VALUE-BASED HEALTHCARE SUMMIT:
TRANSFORMING HEALTHCARE BY REDEFINING VALUE

Summary Report
Prepared by CFHI

March 19, 2018

Presenting Sponsors:
Canadian Foundation for Healthcare improvement
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SUMMARY REPORT

Background

Since the 2006 publication of Redefining Health Care: Creating Value-Based Competition on Results by Michael Porter and Elizabeth Teisberg, Value-Based Healthcare (VBHC) has become a leading approach to improving patient and health system outcomes around the world.

The concepts and strategies that underlie this standards and data-driven approach present tremendous opportunities for health systems in Canada.

A group of Canadian delegates met formally in October 2017 at the conference of the International Consortium for Health Outcomes Measurement (ICHOM) to discuss the potential for the development of additional VBHC resources and coordination in Canada. Representatives from 45 organizations including government, pan-Canadian health organizations, industry and patient organizations were invited.

Participants agreed that a national summit on VBHC would be the preferred first step. In addition to reinforcing a focus on value for patients and families, the summit would explore opportunities to implement VBHC in a Canadian context, and serve as forum for discussion and consensus-building around the establishment of a pan-Canadian coalition, network or other formal partnership to advance VBHC initiatives.

The VBHC Summit was held March 19th, 2018 at the Rotman School of Management in Toronto, Ontario, and brought together health system leaders, healthcare providers, patient organizations, governments, industry and other stakeholders interested in developing and implementing VBHC initiatives at all levels of health systems.

At the Summit, participants received an overview of the key concepts of VBHC and heard about examples from Canada and around the world.

Workshop Planning

A Summit Planning Committee was established following the ICHOM meeting (See Appendix 1) and a project management partner was invited to join to coordinate the work. The Planning Committee was responsible for developing the Summit program (see Appendix 1).

A Steering Committee of representatives of pan Canadian organizations, government, industry and patients was also formed to provide feedback and advice on the program and assist in promoting the event. The Steering Committee will also provide input on how we can support VBHC on a go-forward basis in Canada.

Summit objectives were:
1. Explore foundational concepts of VBHC and provide an overview of global progress to date;
2. Identify and profile current VBHC activities in Canada, including early lessons to support implementation and spread; and
3. Discuss considerations for a successful pan-Canadian approach to VBHC.

The day consisted of a mix of presentations, discussions and group feedback generated via both live Q&A sessions, and online Sli.do polling and comments.

SUMMARY OF PROCEEDINGS

Official Welcome to the Rotman School of Management

**Brian Golden** – Chair of Health Sector Strategy, Rotman School of Management

Brian welcomed delegates, noting his pleasure in hosting the Summit at Rotman. He recalled his meeting in 2005 with Michael Porter about introducing VBHC principles in Canada, which were being taken up around the world, but not yet in Canada. Since then, Brian noted, Canada has begun to introduce initiatives that are having a measurable impact and generating lessons for further uptake of VBHC.

Patient Reflection

**Louise Binder** – Health Policy Consultant, Save Your Skin Foundation

What does “value” mean to patients? How do they know it when they see it? What will it take to move toward VBHC?

**Key Messages:**

- Patients have a vision of a world where they are well. Louise argued that first and foremost value means a system that uses reasonable resources and initiatives to prevent people from getting sick. After all, as her mother always repeated, “An ounce of prevention is worth a pound of cure.”

- We can’t ignore important social determinants of health such as housing, race, ethnicity, employment and income which, individually and collectively, impact people’s ability to be well. To provide value for everyone, we need to create an equitable and accessible health system.

- Louise contends that a re-engineering of the system needs to take place to meet patients’ needs, including deploying resources in a timely manner to ensure the best possible care.

“We are the early adopters of VBHC. Of course there will be detractors – I say ignore them! Let’s develop a network of stakeholders to map the strategy for how VBHC gets done in Canada.”

- Louise Binder
Overview of the Day

Fred Horne – Chair, Summit Steering Committee

Fred explained the motivation for bringing together this group of stakeholders, which stems from the ICHOM global conference in October 2017, which brought together a range of nearly 600 healthcare leaders from 33 countries interested in VBHC.

Keynote Address

Scott Wallace – Managing Director, Value Institute for Health and Care and Associate Professor, Dell Medical School, The University of Texas at Austin (Slides available at: www.vbhcanada.com/s/830-930_KeynoteAddress_Wallace.pdf)

VBHC is gaining momentum globally. What are the foundational principles and how can Canada make even greater strides towards VBHC?

Key Messages:

• The problem with healthcare is that it does not improve health enough; we are spending a lot, but we are not getting a lot in return.

• Focus on prevention and appropriate/effective management of health problems because living in good health is inherently less expensive.

• The debate on whether to spend more or ration healthcare is a false dichotomy. We need to think about how we can dramatically improve healthcare value.

• There is only one perspective – value for patients. If we aren’t creating value for them, there is nothing else to discuss.

• Two big problems: we generally don’t measure outcomes and we don’t measure costs. Currently, there is a focus on collecting process measures, but we need to start measuring outcomes that matter as well.

"Healthcare is one of the world’s great data-free zones."
- Scott Wallace

• Simply reducing waste or paying less for ineffective care is not enough. If we dramatically change outcomes, then the cost savings will follow. When you do things better they’re less expensive.

• Link health outcomes to physicians and identify high-performers and elements of their clinical practice that may be leading to better health outcomes.

Figure 1: Definition of value in VBHC

Value

Outcomes that matter to patients

Costs throughout the patient journey

Value = ----------------------------------------

Outcomes that matter to patients

Costs throughout the patient journey


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What health outcomes to measure?

- The right question in healthcare is “How are you?” not “How were we?”
- The outcomes that matter the most depend on the nature of the healthcare service. Mortality is not always relevant, and other health outcomes may be more important, such as:
  - **Capability**: Are patients able to do things that are important to them (e.g. maintain urinary continence following prostate cancer surgery, or walk after hip replacement). We also need to measure changes (improvement or decline) in capability.
  - **Comfort**: Did we decrease the pain and suffering of the patient and how much?
  - **Calm**: Did we enable calm to promote greater healing?

- How and when to measure
  - Around medically defined patient segments.

> At individual patient level during and after care.

> A limited set of measures (3-5 within the framework of capability, comfort and calm).

- Recommendations for guiding a national effort to improve value
  - Move from a service line to a segment structure: reorganize (e.g., co-locate services) around medically defined patient segments with overlapping needs, and move away from structures that are organized around how physicians are trained or compensated.
  - Measure the outcomes that are meaningful and specific to the patient’s medical circumstances.
  - Leadership sets the direction and fosters local initiatives.

*Experience groups bring together patients that have similar conditions to talk about the experience of living with the condition. The purpose is to understand patient experiences, which is different from focus groups that seek patients’ solutions, opinions or ideas.*

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Discussion questions:

What do we do first?

- We need to start by measuring current health outcomes to understand the state of the health system. We need to first define the problem before we can find a solution.

- For example, it was assumed that stabilizing a serious trauma patient before transport to a trauma center would increase survival. In fact, 90% of stabilized patients died, compared to 40% that were transported directly to the trauma center. This data led to an immediate change to the standard of care.

How important is it to get permission to get started?

- Most changes are led by one person, one place at a time. Broader support is needed for system-level change.

- Collect pilot data to show that the innovation works. Use comparable measures to the status quo so that the value of the innovation is clear.

- Don’t get hung up on payment structures; you can’t pay for something that doesn’t exist!
VALUE-BASED HEALTHCARE: Executive Brief and Case Profiles

Session Chair:
Jennifer Zelmer – President, Azimuth Health Group; CFHI Faculty

VBHC is in its infancy in Canada. Who are the leaders and early adopters and what have they learned so far?

Panel:
Erik Sande – President, Medavie
Mary Lou Ackerman – Vice-President of Innovation, Saint Elizabeth
Alexis Wise – Senior Manager, Capital Advisory, MaRS Centre for Impact Investing
William Charnetski – Ontario Chief Health Innovation Strategist (OCHIS)

Key Messages:
Erik Sande

- Medavie Health Services has been working on the integration of EMS, telehealth and homecare to increase capacity and manage costs in several provinces (e.g., New Brunswick, Nova Scotia, and Prince Edward Island), allowing savings to be re-invested back into the system. For example, paramedics are providing support in long term care facilities to avoid preventable emergency department visits.

- In New Brunswick, Medavie has responsibility for the Extra-Mural Program (EMP), which delivers a range of primary health care services to New Brunswickers of all ages in their homes and communities. Medavie is compensated under the EMP if specific metrics are met:
  » Increased capacity for homecare
  » Reduced number of emergency room visits by 50%
  » Reduced time to care from 3 days to 1 day from order of care from physician
  » Increased physician referrals by 20%
  » Achieved a minimum 95% patient satisfaction
Mary Lou Ackerman

- Saint Elizabeth is Canada’s largest social enterprise, and has worked on many initiatives with a focus on value.

- Recently Trillium Health Partners and Saint Elizabeth partnered on an integrated (bundled) funding model, with support from Mississauga Halton Local Health Integration Network, to get people with chronic obstructive pulmonary disease and congestive heart failure transferred from hospital to home as seamlessly as possible. This was done using a coordinated team approach across healthcare partners to reduce costs associated with emergency department visits and hospitalizations (hospital – both acute and outpatient, community, and primary care).

- They are now looking to expand these services for other patient segments.

Alexis Wise

- About one hundred Social Impact Bond (SIB) models (with approximately 20 in the health sphere) have been launched internationally, representing a shift in how health and social services are funded.

- SIBs are not a mechanism for restructuring healthcare. They are a way to identify new funding and delivery approaches that make a demonstrable difference for patients and that can be scaled up.

- However, SIBs and VBHC both:
  » Revolve around impact investing and social finance.
  » Emphasize meaningful and measurable outcomes.
  » Make efforts to change the way money is deployed.

- Typically in an SIB agreement, a health or social service provider partners with government and seeks a private investor to obtain working capital. The private partner takes on financial risk, with the dual aim of positive social impact and potential redemption of rewards which are contingent on the achievement of pre-determined outcomes.

- Key factors for a successful SIB program include a defined target population, and measurable outcomes that matter to the target population.

William Charnetski

- The purpose of OCHIS is to increase innovation receptor capacity in the province, grow Ontario companies and scale solutions. In reviewing the current approaches, three things became clear:

  » Need to shift towards value-based procurement in Ontario because a large population of 13.5 million people (bigger than Kaiser Permanente) obliges a strategic approach to procurement focused on value.

  » Need to get better at identifying innovations and pulling them into the system.

  » Many barriers exist in such a large, complex system. We need to help colleagues make the shift to VBHC.
Where is VBHC best poised? What is the value of VBHC?

• Homecare. In this context, VBHC means addressing the unmet needs of patients and their families by forming new relationships to improve continuity and transitions in care.

• VBHC can be used to improve accountability by creating a financial penalty. For example, if healthcare providers do not do it then they will not get paid.

• The current healthcare system is not sustainable with the demographic changes ahead. Adoption and scale of innovation is necessary. It needs to be evidence-based with incentives aligned to objectives. We need to be open to doing things differently. There has to be the potential to generate evidence and implement the results with appropriate change management. The current health system does not allow for this.

What specific areas could benefit from VBHC? What should be tackled first?

• Shifting from acute to community-based care, better access to primary care, and improving the health of the aging population could benefit from VBHC. We need to build the team of clinical providers around the patients to address the capacity issue so that we can give more with the same team.

• Palliative and end-of-life care: Many patients would prefer to die at home, but end up in the hospital.

What aren’t we talking about now related to VBHC that we should be?

• What is being done better and differently elsewhere in the world?

• Our level of commitment for moving pilots to spread and scale. It’s a fallacy to think that a successful VBHC project will automatically sustain and scale. The appropriate systems, metrics and resources need to be in place for scale to happen.

How can we ensure frontline engagement in VBHC?

• Work collaboratively as a community and be open to reallocation of responsibilities. Consider unspoken issues including interprofessional competition.

What is the single most important thing others should know about VBHC?

• Find a champion who thinks like you and is passionate and willing to join you in taking a calculated risk. Champions are typically interested in incremental improvements, but also want to take a big leaps, and can look beyond short political cycles.

• Think about care based on values as a starting point, i.e. what’s the value to patients and caregivers?

• Just start. Build capacity. Measure the outcomes. Do more next year and keep building and learning!

Discussion questions:
Integrating for Value

Session Chair:
Kim Furlong – Director of Federal Government Affairs, Amgen Canada

Transforming the organization and delivery of care is essential to the value-based approach. Fundamental changes to the design and leadership of care teams, and a shift from specialty-focused departments to multispecialty collaboration is critical to success. This session brought together Canadian and international experts who discussed integrated care models, approaches to change management and lessons learned.

Panel:
Henk Veeze – Diabeter, The Netherlands
Caleb Stowell – Enterprise Director, Value-Based Care, Providence Health and Services, Seattle
Shirlee Sharkey – CEO, Saint Elizabeth

Key Messages:
Henk Veeze

- Resigned from his hospital position and applied for funding to build his own health services structure. He co-founded the integrated practice unit Diabeter for patients with Type 1 Diabetes.

- He delegated administrative work so that physicians could see twice as many patients.

- Created dashboards ranking physicians to identify high-performers that could help other staff improve their clinical practices.

- Diabeter has been in place for 10 years and has moved to bundled payments. They are funded for 3-4 month periods to cover all costs. Based on the patient profiles, they can renegotiate for risk sharing agreements.

- The largest cost saving to the healthcare system has been through reduced hospitalizations – only 3% for Diabeter patients vs 8% for other patients resulting in a cost savings of 8.6%.

Caleb Stowell

- Providence St. Joseph Health changed from being a holding company to an operating company.

- Consolidation led to increased volume and process efficiency.

- Patients are triaged to identify the appropriate facility to meet their needs.

- Digital resources are available to provide support for patients and families outside of the clinical encounter.

Figure 4: Caleb Stowell’s slide, “The Michael Porter features of an Integrated Practice Unit (IPU)”


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**Shirlee Sharkey**

- Saint Elizabeth is not a hospital, but it is everything else. It is thought of as the missing piece in the healthcare puzzle.

- The organization customizes and personalizes care for their patients and empowers them to become partners in care.

- VBHC needs innovation and change. Saint Elizabeth identified gaps and co-designed new approaches to improve quality of care.

- There was no additional funding to make the changes happen. The organization wanted it to happen and worked to put the necessary services in place.

**Summary Messages:**

- Consolidation to remove duplication of services has resulted in better outcomes at a lower cost.

- Stay focused and do not mix medically defined patient segments.

- High quality measurement, data and data platforms:
  - Are key to understanding effectiveness of the program and experience of patients.
  - Can be a powerful way to nudge providers to deliver better care and root out low value practices.
  - Allow learning, adjustment, and self-management between visits and consultations with the healthcare provider, when accessible by both patients and providers.

- The one thing panelists want the audience to know
  - Challenge the consistency of pathways and data. There needs to be a redesign of linear, mechanistic pathways, especially in locations that are less controlled.
  - Follow your patient segment to understand their journey, and then build a team to solve the problem of how to create the best care and outcomes for them.
  - Think big. Act small. And don’t wait.
Funding for Value

Session Chair:

Jason Vanderheyden – National Director, Value-Based Healthcare, Medtronic Canada

The move to VBHC will require a shift to alternative payment models. Providers and payers will need to collaborate to begin paying for outcomes instead of activity. New models such as bundled payments can help incentivize care providers to organize around the patient. This session explored innovative models being used in Canada and abroad to support the move to a more patient-centric funding approach that rewards providers for outstanding patient outcomes.

Panel:

Fredrika Scarth – Director, Health Quality Ontario Liaison and Program Development Branch

Brian Golden – Chair of Health Sector Strategy, Rotman School of Management

Kevin Smith – CEO, St. Joseph’s Health System, Ontario

Jason Sutherland – Associate Professor, UBC School of Population & Public Health

Key Messages:

Jason Sutherland

• Value-based funding is re-allocation of funding rather than cutting of resources.

• Global budget, fee-for-service and contracts are common.

• What’s new? Bundled payments. However, all bundles are different (e.g. cover different healthcare services across variable amounts of time).

• Accountable Care Organizations (ACOs) and Diagnosis Risk Groups (DRGs) are evolving. Hospitals are acquiring specialist offices. Healthcare professional roles are changing. Evidence is evolving quickly. There are no silver bullets, people are simply trying new approaches.

• What’s next for Canada? Framing of the context and policy changes are available. We should aim new developments toward where the opportunities lie.

• We need investment to induce changes. DRGs, Case Mix Groups (CMGs) and Quality-Based Procedures (QBP) could be used. Bundled payments are most likely since this approach provides a financial incentive for providers to deliver better care.

• What are the gaps? We need to develop learning health organizations to reflexively respond to what is happening in the healthcare system.

• We have a patchwork for payment of providers, so we will likely move with incremental changes.

Fredrika Scarth (Slides available at: www.vbhcanada.com/s/1245-1345_FundingForValue_Scarth.pdf)

• Funding should enable integrated care.

• Ontario has been moving to reform hospital payments from global budget to activity-based funding and bundled care for inpatient, outpatient and home care.

• Ontario has conducted six bundled payment pilots and is scaling up the bundles based on the results. Bundles include acute, post-acute and home care.

• Ontario offered the bundles to hospitals. They were careful not to be prescriptive on how to deliver care or how providers work together. Hospitals stated which patients are eligible, the costs and the outcomes measures.

• Evaluation lessons from the Ontario bundled-payment pilot projects:

  » Have a third party (objective) evaluator.

  » Go fast on bundles for acute, episodic care. It’s clear what should be included in the bundle and there is good evidence on outcomes.

  » Go slow on bundles for chronic, complex conditions as evaluation showed challenges with implementation. More development work is needed on care pathways and what is in/out of the bundle.
Even blunt level evaluative data showing that better care being delivered to more people at a comparable cost will appeal to politicians and decision-makers.

- Design and implementation lessons from the Ontario bundled-payment pilot projects:
  - Patient and family partnerships enhanced the program design.
  - Physician engagement and commitment was critical to success across all projects.
  - Frontline staff input and rapid course correction helped keep programs clinically feasible, relevant and on track.

- Leadership lessons from the Ontario bundled-payment pilot projects:
  - Involve Boards in determining what VBHC looks like and tracking progress.
  - Leaders can empower teams to test out new ideas without necessarily worrying about resourcing, but introducing innovation in an already constrained system requires new or reallocated resources.
  - No investment means incremental improvement, not innovation. Leaders need the courage to change the way funding is distributed to spark innovation.

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**Kevin Smith** (Slides available at: [www.vbhcanada.com/s/1245-1345_FundingForValue_Smith.pdf](http://www.vbhcanada.com/s/1245-1345_FundingForValue_Smith.pdf))

- We can achieve integrated care through bundling episodes of care and funding with the goal of better, faster and cheaper healthcare.

- St. Joseph’s Health System identified diseases where potential savings could be gained. Essential elements for development of integrated care bundles were: patient and family partnership, physician engagement and commitment, senior leadership attention, frontline staff input and course correction.

- Bundles allow the provider to decide what should be done. In the current system, some services are provided simply because physicians would not get paid if they did not do it, even if patients and physicians do not see its value.

- The Canadian advantage is that we can innovate before figuring out the funding. The goal is to put as much as we can into the bundle (eventually even physician and drug costs).

- Innovation requires investment, and no investment means incrementalism not innovation.

- Evaluate before you congratulate.


- We need distributed payment for value. The selection of team, bundle and payment are important.

- We need to look for opportunities where we can shift from a higher cost provider while maintaining or improving the quality of care. To do this, organizations must know their costs and payers have to understand the true cost of providing care.

- We need transfer payment capabilities to facilitate collaboration, and most organizations cannot do this. To do this, we need enabling information technology. With it we could set a price and see who could do it for that price, then adjust the price up or down as necessary.

- We need courage to change the way that funding is allocated to align funding with the outcomes that we want. We need to work with physicians to get there since their compensation may be affected.

**Discussion Questions:**

**What is the role of physicians?**

- Changes to funding cannot be done without the engagement, support and leadership of physicians. **Importantly**, physician compensation has not yet been included in bundled payments since we have not yet had the opportunity to negotiate the price.

- Champions tend to be physicians. They want to be involved since they think that VBHC will have a positive impact for their patients. It may also mean a dramatic improvement in the quality of their work-life balance.

**How to improve our understanding of costs? What methods to use?**

- We don't know our detailed costs in healthcare – we haven't invested in measuring them.

- Providers and hospitals are competent in understanding their costs. If we create a system where it matters to providers to figure out costs, then physicians will figure it out.

- If we can show better care for the same cost, then policy makers will be pleased.

>“Every system is perfectly designed to get the results it gets.” - Paul Batalden
### Measuring Value: Data, Standards, and Cost

**Session Chair:**

Andre Dias – Head of Commercial and Regulatory Development, MYIA Labs

Data and analytics are critical enablers of any VBHC initiative. Healthcare teams, patients, payers and policy makers all need to understand the desired outcomes and the cost of achieving them to be able to succeed in the shift from volume to value. This session explored information and strategies required to power VBHC at all levels of health systems.

**Panel:**

**Jacob Lippa** – Manager of Clinical Analytics, Value-Based Healthcare, Providence St. Joseph Health, Seattle

**Angela Copeland** – Director, Data & Analytics Strategic Initiatives & Governance, Analytics and Informatics, Cancer Care Ontario

**Lynne Zucker** – Vice President, Clinical Systems Integration, Canada Health Infoway (CHI)

**Greg Webster** – Director, Acute and Ambulatory Information Services, Canadian Institute for Health Information (CIHI)

**Key Messages:**


- Described how cost and health outcome data are collected and used at Providence St. Joseph Health to assess value and identify opportunities to improve.
- The information is presented using a value plot with various data filters so that users can change the granularity to view the information that they need.
- Traditional outcomes, patient experience and patient-reported outcomes can be viewed individually or in composite.

**Angela Copeland**

- Cancer Care Ontario is focused on performance and quality improvement for cancer and chronic kidney disease.
- CCO oversees the funding of health services as well as collects, manages, and disseminates health-related data and information.
- Angela believes that VBHC will help to bridge silos. In particular, it would be useful to combine data around continuity of care to identify areas for improvement.


- Canada Health Infoway is moving toward offering digital solutions, rather than just funding.
- The organization has developed a new national prescribing service that will offer opportunities to collect valuable information, including standardized prescription data.
- They are also conducting a pilot study to assess the value of giving citizens access to personal health record (PHR).
- The system offers various e-services: e-view (viewing health information), e-visit (secure email or text messaging), virtual visit (face-to-face virtual encounter with healthcare provider), and online request for prescription renewal. Preliminary results show that the program reduces health system, as well as patient and caregiver costs.
Greg Webster

- We are short on the right kinds of data in Canada to support VBHC.
- CIHI collects, links and disseminates health data. The organization has three strategic goals to: (1) be a trusted source of standards and quality data; (2) expand analytical tools to support measurement; and (3) produce actionable analysis and accelerate its adoption.
- CIHI can provide the data to drive VBHC. However, CIHI’s data is not comprehensive and there are gaps to be filled. For example, increasing access to physician billing data, PROMs and PREMs.
- We need to identify the information that we want and make data collection easier, particularly from patients.

Summary:

- Data is the currency of VBHC.
- There is a need for pan-Canadian capacity to collect, link and disseminate data across the country.
- Quite a bit of data is available at the national level, including clinical, pharmaceutical, costing, and patient-reported experience and outcomes measures data. Bringing the various data together provides a big opportunity for informing VBHC endeavours.

Discussion questions:

What are patient reported outcome measures (PROMs) and how do you start to capture that at the hospital level?

- Any self-report of patient status. For example functional, cognitive status, pain level. This is the outcomes of care from the patient’s perspective, and does not include the experience.
- First, we need to figure out what is worth measuring. Then transform the data analytics and platform to capture the data.
- We need new data collaboration and modern mechanisms to bring the data to bear. We need to put it in a place where everyone can leverage the data (e.g. CIHI). We also need a digital ID for all citizens to facilitate linkage with provincial databases. We need organizations to link their data, even if it is de-identified.

How were these measures developed?

- Clinical steering groups and scientific advisory groups, including patients at the centre.
- By starting to look at data differently and pushing the boundary from the standard/traditional measures and by looking at the patient journey.
- To know which types of services are working best for patients, it’s important to look at costs and build in some measures for the unpaid caregiver.

Are there existing standards about what to measure and how? How do we ensure we are not re-inventing the wheel?

- It’s one thing to set standards, but people don’t necessarily adopt them. We must think about appropriate incentives.
- There are hundreds of measures to choose from.
- Ideally jurisdictions will align measures to allow for cross-jurisdictional comparability.

Which organization is in the best position to drive VBHC nationally?

- It was suggested that VBHC needs to be federally-driven, and coordinated amongst the provinces/territories, and that the federal/provincial/territorial ministries of health need to come to an agreement on core measures of VBHC. Alternatively, the federal role could be to identify and share effective provincially-driven initiatives.
- May be too much for one organization, but we need national alignment. CIHI and CHI are potential organizations to undertake this kind of work.
- Need economies of scale. For example, work with CIHI and others on datasets, analysis and sharing data.

• Attaching funding helps get alignment.

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Implementation and Lessons Learned: Accelerating VBHC in Canada – Open Dialogue

Four questions were brought forward for discussion:

1. What leadership is required to support the shift to VBHC?
2. What are the key resources and enablers needed to move ahead?
3. What hurdles should we expect and what are the likely solutions?
4. What are the roles and opportunities related to working on VBHC with industry?

Maria asked everyone to take two minutes to reflect on the day and discuss these questions with another participant. At two minutes, participants were asked to speak to someone else, and finally to record responses in the online Sli.do polling and comment application.

As a group we need to put the structures and systems in place to make VBHC a reality. We are on a journey to understand what VBHC is and what it is not, what it means, who needs to do what, what’s working, why and how.

Fred thanked CFHI for being a great place to bring ideas. Maria Judd and Maureen O’Neil enthusiastically supported the summit from the outset.

Maria acknowledged that VBHC is a good fit given that CFHI identifies proven healthcare innovations and helps them to accelerate their spread across Canada by helping organizations adapt, implement and measure solutions that improve the patient experience, healthcare outcomes, and value for money.

A group of pre-identified senior health systems leaders helped lead the discussion by providing targeted feedback and responses, along with participants’ reflections, including:

- William Charnetski – Chief Health Innovation Strategist, Ontario
- Janet Davidson – Chair, Canadian Institute for Health Information
- Neil Fraser – President, Medtronic Canada
- Brian Golden – Centre for Health Sector Strategy, Rotman School of Management
- Peter Juhn – Head of Global Value-based Partnerships, Amgen
- Brian O’Rourke – President and Chief Executive Officer, Canadian Agency for Drugs and Technologies in Health
- Fredrika Scarth – Director, HQO Liaison and Program Development Branch, Health System Quality and Funding Divisions, MOHLTC
- Jennifer Zelmer – President, Azimuth Health Group
Discussion questions:

What leadership is required to support a shift to VBHC?

- Leaders willing to engage with patients in a meaningful way. In many cases patient engagement is absent, passive, or even adversarial.
- While a leader doesn’t get into the nuts and bolts, they must have an innovative, problem-solving mentality of asking ‘why not?’ so they don’t get stuck perpetuating the status quo.
- Innovations need to be co-led by physicians. Success follows a tight-loose-tight framework: Be tight on your expectations, loose on how they will be delivered and tight on performance measurement.

What are the key resources and enablers needed to move ahead?

- A pan-Canadian solution on VBHC may be tantamount to boiling the ocean. But the provinces and territories can make progress, and organizations like CFHI can identify and help spread best practices, while other organizations can help keep the conversations and learnings on VBHC happening from coast to coast.
- Generally new things we want to do in healthcare are ‘cost plus’ items. Eliminate the things that don’t add value in the system so that we can make room for the things that do. For example, collect data on outcomes that are important to patients and look at whether drugs and devices are delivering these outcomes. If we are not achieving the desired outcomes, the drug, technology or device should be removed from the system.
- CADTH (and INESS in Québec) have always been focused on the value of new drugs, technologies and devices compared to those that are currently being used. And they now incorporate patient input into everything they do.

What hurdles should we expect and what are the likely solutions?

- Strengthening the patient and family voice requires bolstering organizational culture and infrastructure. Patient partners must be a part of decision-making bodies and processes in a systematic and intentional way.
- Could we start by looking at what outcomes we want– and our patients want– and then establish the best way to bundle payments, assemble teams, etc? This will help us learn where systems are working well and where they need to change.
- VBHC is about changing how we work. Research tells us this can take years, but it can be accelerated by having strong leadership and the voice of patient organizations at provincial/territorial and pan-Canadian levels.
- It’s very important to have a strong description of and rationale for VBHC that people can understand. Otherwise, people will be skeptical and fatigued about ‘yet another change’.
- Small changes can be helpful. We do not necessarily need a national strategy for everything right away. We need thoughtful adaptation and learning.
- We need to think about how to fund patient groups differently, to avoid the inherent risks of pharmaceutical industry funding.
“Why don’t we do something radical and ask patient experts what they want, and then design around that.”
- Participant

What are the roles and opportunities related to working on VBHC with industry?

- What are the strategic opportunities to work with industry? Historically, industry hasn’t been seen positively. We need to shift to seeing industry as a partner within certain parameters. We need to challenge industry to be credible partners.

- Industry can provide leadership by focusing their organizations on patient outcomes, cutting-edge technologies, deep clinical research expertise to bring products to market, and insights on maximizing productivity management for informing clinical programs and pathways.

- Industry can take ownership of the benefits that patients receive from their products. Through social impact bond investment arrangements, for example, they can take on a share of the risk in efforts to achieve specified health outcomes.

Patient Reflection

Angela Morin – Patient Partner, Canadian Foundation for Healthcare Improvement

Key Messages:

- Angela emphasized that, just as the doctors in the room do not speak for all doctors, she does not speak for all patients.

- Angela reflected that the Summit was about building a VBHC system that will be better for all of us. However, before we can truly move toward such a system, we must engage patients, not just as the receivers of healthcare, but to ensure patient values are included in the design of healthcare from the beginning. As an example, she highlighted an exercise where the outcome of a patient journey mapping exercise looks vastly different when done with patients versus one done by providers. Patients see the big picture.

- Following the day’s discussions, the key question will be how to design a healthcare system that meets the needs of patients. Angela asked delegates to think seriously about how they will find out what matters to patients and to define the vision and core principles for VBHC with patients, not just for them. There is great power in all stakeholders working together toward a common goal.
Summary and Next Steps

Fred Horne – Chair, Summit Steering Committee

Fred thanked participants, sponsors and organizers. Immediate next steps included:

• A steering committee debrief
• Slide presentations posted online at www.vbhcanada.com
• Brief key lessons and outcomes report circulated to delegates

Networking Reception

Delegates were invited to Rotman’s Atrium for an informal reception hosted by the Summit Steering Committee.

From left to right: Fred Horne, Andre Dias, Kim Furlong, Jason Vanderheyden, Jessica Rudd and Jewel Buksa
APPENDICES

Appendix 1: Program, Committees & Certification

Transforming Healthcare by Redefining Value

MARCH 19, 2018 | ROTMAN SCHOOL OF MANAGEMENT | TORONTO, ONTARIO

Presenting Sponsors:

Canadian Foundation for Healthcare Improvement
Fondation canadienne pour l’amélioration des services de santé

Contributing Sponsors:

AMGEN  CADTH  Canada Interroute Health Infoway du Canada  Medtronic  Rotman Centre for Health Sector Strategy
**Summit Program**

Bios of speakers can be found at [www.vbhcanada.com/program](http://www.vbhcanada.com/program)

07:30 - 08:15
Registration and Breakfast

08:15 - 08:20
**Official Welcome to the Rotman School of Management**
- Brian Golden, Sandra Rotman Chair in Health Sector Strategy, Rotman School of Management

08:20 - 08:25
**Patient Reflection**
**What does “value” mean to patients?**
**How do they know it when they see it?**
- Louise Binder, Health Policy Consultant, Save Your Skin Foundation

08:25 - 08:30
**Overview of the Day**
Fred Horne, Principal, Horne and Associates and Chair, Summit Steering Committee

08:30 – 09:30
**Keynote Address**
VBHC is gaining momentum globally. What are the foundational principles and who is leading the way?
- Scott Wallace, Managing Director, Value Institute for Health and Care and Associate Professor, Dell Medical School, The University of Texas at Austin

09:30-10:45
**Toward a Pan-Canadian Perspective on VBHC**
(CFHI Commissioned Research)

**Session Chair:**
- Jennifer Zelmer, President, Azimuth Health Group; CFHI Faculty

**Panel:**
- Mary Lou Ackerman, Vice-President of Innovation, St. Elizabeth
- William Charnetski, Ontario Chief Health Innovation Strategist
- Erik Sande, President, Medavie
- Alexis Wise, Health Lead, MaRS Centre for Impact Investing

VBHC is in its infancy in Canada. Who are the leaders and early adopters and what have they learned so far?

10:45 – 11:00
Networking Break

11:00 – 12:00
**Integrating for Value**

**Session Chair:**
- Kim Furlong, Director of Federal Government Affairs, AMGEN Canada

**Panel:**
- Shirlee Sharkey, CEO, St. Elizabeth
- Caleb Stowell, Enterprise Director, Value-Based Care, Providence Health and Services, Seattle
- Henk Veeze, Diabeter, The Netherlands
Transforming the organization and delivery of care is essential to the value-based approach. Fundamental changes to the design and leadership of care teams, and a shift from specialty-focused departments to multispecialty collaboration are critical to success. This session will bring together Canadian and international experts to discuss integrated care models, approaches to change management and lessons learned.

12:00 - 12:45
Lunch – Will take place in the Atrium

12:45 - 13:45
Funding for Value

Session Chair:
Jason Vanderheyden, National Director, Value-Based Healthcare, Medtronic Canada

Panel:
Melissa Farrell, Assistant Deputy Minister, Health System Quality and Funding, Ontario Ministry of Health and Long-term Care
Brian Golden, Rotman School of Management
Kevin Smith, CEO, St. Joseph's Health System, Ontario
Jason Sutherland, Associate Professor, University of British Columbia, School of Population and Public Health

The move to value-based health care will require a shift to alternative payment models. Providers and payers will need to collaborate in an effort to begin paying for outcomes as opposed to activity. New models such as bundled payments can help incentivize care providers to organize around the patient. This session will explore innovative models in Canada and abroad to support the move to a more patient-centric funding approach that rewards providers for outstanding patient outcomes.

13:45 - 14:45
Measuring Value: Data, Standards, and Cost

Session Chair:
Andre Dias, Head of Commercial and Regulatory Development, MYIA Labs

Panel:
Angela Copeland, Director, Data & Analytics Strategic Initiatives and Governance, Analytics and Informatics, Cancer Care Ontario
Jacob Lippa, Manager of Clinical Analytics, Value-Based Care, Providence St. Joseph Health, Seattle
Greg Webster, Director, Acute and Ambulatory Information Services, Canadian Institute for Health Information
Lynne Zucker, Vice-President, Clinical Systems Integration, Canada Health Infoway

Data and analytics are critical enablers in any value-based health care initiative. Health care teams, patients, payers and policy makers all need to understand desired outcomes and the cost of achieving them in order to succeed in the shift from volumes to value. This session will explore information and strategies required to power value-based care at all levels of health systems.

14:45 - 15:00
Networking Break

Steering Committee
Fred Horne, Horne and Associates (Chair)
Owen Adams, Canadian Medical Association
David Barrett, Ivey International Centre for Health Innovation, Western University
Louise Binder, Save Your Skin Foundation
Gavin Brown, Health Canada / Government of Canada
William Charnetski, Government of Ontario
Janet Davidson, Canadian Institute for Health Information
Neil Fraser, Medtronic Canada
Brian Golden, Centre for Health Sector Strategy, Rotman School of Management
Michael Green, Canada Health Infoway
Maria Judd, Canadian Foundation for Healthcare Improvement
Peter Juhn, Head of Global Value-based Partnerships, AMGEN
Maureen O’Neil, Canadian Foundation for Healthcare Improvement
Brian O’Rourke, Canadian Agency for Drugs and Technologies in Health
David O’Toole, Canadian Institute for Health Information
Shirlee Sharkey, St. Elizabeth

Planning Committee
Jewel Buksa, BUKSA Associates Inc.
Andre Dias, Myia Labs
Kim Furlong, AMGEN Canada
Fred Horne, Horne and Associates
Jessica Rudd, Medtronic Canada
Jason Vanderheyden, Medtronic Canada
15:00 - 15:55
**Open Discussion with Summit Participants**

**Implementation and Lessons Learned: Accelerating VBHC in Canada**

**Moderators:**
- Fred Horne, Chair, Summit Steering Committee
- Maria Judd, Vice-President, Programs, Canadian Foundation for Healthcare Improvement

This session builds on key learnings from the day and features open dialogue with presenters and participants about the concrete steps needed to organize, accelerate and support a shift to VBHC in Canada.

Some questions to be explored include:
- What leadership is required to support the shift to VBHC?
- What are the key resources and enablers needed to move ahead?
- What hurdles should we expect and what are the likely solutions?

A group of senior health system leaders will help lead the discussion by providing targeted feedback and responding to questions.
- William Charnetski, Chief Health Innovation Strategist, Ontario
- Janet Davidson, Chair, Canadian Institute for Health Information
- Melissa Farrell, Assistant Deputy Minister, Health System Quality and Funding, Ontario Ministry of Health and Long-term Care
- Neil Fraser, President, Medtronic Canada
- Brian Golden, Centre for Health Sector Strategy, Rotman School of Management
- Peter Juhn, Head of Global Value-based Partnerships, AMGEN
- Brian O’Rourke, President and Chief Executive Officer, Canadian Agency for Drugs and Technologies in Health
- Jennifer Zelmer, President, Azimuth Health Group; CFHI Faculty

15:55 - 16:00
**Patient Reflection**

What would patients say?

How will patients’ partners respond to efforts to advance VBHC?
- Angela Morin, Patient Partner, Canadian Foundation for Healthcare Improvement

16:00 - 16:15
**Summary and Next Steps**

- Fred Horne, Chair, Summit Steering Committee

16:15 - 17:30
**Networking Reception**

Participants are invited to the Atrium for a reception hosted by the Summit Steering Committee.

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**Maintenance of CCHL Certification**

Attendance at this program entitles certified Canadian College of Health Leaders members (CHE / Fellow) to 3.25 Category II credits towards their maintenance of certification requirement.

**Maintien de la certification**

Une participation à cette réunion par un membre certifié du Collège canadien des leaders en santé (CHE / Fellow) vaut 3.25 crédits de la catégorie II du MDC à l’égard de l’exigence du maintien de la certification à laquelle ceux-ci sont soumis.
Appendix 2: Participants

One hundred and twenty-five individuals with a broad range of expertise and perspectives attended the March 19, 2018 Summit. Participants included researchers, clinicians and representatives from patient, public and professional organizations from 10 provinces and territories, as well as a handful of international representatives.

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<tr>
<td>Ministry of Health and Long-Term Care Ontario</td>
<td>Fredrika</td>
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<td>Shirlee</td>
<td>Sharkey</td>
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<tr>
<td>The CML Society of Canada</td>
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<td>Simoneau</td>
<td>Founder</td>
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<td>Dan</td>
<td>Skwarchuk</td>
<td>Assistant Deputy Minister and Chief Financial Officer</td>
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<tr>
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<td>Alexander</td>
<td>Smith</td>
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<td>Collette</td>
<td>Smith</td>
<td>Vice President</td>
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<tr>
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<td>Kevin</td>
<td>Smith</td>
<td>President &amp; Chief Executive Officer</td>
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<td>Geoff</td>
<td>Sprang</td>
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<td>John</td>
<td>Sproule</td>
<td>Senior Policy Director</td>
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<tr>
<td>Canadian Foundation for Healthcare Improvement</td>
<td>Kelly</td>
<td>Stanistreet</td>
<td>Improvement Evaluation Analyst</td>
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<tr>
<td>Mohawk Medbuy Corporation</td>
<td>Bob</td>
<td>Stark</td>
<td>Director</td>
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<tr>
<td>BTFC &amp; DPPS Working Groups</td>
<td>Leah</td>
<td>Stephenson</td>
<td>Consultant &amp; Volunteer</td>
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<tr>
<td>Providence St. Joseph Health</td>
<td>Caleb</td>
<td>Stowell</td>
<td>Enterprise Director, Value Based Care</td>
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<tr>
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<td>Jason</td>
<td>Sutherland</td>
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<td>Canadian Foundation for Healthcare Improvement</td>
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<tr>
<td>Independent</td>
<td>Rose</td>
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<tr>
<td>Health Canada</td>
<td>Lindy</td>
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<td>Jason</td>
<td>Vanderheyden</td>
<td>National Director, Value-Based Healthcare</td>
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<tr>
<td>Diabeter</td>
<td>Henk</td>
<td>Veeze</td>
<td>Medical Director</td>
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The Canadian Foundation for Healthcare Improvement identifies proven innovations and accelerates their spread across Canada by supporting healthcare organizations to adapt, implement and measure improvements in patient care, population health and value-for-money.

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