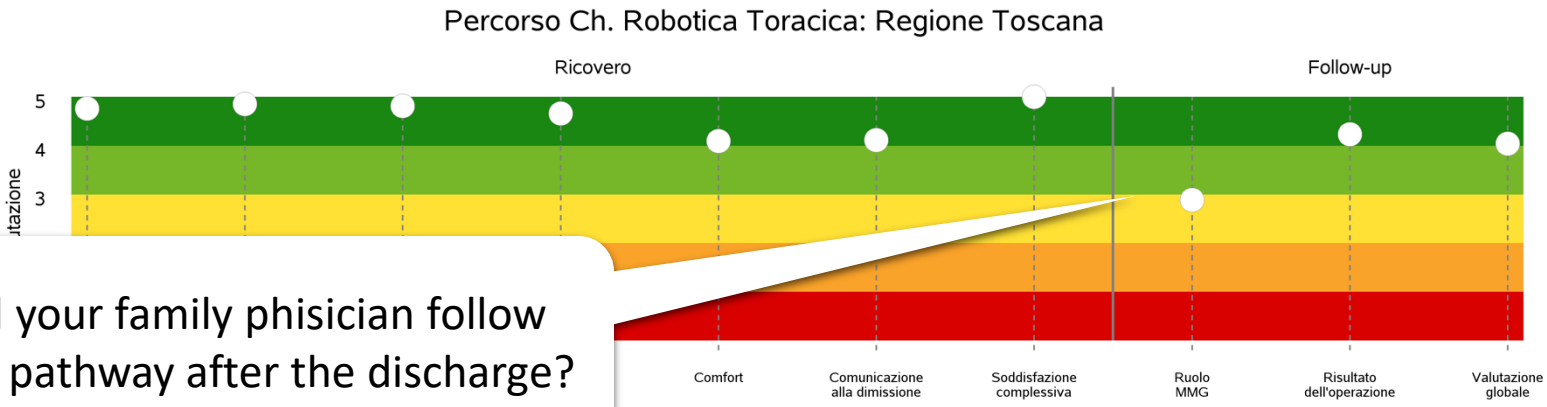
Reconstruction Surgery for Breast Cancer PROMs



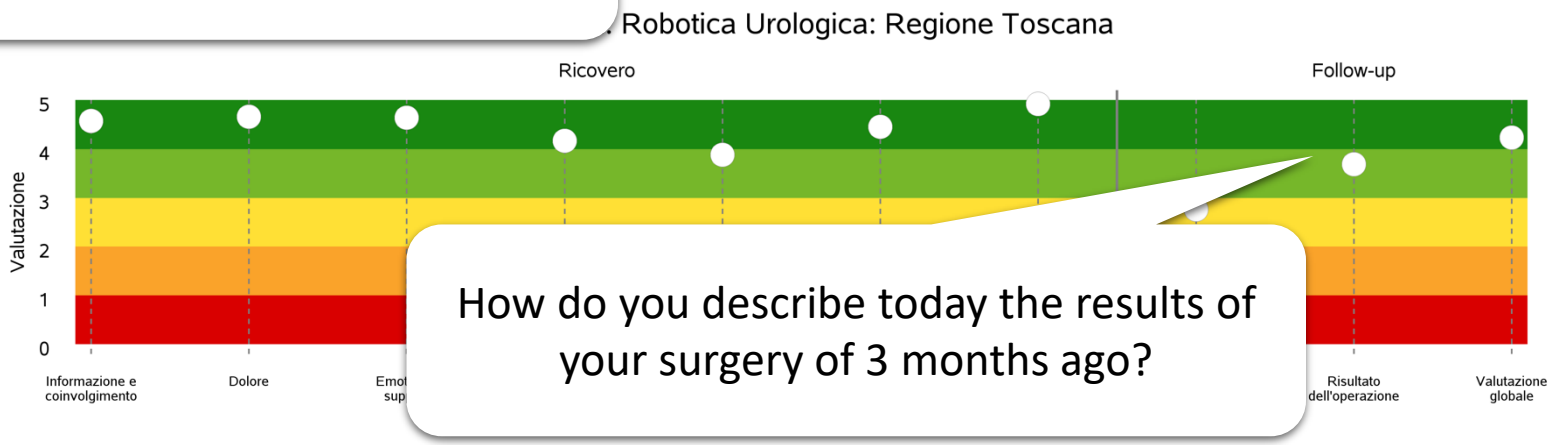
How long did it take between the decision of the surgery and the day of the surgery?

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

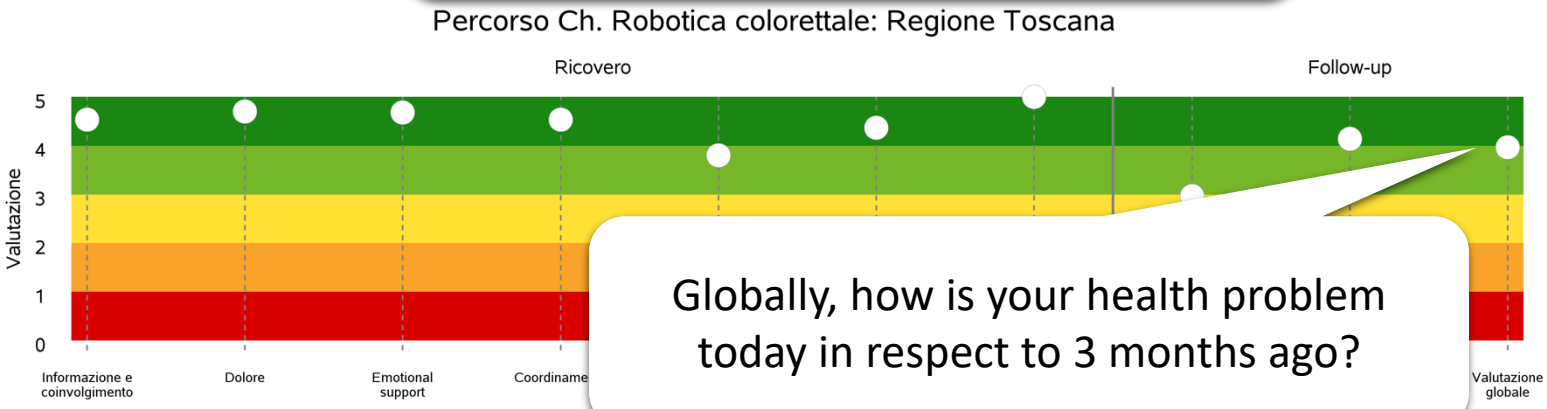
Oncologic Robotic Surgery PROMs



Did your family phisician follow your pathway after the discharge?

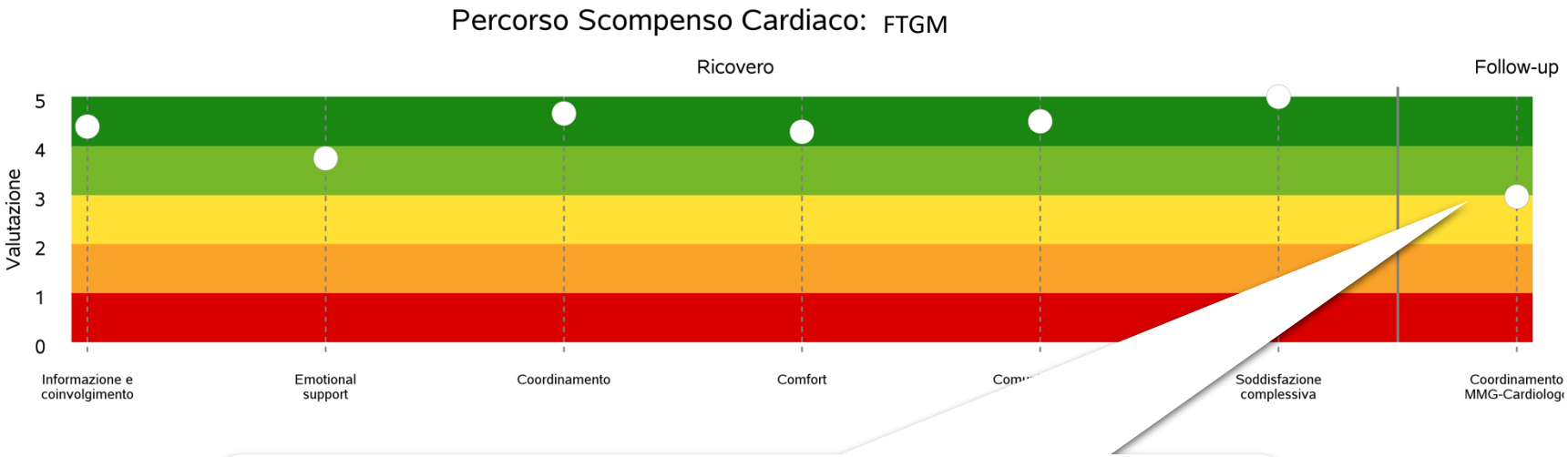


How do you describe today the results of your surgery of 3 months ago?



Globally, how is your health problem today in respect to 3 months ago?

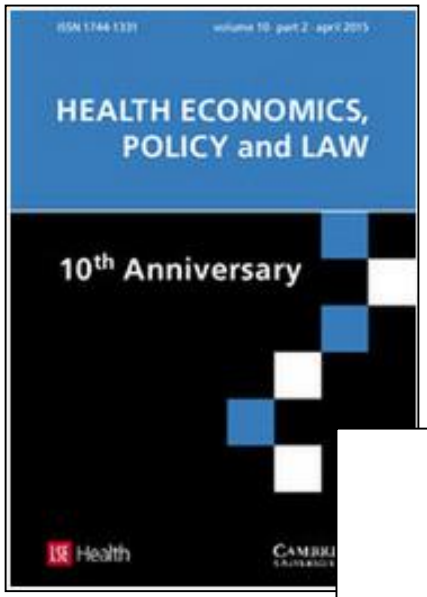
Heart Failure PROMs



In the last 6 months, was your family phisician in contact with the cardiologist to follow your pathway?

	Region	Percentage of improved indicators	Percentage of stable indicators	Percentage of worsened indicators
Medium and large Regions (>2M inhabitants)	Puglia	62.3%	13.0%	24.7%
	Toscana	51.5%	16.2%	32.3%
	Lombardia	52.2%	20.3%	27.5%
	Veneto	61.7%	17.0%	21.3%
	Average	56.9%	16.6%	26.5%
Medium Regions (1-2M inhabitants)	FVG	51.6%	18.3%	30.1%
	Umbria	49.5%	15.1%	35.5%
	Liguria	51.6%	16.8%	31.6%
	Marche	50.0%	19.5%	30.5%
	Average	50.7%	17.4%	31.9%
Small Regions (<1M inhabitants)	Basilicata	46.2%	15.4%	38.5%
	Bolzano	51.7%	14.6%	33.7%
	Trento	50.6%	11.8%	37.6%
	Average	49.5%	13.9%	36.6%

Improving value for population….



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Making governance work in the health care sector: evidence from a 'natural experiment' in Italy

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