
De: Patrick-Emmanuel Parent
Envoyé: 19 novembre 2019 18:00
À: MSSS - Secrétariat administratif
Objet: Fwd: Questions suite au Décret 1064-2019
Pièces jointes: image001.png; ATT00001.htm; image002.jpg; ATT00002.htm; image003.png; ATT00003.htm; image006.jpg; ATT00004.htm; Décret_1064-2019.pdf; ATT00005.htm; breast-cancer-flyer.pdf; ATT00006.htm; colorectal-cancer-flyer.pdf; ATT00007.htm; lung-cancer-flyer.pdf; ATT00008.htm; value-based-healthcare-core-concepts.pdf; ATT00009.htm; CanREValue slides Nov 6.pdf; ATT00010.htm

Catégories:

Début du message transféré :

Expéditeur: Eva Villalba <evavillalba@icomm.qc.ca>
Date: 19 novembre 2019 à 17:04:56 HNE
Destinataire: Patrick-Emmanuel Parent <Patrick-Emmanuel.Parent@msss.gouv.qc.ca>
Objet: RE: Questions suite au Décret 1064-2019

Bonjour M. Parent,

Je fais référence au décret 1064-2019, ci-joint.

Notre projet de démonstration est dans la phase de finalisation des chercheurs et centres qui vont y participer, dont deux à Montréal et deux à Québec.

Le but du projet est de faire la démonstration des soins de santé axés sur la valeur (Value-Based Health Care) dans des segments de patients spécifiques au Québec: cancer du sein, cancer du poumon, cancer colorectal.

Ce serait le premier projet de son genre au Canada, et en collaboration avec le Conference Board of Canada, qui en feront éventuellement dans le reste du pays. Le Québec peut donc être le modèle pour les autres provinces. Nous commençons en oncologie, car quasiment la moitié des dépenses sont pour le cancer, et ça touche une majorité de la population, mais d'autres maladies seront éventuellement étudiées aussi.

Je vous joins, pour votre information, un court résumé du concept de Value Based Health Care, par le Professeur Michael Porter de Harvard.

Il y a 4 éléments à notre projet préliminaire, dont certains se recoupent (peut-être?) avec le projet expérimental, dont nous avons pris connaissance seulement récemment.

1. Valider les valeurs et mesures de résultats de santé développés par ICHOM<<https://can01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.ichom.org%2Fstandards-sets%2F%23malignant-neoplasms&data=02%7C01%7Cpatrick-emmanuel.parent%40msss.gouv.qc.ca%7C70804227b47643d502b808d76d3c42f1%7C06e1fe285f8b4075bf6cae24be1a7992%7C0%7C0%7C637097978923456758&sdata=r5Lz3Fu3qB5aZKHbsvcxgEq5HHRdtEbToPPfgrssVXU%3D&reserved=0>> pour les cancers ciblés par le projet, avec des groupes de patients, afin de déterminer les PROMs à mesurer (Patient Reported Outcomes Measures). Un exemple des mesures cliniques et de qualité de vie pour chaque cancer ciblé est joint à ce courriel.

2. En fonction des résultats désirés, cliniquement et basés sur la qualité de vie et des valeurs des patients, analyser comment nous pouvons optimiser la trajectoire de soins, notamment, en mieux planifiant les ressources et traitements et réduisant les délais.
3. Mesurer les coûts tout au long de la trajectoire, et identifier les opportunités d'amélioration. Cet élément est potentiellement le même que votre projet – nous aimerions valider et mieux comprendre.
4. Établir, pour chaque segment de patients, l'équipe multidisciplinaire idéale pour accompagner le patient, ainsi que le panier de services idéal.

J'aimerais connaître plus de détails sur le projet expérimental, incluant quels sites seront ciblés. La raison est simple - nous ne souhaitons pas empiéter sur des projets déjà en cours, mais bien de pouvoir fournir des données complémentaires qui serviront au MSSS et à la DGC de mieux intégrer le patient et ses valeurs dans l'organisation du système de la santé.
Nous avons 3 objectifs plus grands avec ce projet :


1. Mettre le patient au centre de l'organisation de ses soins de santé;
2. Améliorer l'accès aux bons traitements pour le bon patient;
3. Améliorer l'utilisation des ressources pour le système de santé.

Je pourrais également me rendre disponible la semaine du 9 décembre si ça vous convient mieux.



N'hésitez pas à me contacter si vous avez des questions ou commentaires.

Au plaisir de vous rencontrer bientôt.

Eva Villalba, MBA
Directrice générale / Executive Director
Coalition Priorité Cancer au Québec / Quebec Cancer Coalition


www.coalitioncancer.com<<https://can01.safelinks.protection.outlook.com/?url=http%3A%2F%2Fwww.coalitioncancer.com&data=02%7C01%7Cpatrick-emmanuel.parent%40msss.gouv.qc.ca%7C70804227b47643d502b808d76d3c42f1%7C06e1fe285f8b4075bf6cae24be1a7992%7C0%7C0%7C637097978923456758&sdata=pKeDqC8MgHNgeE4bMNtJyYImC7ZRmDt894%2FW4%2B61UBU%3D&reserved=0>>
[cancer-coalition_logo_final]

p.s. La diapositive dont je parlais était sur le projet pancanadien, CanREValue, à la page 7, mais je ne sais pas si c'est aussi dans votre mandat. Je joins les diapos en dernier.

From: Patrick-Emmanuel Parent [<mailto:patrick-emmanuel.parent@coalitioncancer.com>] 
Sent: Tuesday, November 19, 2019 4:26 PM
To: Eva Villalba <evavillalba@coalitioncancer.com> 

Subject: RE: Questions suite au Décret 1064-2019

Bonjour,

Je prends connaissance à l'instant des échanges que vous avez eu avec mon collègue Christophe.

J'aimerais que vous me soumettiez les détails dudit projet de démonstration pour lequel vous souhaitez obtenir une confirmation de complémentarité.

Également me transmettre ladite diapositive mentionnée dans votre courriel du 6 novembre.

Ensuite, je me familiariserai dans les prochains jours avec le décret dont vos questions feront l'objet, ce dossier étant nouveau dans mes responsabilités.

Je pourrai à ce moment convenir d'un moment avec vous, qui ira sans doute dans la semaine du 9 décembre, ou au retour des Fêtes, dans la semaine du 6 janvier 2020.

Cordialement,

— [Signature] —

BREAST CANCER

Treatment approach covered

(Reconstructive) Surgery | Radiotherapy | Chemotherapy | Hormonal Therapy | Targeted Therapy

For a complete overview of the ICHOM Standard Set, including definitions for each measure, time points for collection, and associated risk factors, visit ichom.org/medical-conditions/Breast-Cancer



Details

- ¹ Complications will be recorded based on the type of therapy needed or action required to correct the complication as described in the Clavien-Dindo Classification and CTCAE v4.0
- ² Includes depression and anxiety.
- ^{3, 4} Recommended to track via the EORTC Quality of Life Questionnaire - Core Questionnaire (EORTC QLQ-C30).
- ⁵ Includes body image and satisfaction with breast(s). Recommended to track via the EORTC Quality of Life Questionnaire - Breast Cancer Specific Questionnaire (EORTC QLQ-BR23) and the BREAST-Q - Satisfaction with Breasts.
- ⁶ Includes arm and breast symptoms. Recommended to track via the EORTC Quality of Life Questionnaire - Breast Cancer Specific Questionnaire (EORTC QLQ-BR23).
- ⁷ Recommended to track via the EORTC Quality of Life Questionnaire - Breast Cancer Specific Questionnaire (EORTC QLQ-BR23).
- ⁸ Recommended to track via a single item from the EORTC Quality of Life Questionnaire - Liver Metastases Colorectal Module (EORTC QLQ-LMC21).
- ⁹ Recommended to track via a subset of questions from the Endocrine Subscale (ES) of the Functional Assessment of Cancer Therapy (FACT).
- ¹⁰ Includes sexual functioning and vaginal symptoms. Recommended to track via the EORTC Quality of Life Questionnaire - Breast Cancer Specific Questionnaire (EORTC QLQ-BR23) and via a subset of questions from the Endocrine Subscale (ES) of the Functional Assessment of Cancer Therapy (FACT).
- ¹¹ Includes physical, emotional, cognitive and social functioning, ability to work and overall well-being. Recommended to track via the EORTC Quality of Life Questionnaire - Core Questionnaire (EORTC QLQ-C30).
- ¹² Includes overall and cause-specific survival.

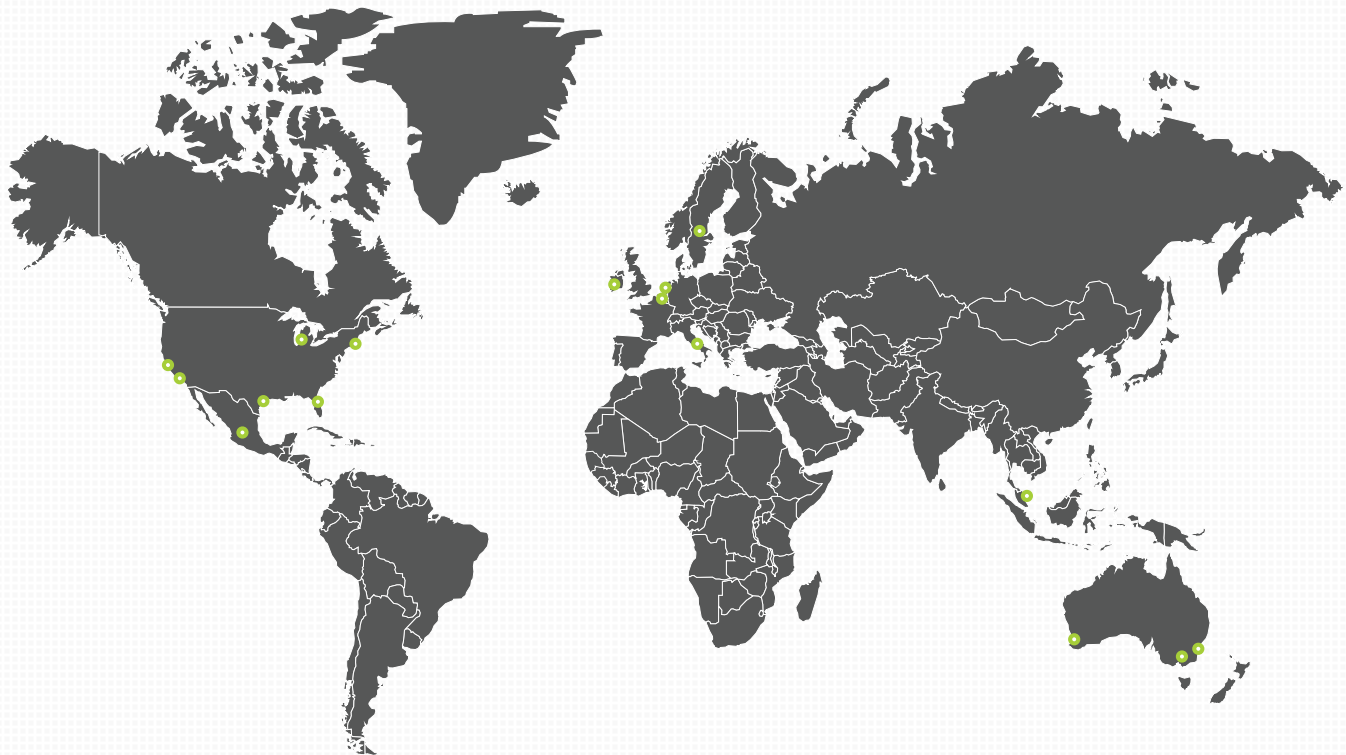
CONTRIBUTORS

For more information about the process of developing a Standard Set, visit ichom.org/how-we-work/

The Sponsors



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ICHOM Standard Set for

COLORECTAL CANCER

Treatment approach covered

Surgery | Radiotherapy | Chemotherapy | Targeted therapy

For a complete overview of the ICHOM Standard Set, including definitions for each measure, time points for collection, and associated risk factors, visit ichom.org/medical-conditions/Colorectal-Cancer



Details

- ¹ Complications will be recorded based on the type of therapy needed or action required to correct the complication as described in the Clavien-Dindo Classification and CTCAE v4.0.
- ^{2, 3, 4} Recommended to track via the EORTC Quality of Life Questionnaire - Core Questionnaire (EORTC QLQ-C30).
- ⁵ Includes bowel functioning, fecal leakage, stool frequency, diarrhea and dietary issues. Recommended to track via the dietary subscale of the Memorial Sloan-Kettering Cancer Center (MSKCC) Bowel Function. Recommended to track via the EORTC Quality of Life Questionnaire - Colorectal Cancer Module (EORTC QLQ-CR29).
- ⁶ Recommended to track via a single item from the EORTC Quality of Life Questionnaire - Liver Metastases Colorectal Module (EORTC QLQ-LMC21).
- ⁷ Recommended to track via the EORTC Quality of Life Questionnaire - Colorectal Cancer Module (EORTC QLQ-CR29).
- ⁸ Includes erectile dysfunction and vaginal symptoms. Recommended to track via the EORTC Quality of Life Questionnaire - Colorectal Cancer Module (EORTC QLQ-CR29).
- ⁹ Includes physical, emotional and social functioning and mobility and overall well-being. Recommended to track via the EORTC Quality of Life Questionnaire - Core Questionnaire (EORTC QLQ-C30).
- ¹⁰ Includes overall and cause-specific survival.
- ¹¹ Includes pathologic complete response, margin status and recurrence and progression free survival.
- ¹² Includes place of death and preference for place of death according to the patient.



ICHOM
COLORECTAL
CANCER

ICHOM Standard Set

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For more information about the process of developing a Standard Set, visit ichom.org/how-we-work/

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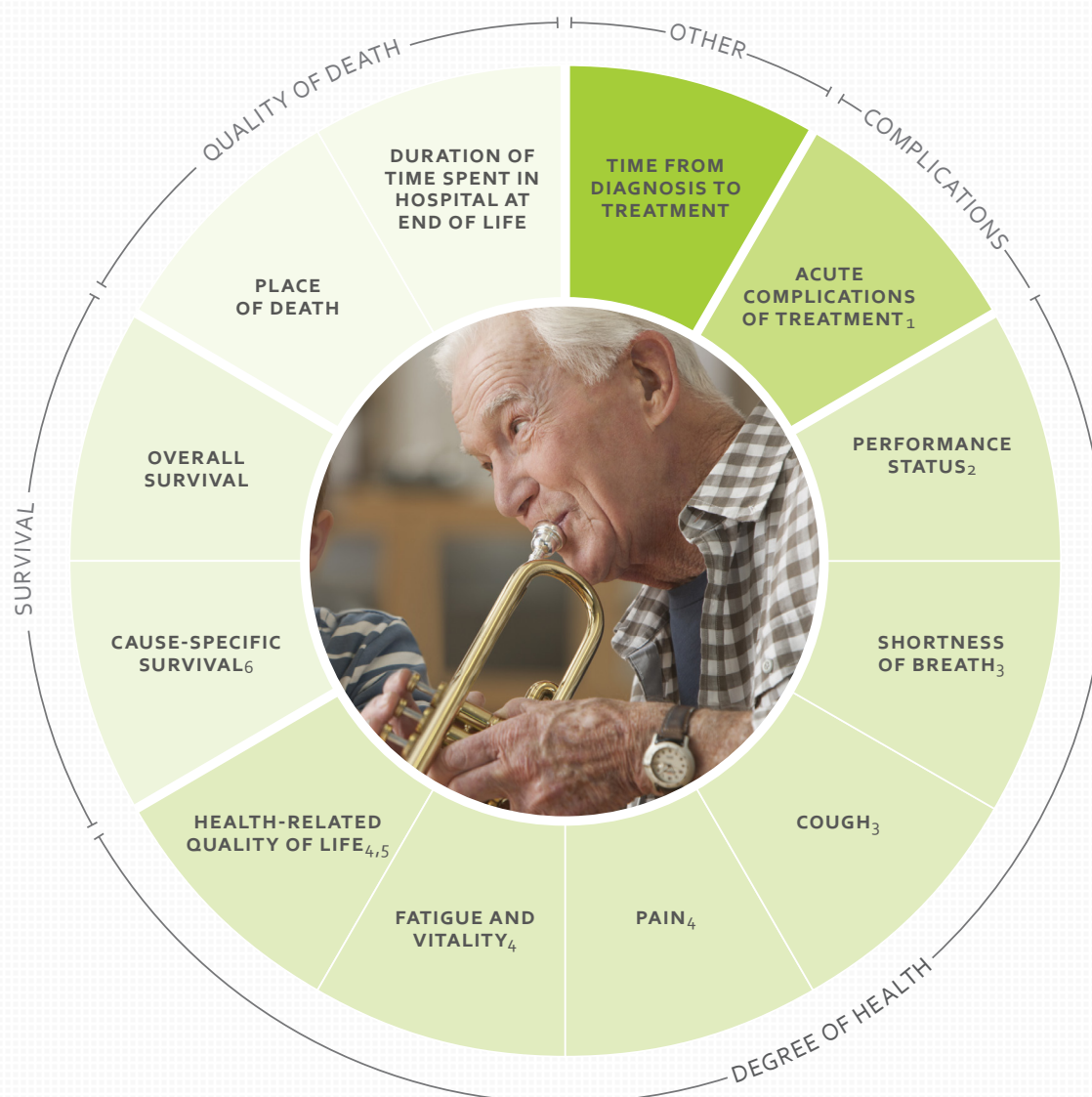
*Patient representative

LUNG CANCER

Treatment approach covered

Surgery | Radiotherapy | Chemotherapy | Targeted therapy | Immunotherapy | Other

For a complete overview of the ICHOM Standard Set, including definitions for each measure, time points for collection, and associated risk factors, visit ichom.org/medical-conditions/Lung-Cancer



Details

- ¹ Includes major surgical complications, major radiation complications, and major systemic therapy complications. Recorded via the Common Terminology Criteria for Adverse Events (CTCAE), version 4.0
- ² Recorded via the Eastern Cooperative Oncology Group (ECOG) score
- ³ Recommended to track via the European Organization for Research and Treatment of Cancer Quality of Life Lung Cancer-Specific Questionnaire (EORTC QLQ-LC13)
- ⁴ Recommended to track via the European Organization for Research and Treatment of Cancer Quality of Life Questionnaire (EORTC QLQ-C30)
- ⁵ Includes physical, emotional, cognitive, and social function and well-being
- ⁶ Includes treatment-related mortality and cause of death



ICHOM
LUNG CANCER

Revised: April 20th, 2015

ICHOM Standard Set

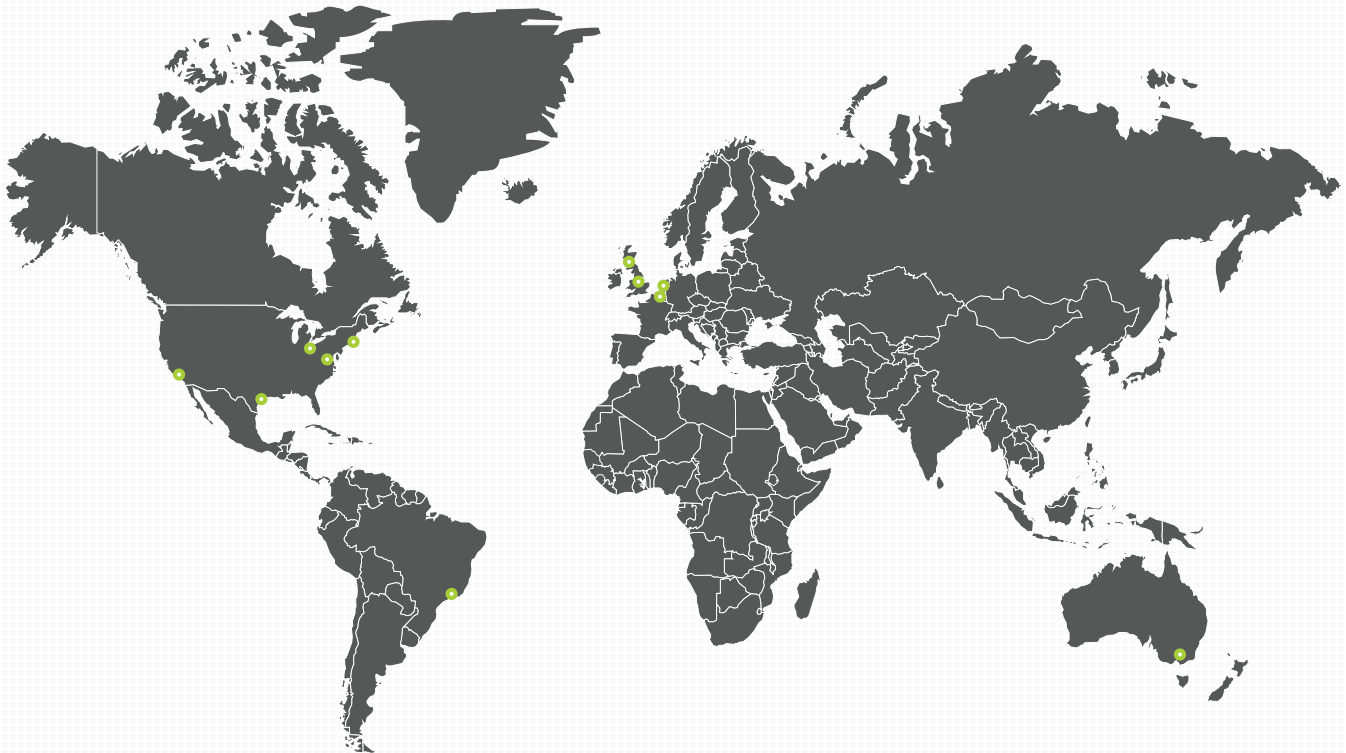
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For more information about the process of developing a Standard Set, visit ichom.org/how-we-work/

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Value-Based Health Care Delivery: Core Concepts

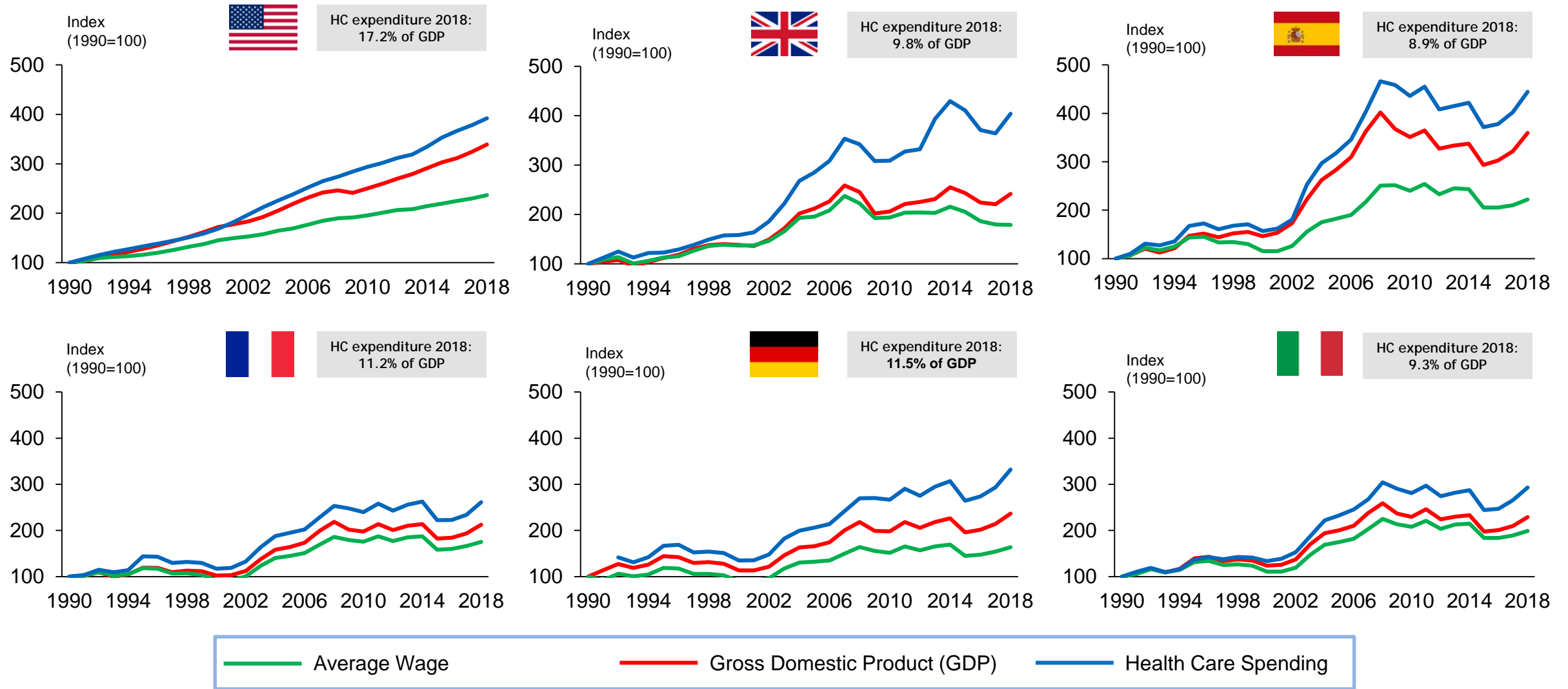
Professor Michael E. Porter
Harvard Business School

Value Measurement for Health Care
Boston, MA
August 5, 2019

This presentation draws heavily on Professor Porter's research in health care delivery including Redefining Health Care (with Elizabeth Teisberg), What is Value in Health Care, NEJM, and The Strategy That Will Fix Health Care, HBR (with Thomas Lee). A fuller bibliography is attached. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means — electronic, mechanical, photocopying, recording, or otherwise — without the permission of Michael E. Porter. For further background and references on value-based health care, see the website of the Institute for Strategy and Competitiveness.

The Health Care Problem Remains a Global Issue

Health Care Spending vs GDP and Income



Creating a Value-Based Health Care System

- Today's care delivery approaches reflect **legacy organizational structures**, **management practices**, and **payment models** based on historical medical science and delivery practices
- There have been **significant advances medical science** yet service delivery practices have not evolved.
- Health care has gotten lost in the **complexity of health care**, and the pursuit of **multiple goals** including patient experience, safety, efficacy, access, research, training, etc.



- In order to transform the system, we need a **single, unifying goal** that aligns all interests

Incremental “Solutions” Have Had Limited Impact

- Evidence-based medicine
- Safety/eliminating errors
- Prior authorization
- Patients as paying customers
- Electronic medical records
- “Lean” process improvements
- Care coordinators
- Retail clinics / urgent care
- Programs to address high cost areas (e.g. readmissions, post acute)
- Mergers and consolidation
- Personalized medicine
- Population health
- Analytics and big data (IBM Watson)



- **Restructuring health care delivery** is needed, not incremental improvements

Solving the Health Care Problem

- The fundamental **goal and purpose** of health care is to deliver high and improving **value for patients**

$$\text{Value} = \frac{\text{Health outcomes that matter to patients}}{\text{Costs of delivering these outcomes}}$$

- Delivering high value health care is the **definition of success**
- Value is the only goal that can **unite the interests** of all system participants
- Improving value is the **only real solution** to reducing the burden of health care on citizens



- The questions are how to design a health care delivery system that **substantially improves patient value**, and shift competition to **competing on value**

Principles of Value-Based Health Care Delivery

- Value **cannot be understood** at the level of a hospital, a care site, a specialty, an intervention, a primary care practice or a broad patient population
- Value is created in caring for a patient's **medical condition(s)** (acute, chronic, behavioral) over the **full cycle of care**

$$\text{Value} = \frac{\text{The **set** of outcomes that matter **for the condition**}}{\text{The **total costs** of delivering these outcomes over the full care cycle}}$$

- In **primary and preventive care**, value is created in serving segments of patients with similar primary and preventive needs



- The medical condition is the fundamental unit of **value creation** and **value measurement** in health care delivery

Creating Value-Based Health Care Delivery

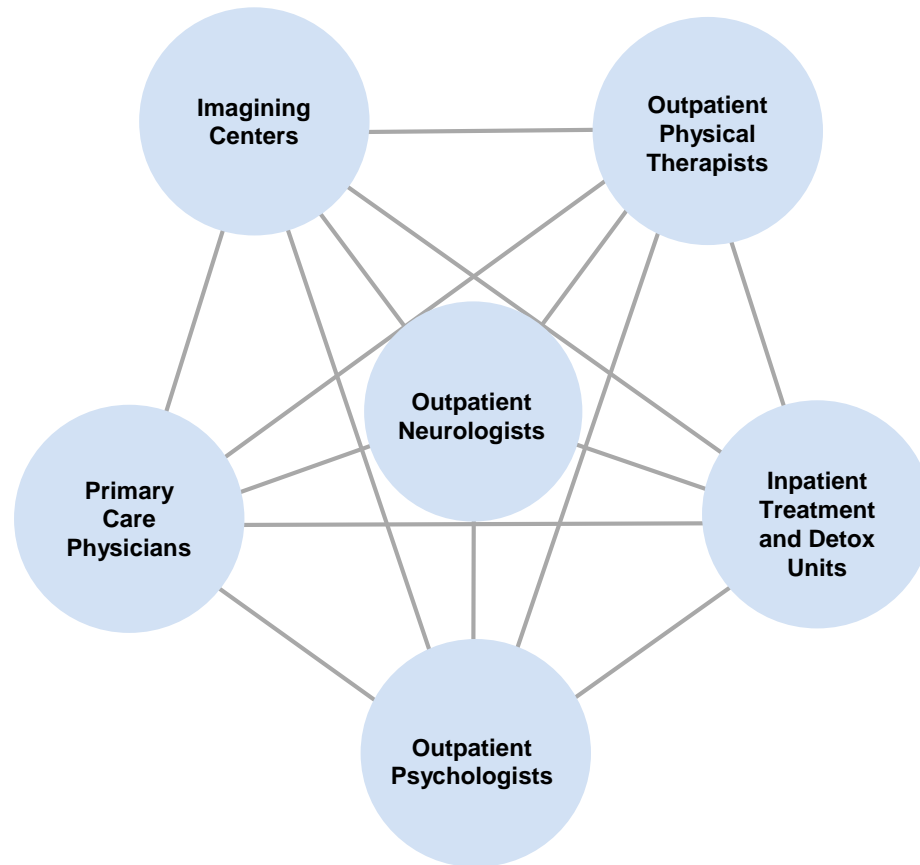
The Strategic Agenda

1. Re-organize care around **patient conditions**, into **integrated practice units (IPUs)**
 - For primary and preventive care, IPUs serve **distinct patient segments**
2. Measure **outcomes** and **costs** for every patient
3. Move to value-based reimbursement models, and ultimately **bundled payments** for conditions and primary care segments
4. Integrate and coordinate multi-site care delivery **systems**
5. Allocate care **across geography** to improve value: the right care in the right location
6. Build an enabling **information technology platform**

Re-organize Care Around Patient Medical Conditions

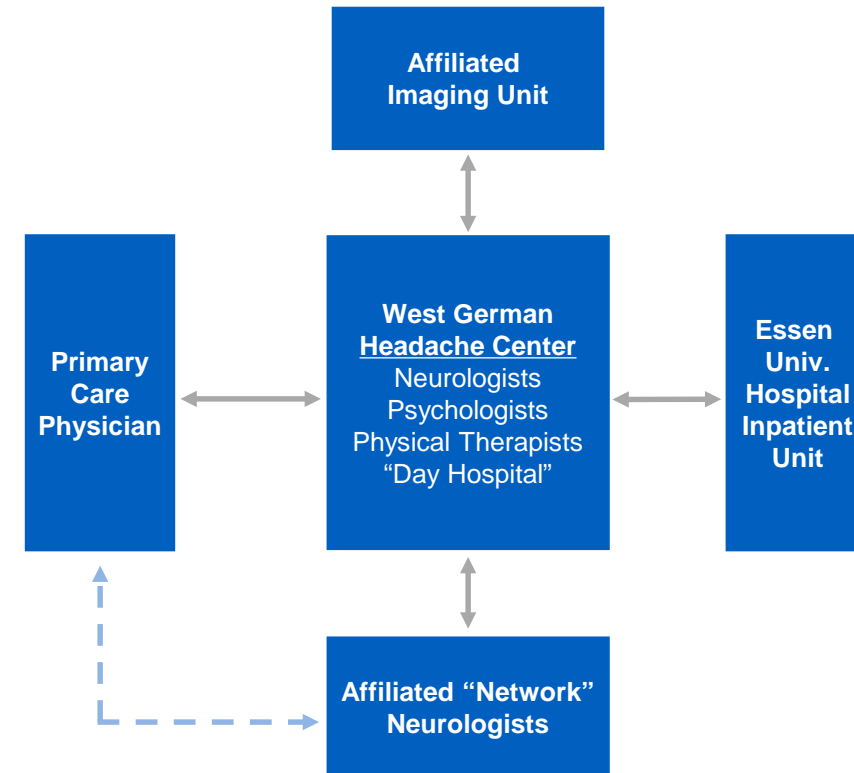
Headache Care in Germany

Organize by Department, Specialty, and Discrete Service



Care by Individuals

Organize around the Patient's Condition, or family of related conditions, into an Integrated Practice Unit (IPU)



Care by a Team

Defining the Medical Condition

- A **medical condition** is an interrelated set of patient medical circumstances best addressed in an integrated way
 - Defined from the **patient's** perspective
 - Involving **multiple** specialties and services
 - **Including** care for common **co-occurring conditions, comorbidities and complications**
 - E.g., diabetes, breast cancer, knee osteoarthritis



- IPUs should be organized around **conditions** or **groups of related conditions** involving a similar team and care process
 - E.g., head and neck cancers, joint replacement

Integrating Over The Cycle of Care

Acute Hip and Knee-Osteoarthritis

 Orthopedic Surgeon

INFORMING AND ENGAGING	<ul style="list-style-type: none"> Importance of exercise, weight reduction, proper nutrition 	<ul style="list-style-type: none"> Meaning of diagnosis Prognosis (short- and long-term outcomes) Drawbacks and benefits of surgery 	<ul style="list-style-type: none"> Setting expectations Importance of nutrition, weight loss, vaccinations Home preparation 	<ul style="list-style-type: none"> Expectations for recovery Importance of rehab Post-surgery risk factors 	<ul style="list-style-type: none"> Importance of rehab adherence Longitudinal care plan 	<ul style="list-style-type: none"> Importance of exercise, maintaining healthy weight
	<ul style="list-style-type: none"> Joint-specific symptoms and function (e.g., WOMAC scale) Overall health (e.g., SF-12 scale) 	<ul style="list-style-type: none"> Loss of cartilage Change in subchondral bone Joint-specific symptoms and function Overall health 	<ul style="list-style-type: none"> Baseline health status Fitness for surgery (e.g., ASA score) 	<ul style="list-style-type: none"> Blood loss Operative time Complications 	<ul style="list-style-type: none"> Infections Joint-specific symptoms and function Inpatient length of stay Ability to return to normal activities 	<ul style="list-style-type: none"> Joint-specific symptoms and function Weight gain or loss Missed work Overall health
ACCESSING	<ul style="list-style-type: none"> PCP office Health club Physical therapy clinic 	<ul style="list-style-type: none"> Specialty office Imaging facility 	<ul style="list-style-type: none"> Specialty office Pre-op evaluation center 	<ul style="list-style-type: none"> Operating room Recovery room Orthopedic floor at hospital or specialty surgery center 	<ul style="list-style-type: none"> Nursing facility Rehab facility Physical therapy clinic Home 	<ul style="list-style-type: none"> Specialty office Primary care office Health club
CARE DELIVERY	MONITORING/ PREVENTING	DIAGNOSING	PREPARING	INTERVENING	RECOVERING/ REHABBING	MONITORING/ MANAGING
	MONITOR	IMAGING	OVERALL PREP	ANESTHESIA	SURGICAL	MONITOR
	<ul style="list-style-type: none"> Conduct PCP exam Refer to specialists, if necessary 	<ul style="list-style-type: none"> Perform and evaluate MRI and x-ray -Assess cartilage loss -Assess bone alterations 	<ul style="list-style-type: none"> Conduct home assessment Monitor weight loss 	<ul style="list-style-type: none"> Administer anesthesia (general, epidural, or regional) 	<ul style="list-style-type: none"> Immediate return to OR for manipulation, if necessary 	<ul style="list-style-type: none"> Consult regularly with patient
	PREVENT	CLINICAL EVALUATION	SURGICAL PREP	SURGICAL PROCEDURE	MEDICAL	MANAGE
	<ul style="list-style-type: none"> Prescribe anti-inflammatory medicines Recommend exercise regimen Set weight loss targets 	<ul style="list-style-type: none"> Review history and imaging Perform physical exam Recommend treatment plan (surgery or other options) 	<ul style="list-style-type: none"> Perform cardiology, pulmonary evaluations Run blood labs Conduct pre-op physical exam 	<ul style="list-style-type: none"> Determine approach (e.g., minimally invasive) Insert device Cement joint 	<ul style="list-style-type: none"> Monitor coagulation Provide daily living support (showering, dressing) Track risk indicators (fever, swelling, other) 	<ul style="list-style-type: none"> Prescribe prophylactic antibiotics when needed Set long-term exercise plan
				PAIN MANAGEMENT	PHYSICAL THERAPY	<ul style="list-style-type: none"> Revise joint, if necessary
				<ul style="list-style-type: none"> Prescribe preemptive multimodal pain meds 	<ul style="list-style-type: none"> Daily or twice daily PT sessions 	

←
Upstream

→
Downstream

The Playbook for Integrated Practice Units (IPUs)

1. Organized around a **medical condition**, or **group of closely related conditions**, over the full cycle of care.
 - Defined patient segments for **primary care**
2. Care includes **common co-occurring conditions** and **complications**
3. Care is delivered by a **dedicated, multidisciplinary team** devoting a significant portion of their time to the condition
 - **IPUs** can also involve **affiliated staff** and integration with **partner services**
4. **Co-located** in **dedicated facilities**. A **hub and spoke** structure connecting multiple or affiliated sites, incorporating telemedicine where appropriate
5. Optimize the **location of care** across services
6. **Patient education, engagement, adherence, follow-up**, and **prevention** are integrated into the care process
7. A **physician team captain, clinical care manager** or **both** oversee each patient's care
8. IPUs have a clear **clinical leader**, a common **scheduling and intake process**, and unified **financial structure** (single P + L)
9. IPUs **routinely measure** outcomes, costs, care processes, and patient experience using a **common platform**, and **accept joint accountability** for results
10. The team **regularly meets formally and informally** to discuss individual patient care plans, process improvements, and how to improve results

Mechanisms for Care Integration

The Software of IPU

Design

- IPU **leadership** team
- Co-location and **shared** work areas
- Patient **team captain**
- Integrated clinician **scheduling**
- Care **coordinators**, **care managers**
- Patient **liaisons**
- Recruit **trainees and new staff** who embrace the model

Care Processes

- **Process mapping/protocols**
 - Including **location** for specific services
- **Handoffs/rituals**
- Clear **timelines**
- Multidisciplinary **rounds**
- Repeated relationships with **outside specialists** with condition specific expertise
- Cultural **norms** around collaboration and learning

Role of Meetings

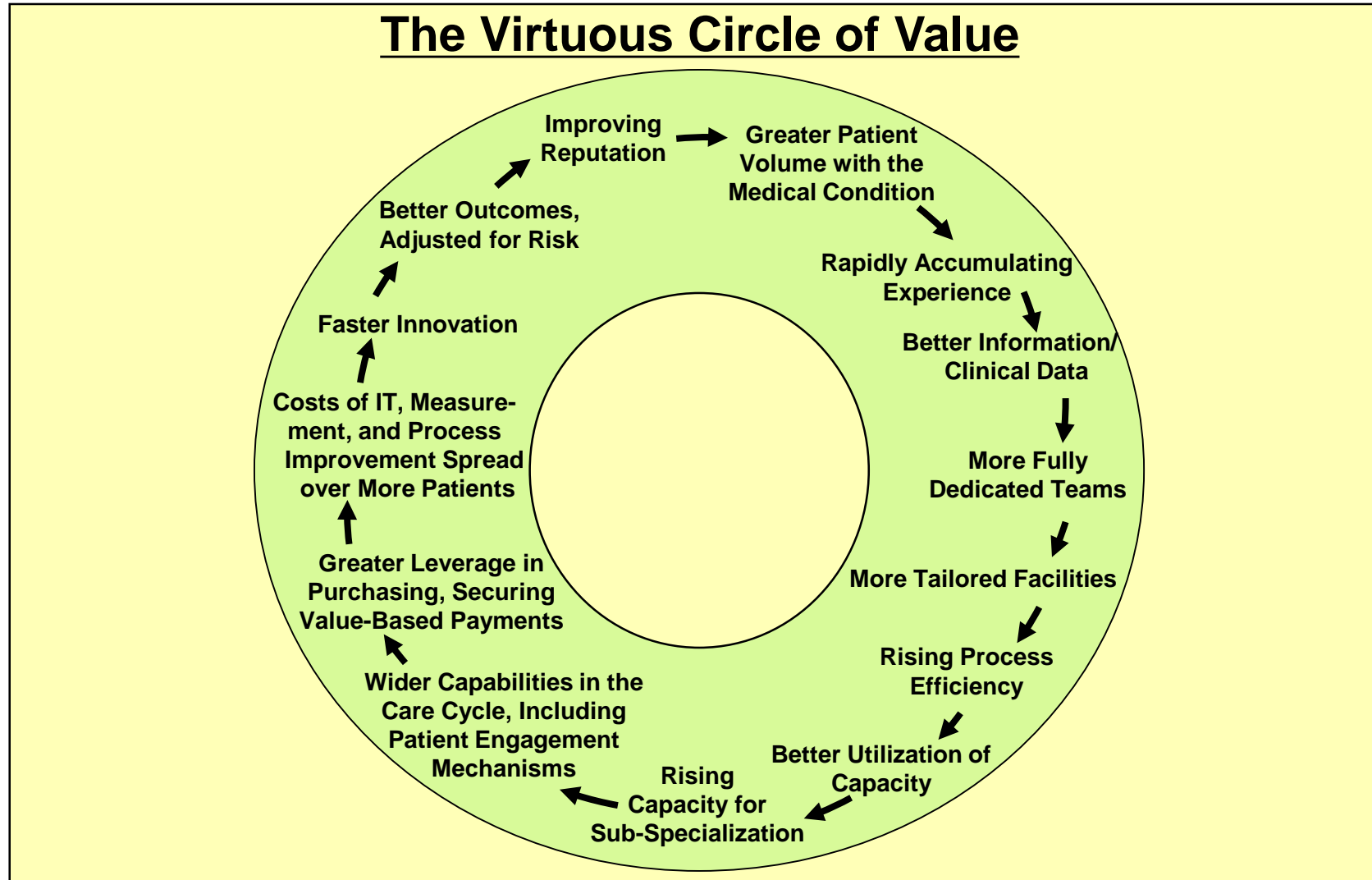
- **Case management** meetings (agree on treatment plan)
- **Multidisciplinary** rounds
- **Difficult case** reviews
- **Outcomes** reviews and improvement processes
- **Literature** workshops

Finance and Incentives

- **Single P+L**
- Compensation reflecting team goals on **value**, not volume

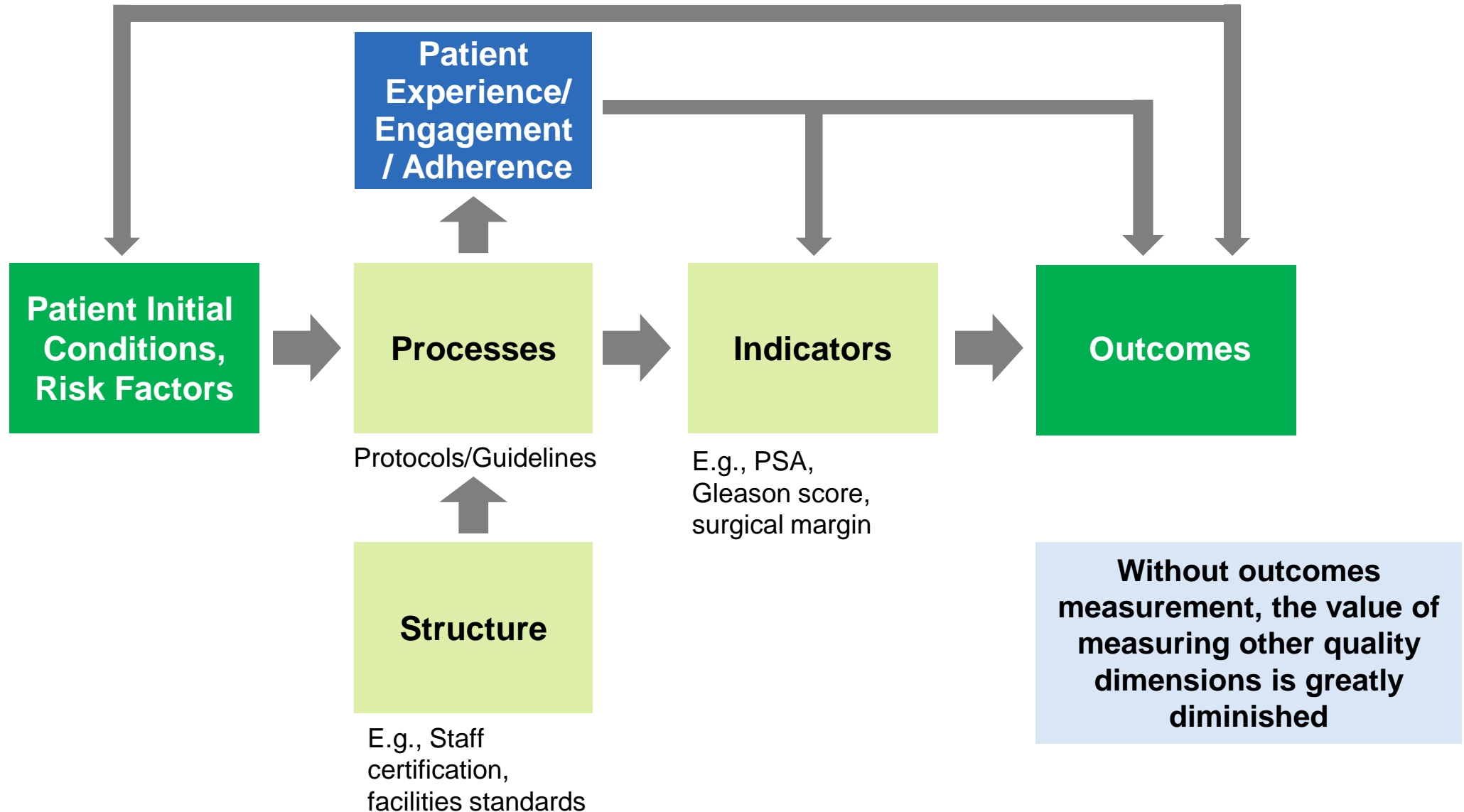
IPU Volume Enhances Value

- **More patients** with the same condition




Measure Outcomes for Every Patient

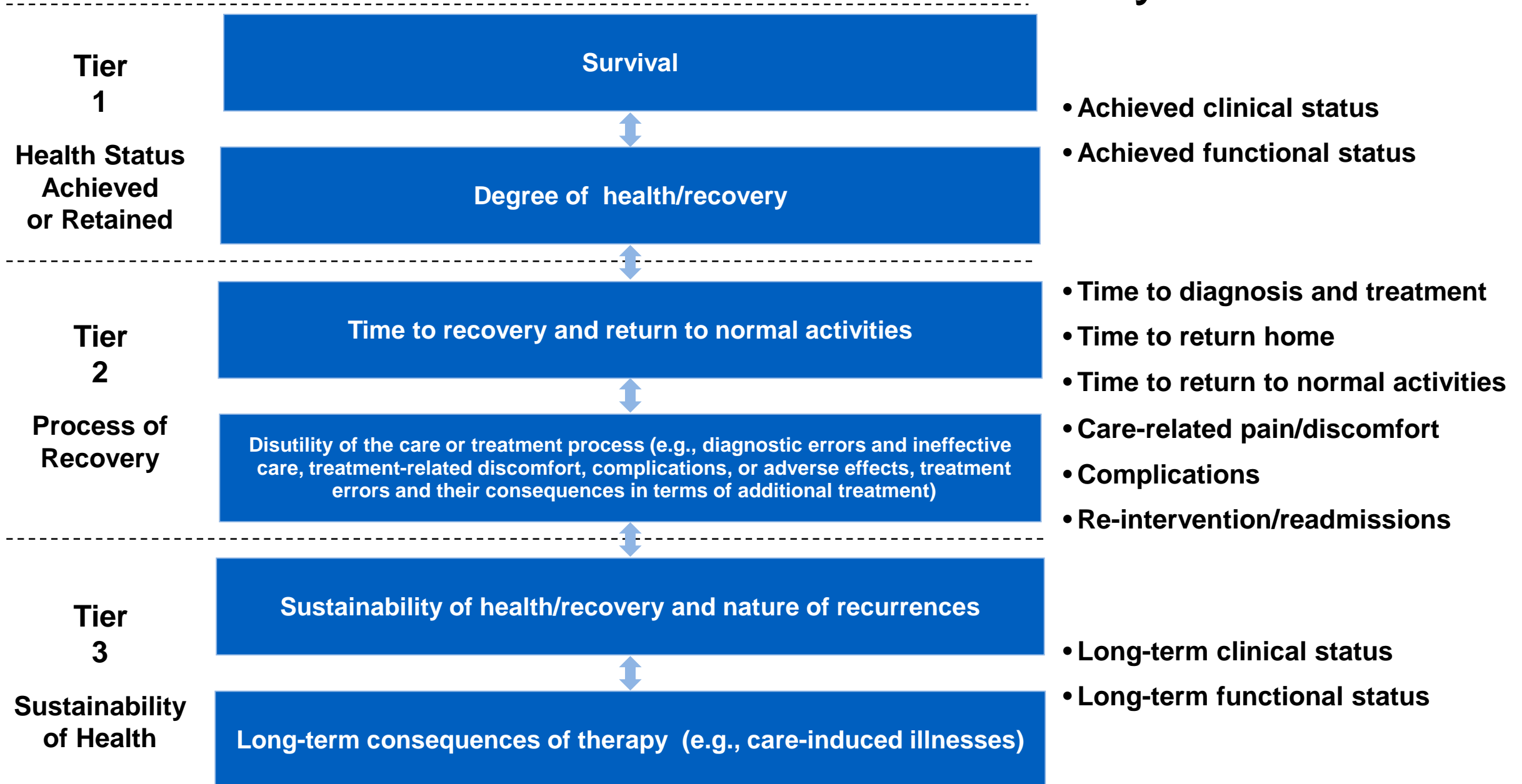
The Quality Measurement Landscape



Principles of Outcome Measurement

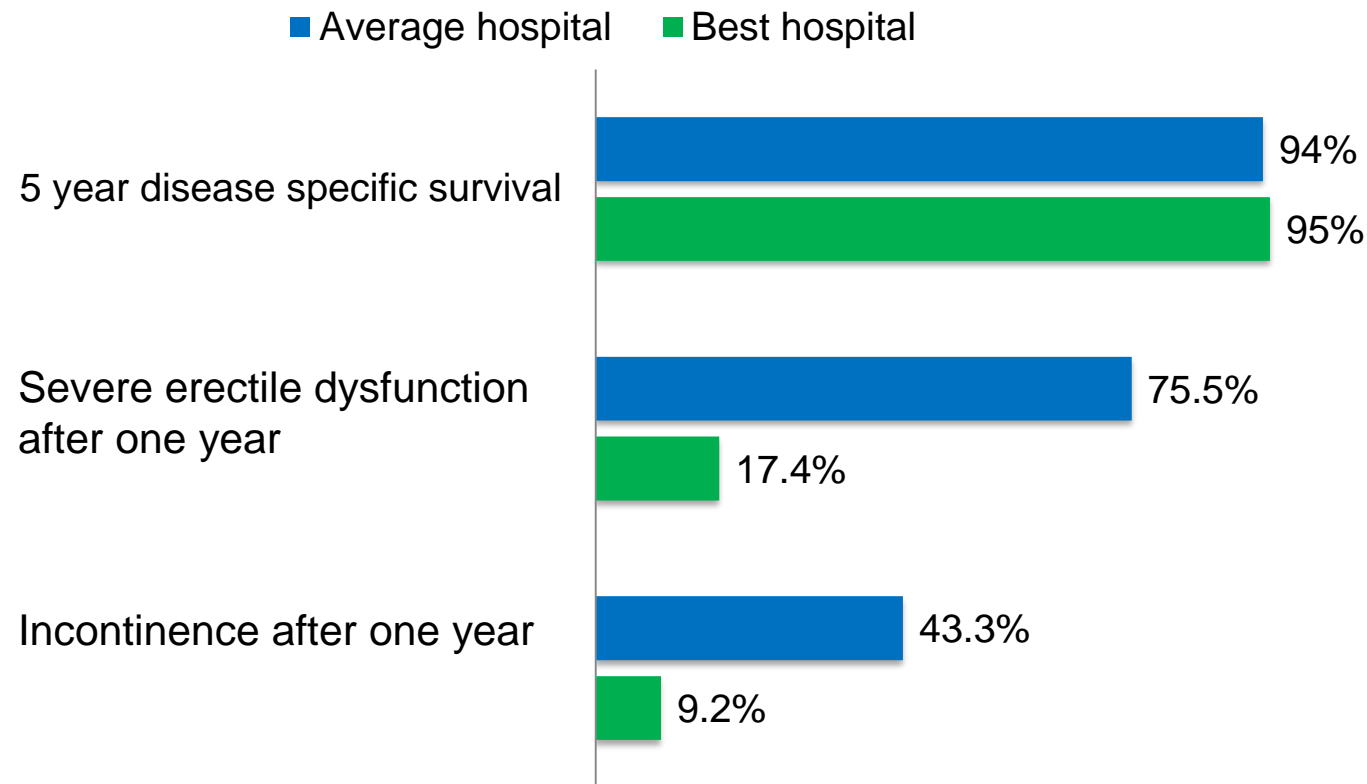
- Outcomes should be measured by **condition** (including related conditions) or **primary care segment**
 - **Not** for specialties, procedures, or interventions
 - Outcomes are **always multi-dimensional** and include what matters most to **patients (and families)**, not just to clinicians
 - **Patient reported outcomes** are important in every condition
 - Outcomes cover the **full cycle of care**
 - Outcome measurement includes **initial conditions/risk factors** to control for patient differences
 - Outcomes must be **standardized** for each condition, to maximize comparison, learning, and improvement
 - Outcomes should be measured in the **line of care**
- 
- Value-based measurement differs from the **historical focus** on measuring **provider behavior** measures **overall patient success**

The Outcome Measures Hierarchy



Measuring Multiple Outcomes

Prostate Cancer Care in Germany



Source: ICHOM

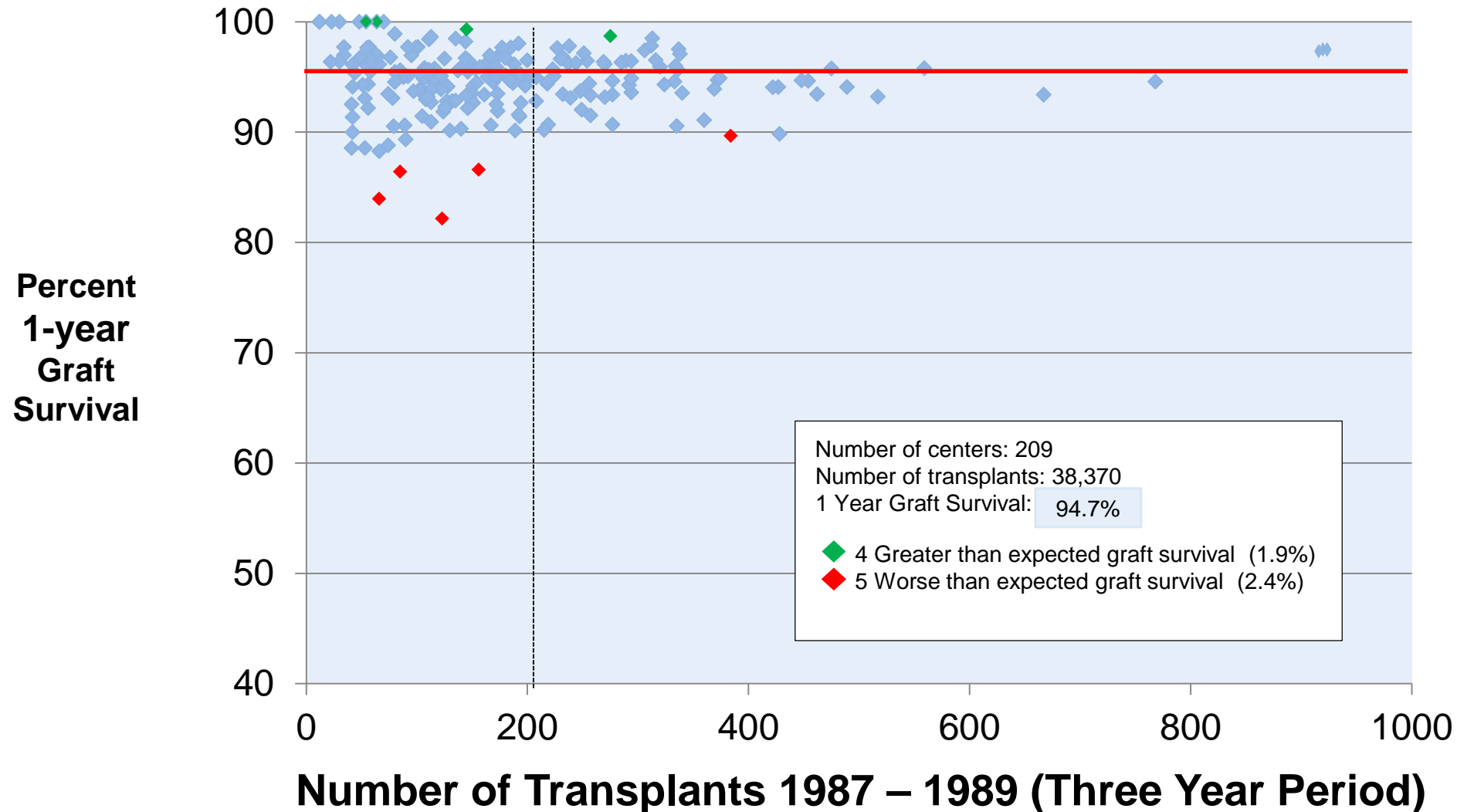
1987 - 1989



The Power of Outcomes – Continued

Adult Kidney Transplant Outcomes

2011 - 2013



Standardizing Outcome Sets

ICHOM




Standard Sets Complete (2013-14)	Standard Sets Complete (2015-16)	Standard Sets Complete (2017-19)	Committed/ In Process
<ol style="list-style-type: none"> 1. Localized Prostate Cancer * 2. Lower Back Pain * 3. Coronary Artery Disease * 4. Cataracts * 5. Parkinson's Disease* 6. Cleft Lip and Palate* 7. Stroke * 8. Hip and Knee Osteoarthritis* 9. Macular Degeneration* 10. Lung Cancer* 11. Depression and Anxiety* 12. Advanced Prostate Cancer * 	<ol style="list-style-type: none"> 13. Breast Cancer* 14. Dementia 15. Frail Elderly 16. Heart Failure 17. Pregnancy and Childbirth 18. Colorectal Cancer* 19. Overactive Bladder 20. Craniofacial Microsomia 21. Inflammatory Bowel Disease* 	<ol style="list-style-type: none"> 22. Chronic Kidney Disease* 23. Congenital Upper Limb Malformations 24. Pediatric Facial Palsy* 25. Inflammatory Arthritis* 26. Hypertension* 27. Oral Health 28. Diabetes 29. Atrial Fibrillation 	<ol style="list-style-type: none"> 30. Overall Adult Health 31. Pediatric Health 32. Hand and Wrist 33. Neonates 34. Congenital Heart Disease 35. Depression and Anxiety in Children and Young People 36. Psychotic Disorders 37. Personality Disorders 38. Substance Misuse

*** Published Thus Far in
Peer-Reviewed
Journals (19)**

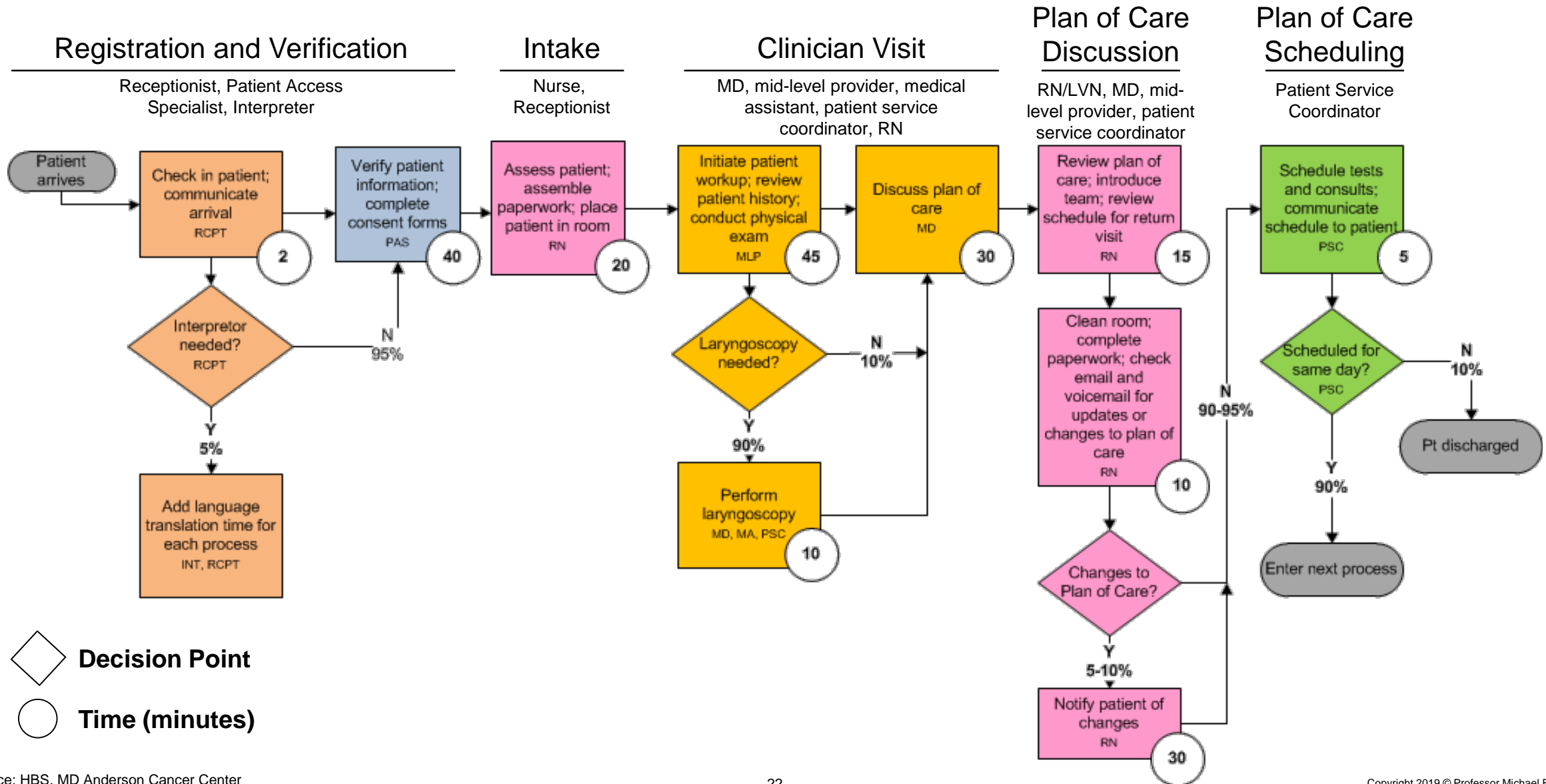
Measure Cost for Every Patient

Principles

- Cost is the **actual expense** of patient care, not the **sum of charges** billed or collected
 - Properly measuring the cost of care requires **different cost accounting** methods than prevailing approaches in health care such as departmental, charge-based, or RVU-based costing
- 
- Cost should be measured for **each patient** over the **full cycle of care for the condition**
 - Cost is driven by the use of **the resources** involved in a patient's care (personnel, facilities, supplies, and support services)
 - Time and actual **costs** of resource use, not arbitrary allocations
 - Understanding costs requires **mapping the care process**

Mapping Resource Utilization

MD Anderson Cancer Center – New Patient Visit



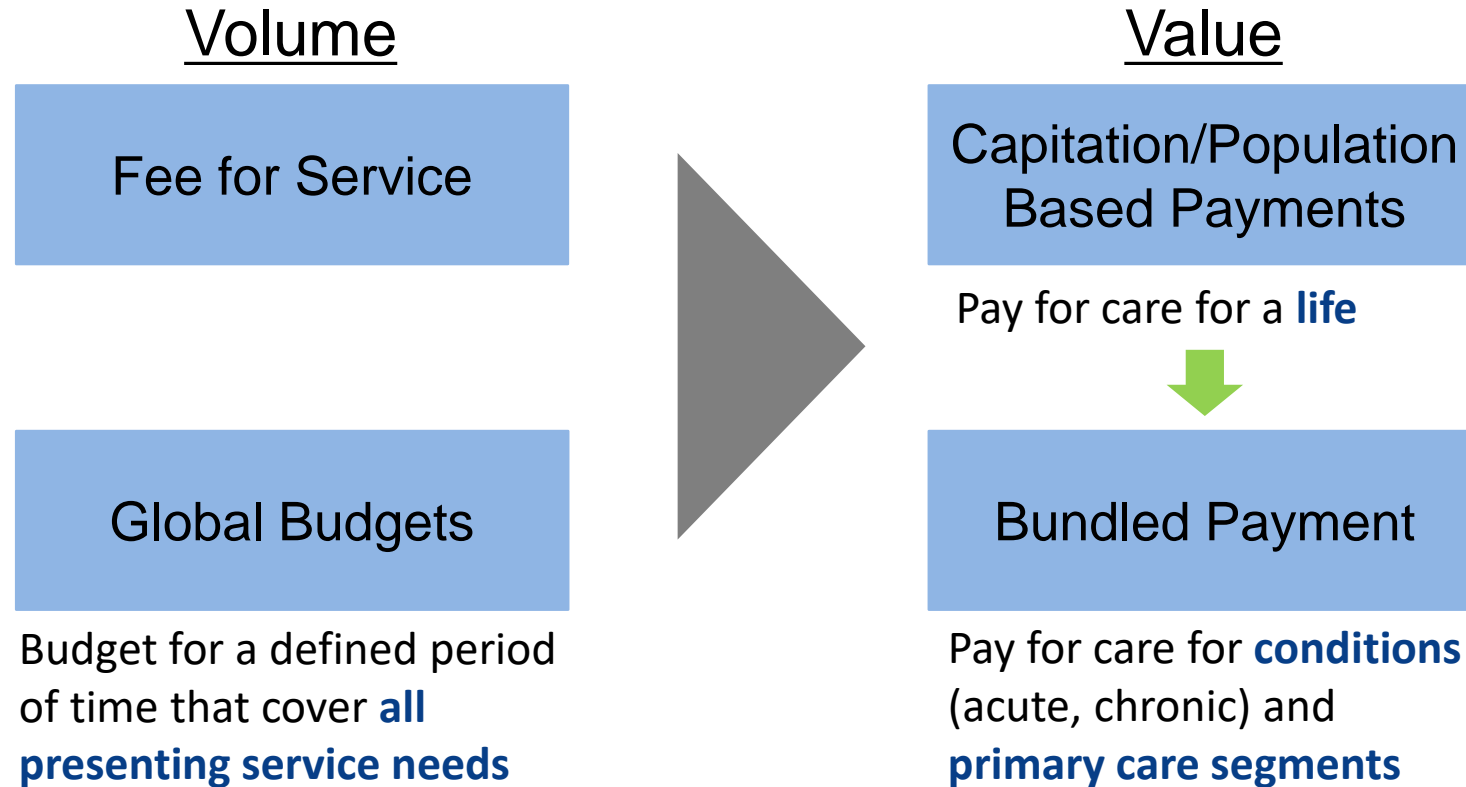
Major Cost Reduction Opportunities in Health Care

- Utilize **physicians and skilled staff** at the top of their licenses
- Reduce **process variation** that increases complexity and raises cost
- Eliminate **low-** or **non-value added** services or tests
- **Reduce cycle times** across the care cycle, which expands capacity with the same staff and facilities
- Invest in additional services (e.g. extra visits, telemedicine), or higher costs inputs that will **lower overall care cycle cost**
- Move uncomplicated services **out of highly-resourced** facilities
- Reduce **service duplication** and **volume fragmentation** across sites
- Rationalize redundant **administrative** and **scheduling** units
- Increase **cost awareness** in clinical teams, (e.g. costs of inputs (sutures vs. staples))
- Improve the efficiency and automation of **claims management** and **billing** processes



- Our work reveals typical **cost reduction opportunities of 30+%**
- Many cost improvements **also improve outcomes**

Move to Value-Based Payment Models

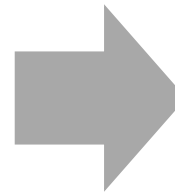


- Both approaches create positive incentives for **reducing costs** and **separate payment** from performing particular services
- Capitation at the hospital or system level can **coexist** with bundle payment at the condition level

Emerging Value-Based Payment Models

Capitation (Population-Based)

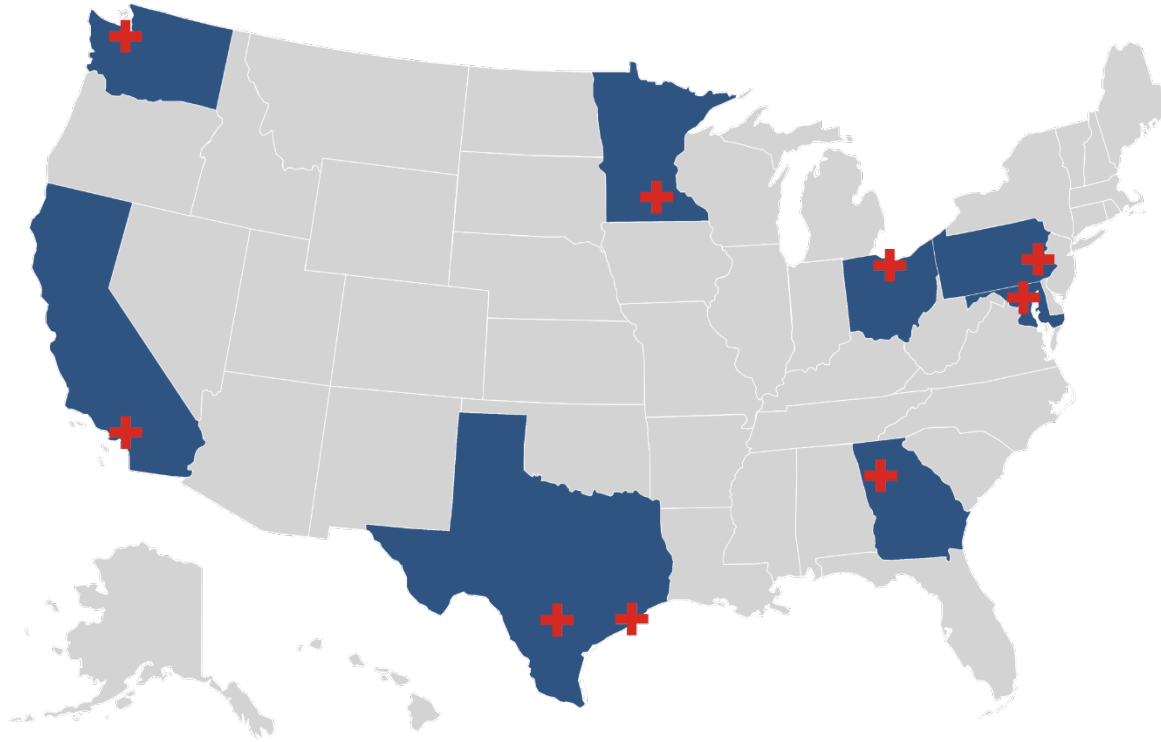
- A single risk-adjusted payment for the overall care for a **life**
- Responsible for **all needed care** in the covered population
- Accountable for **population level quality metrics**
- At risk for the difference between the **sum of payments** for the population and **overall spending**
 - **Providers** take **disease incidence risk**, not just **execution/outlier risk**
- Accountable for **overall cost** and **population level** quality measures



Bundled Payment

- A single risk adjusted payment for the overall care for a **condition**
 - **Not** for a specialty, procedure, or short episode
- Covers the **full set** of services needed **over an acute care cycle**, or a **defined time period** for chronic care or primary care
- Contingent on **condition-specific outcomes**
 - Including responsibility for avoidable **complications**
- At risk for the difference between the **bundled price** and the **actual cost** of all included services
 - **Limits of responsibility** for unrelated care and outliers
- Accountable for costs and outcomes, **patient by patient**, and **condition by condition**

Walmart Centers of Excellence Programs



Centers of Excellence

Cleveland Clinic (OH)

Geisinger (PA)

Kaiser Permanente (CA)

Johns Hopkins (MD)

Mayo Clinic (MN)

Memorial Hermann (TX)

Northeast Baptist (TX)

Virginia Mason (WA)

Emory (GA)

Conditions

- Cardiac
- Cancer
- Joint replacement
- Spine
- Transplant
- Weight loss

Integrate Care Across Sites

Children's Hospital of Philadelphia Care Network



Wholly-Owned Outpatient Units

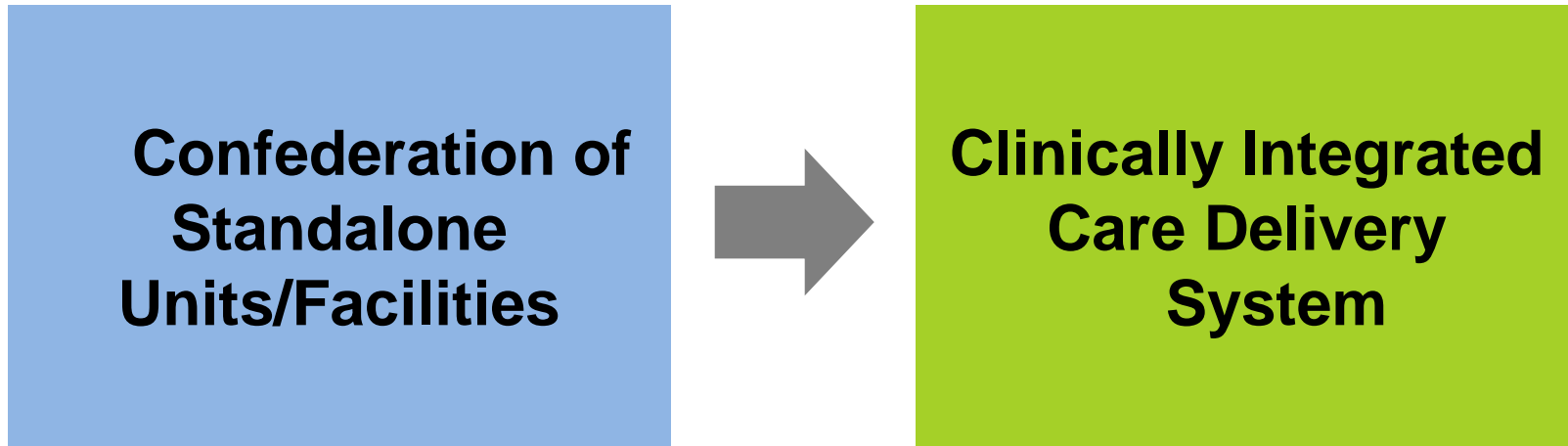
- ★ Primary Care Practices
- Specialty Care Centers
- Specialty Care Center, Surgery Center & After-Hours Urgent Care
- Specialty Care & Surgery Centers
- Specialty Care Center, Surgery Center, After-Hours Urgent Care & Home Care

Community Inpatient Partnerships

- CHOP Newborn Care
- CHOP Pediatric Care
- CHOP Newborn & Pediatric Care
- ▲ Hospital & Integrated Specialty Program



Shifting The Strategic Logic of Health Systems



- Increase **volume**



- More clout in **contracting** and **purchasing**
- **Spread** "fixed overhead" costs
- Use **owned or affiliated** primary care practices to **"guarantee"** referrals

- Increase **value**



- Value-based **delivery models**
- **Concentrate, allocate, and integrate** care across appropriate sites
- The system is **more than** the sum of its parts

Four Levels of Provider System Integration

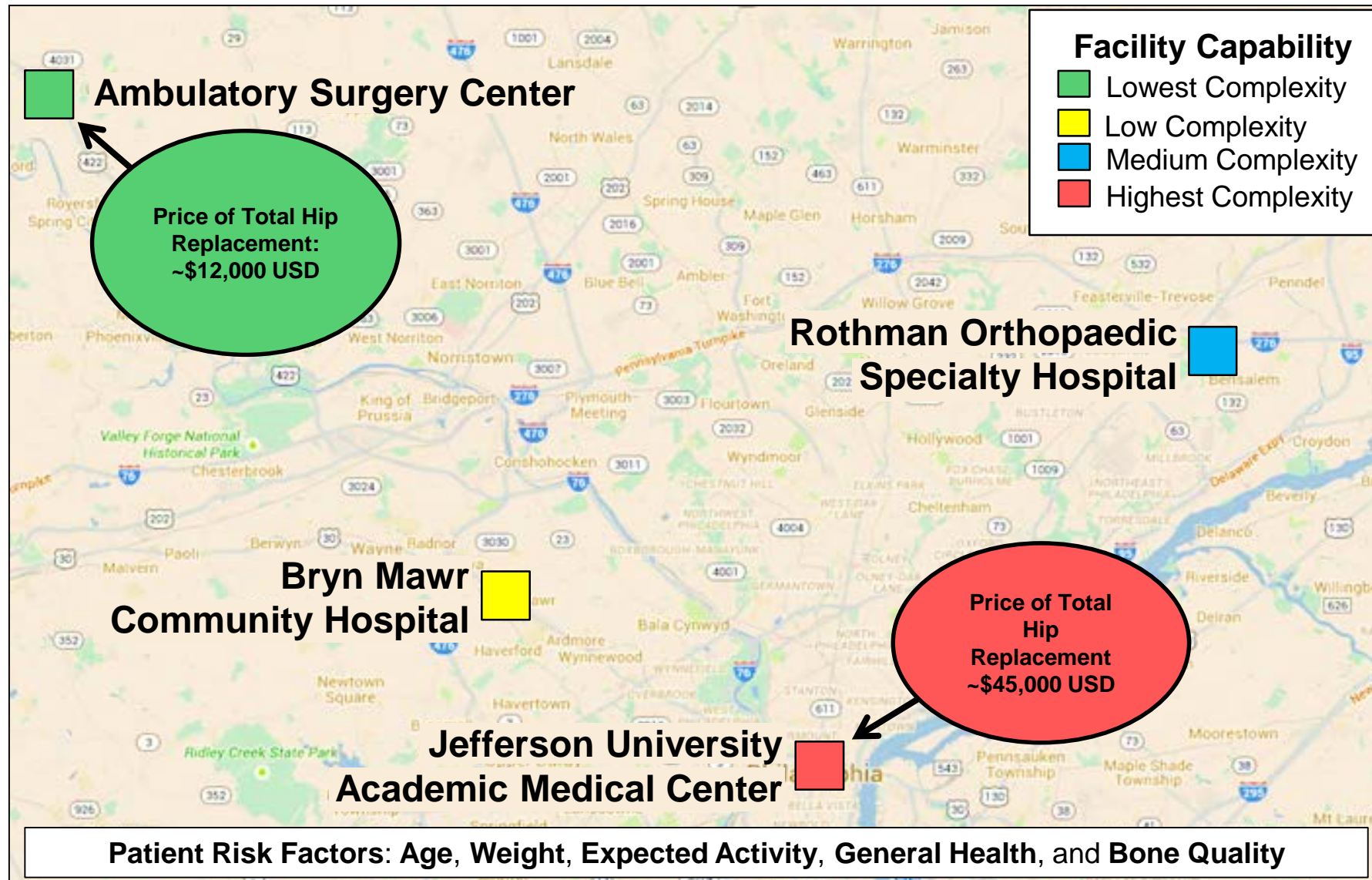
1. Defining the **overall scope of services** for each site, and for the system as a whole, based on **value**
 - **Affiliate** when this creates value
2. Concentrate **volume** of patients **with given conditions** in **fewer locations**, to support IPUs and improve outcomes and efficiency
3. Perform the **right services** in the **right locations** based on acuity level, resource/cost fit, and the benefits of patient convenience for repetitive services
 - E.g., move **less complex surgeries** out of tertiary hospitals to lower acuity facilities and outpatient surgery centers
 - **Affiliate** when this creates value
4. Integrate the care cycle **across sites** via an **IPU structure**
 - Common **scheduling**
 - **Digital services** and **telemedicine** can help tie together the care cycle

The Geography of Care and Value

- The Traditional Care Geography Model
 - Care organized around **specialties** and **interventions** for each site
 - **Duplication** of services across sites/facilities
 - Sites provide care for **multiple acuity levels**
 - **Limited integration** of care across services and sites (multiple hubs)
 - Reinforced by **fee-for-service** model and **siloed IT systems**
- Using Geography to Improve Value: Strategic Principles
 - Organize **care by condition** in IPUs (hubs)
 - Multi-disciplinary teams
 - Responsibility for full care cycle
 - **Allocate services** across the care cycle to sites based on: site capabilities, care complexity, patient risk, and patient convenience
 - **Incorporate** telemedicine, incorporating affiliated provider sites, and home services into the care cycle
 - IPUs need **formal systems** for teams to direct patients to the most appropriate site

Delivering the Right Care at the Right Location

Rothman Institute, Philadelphia

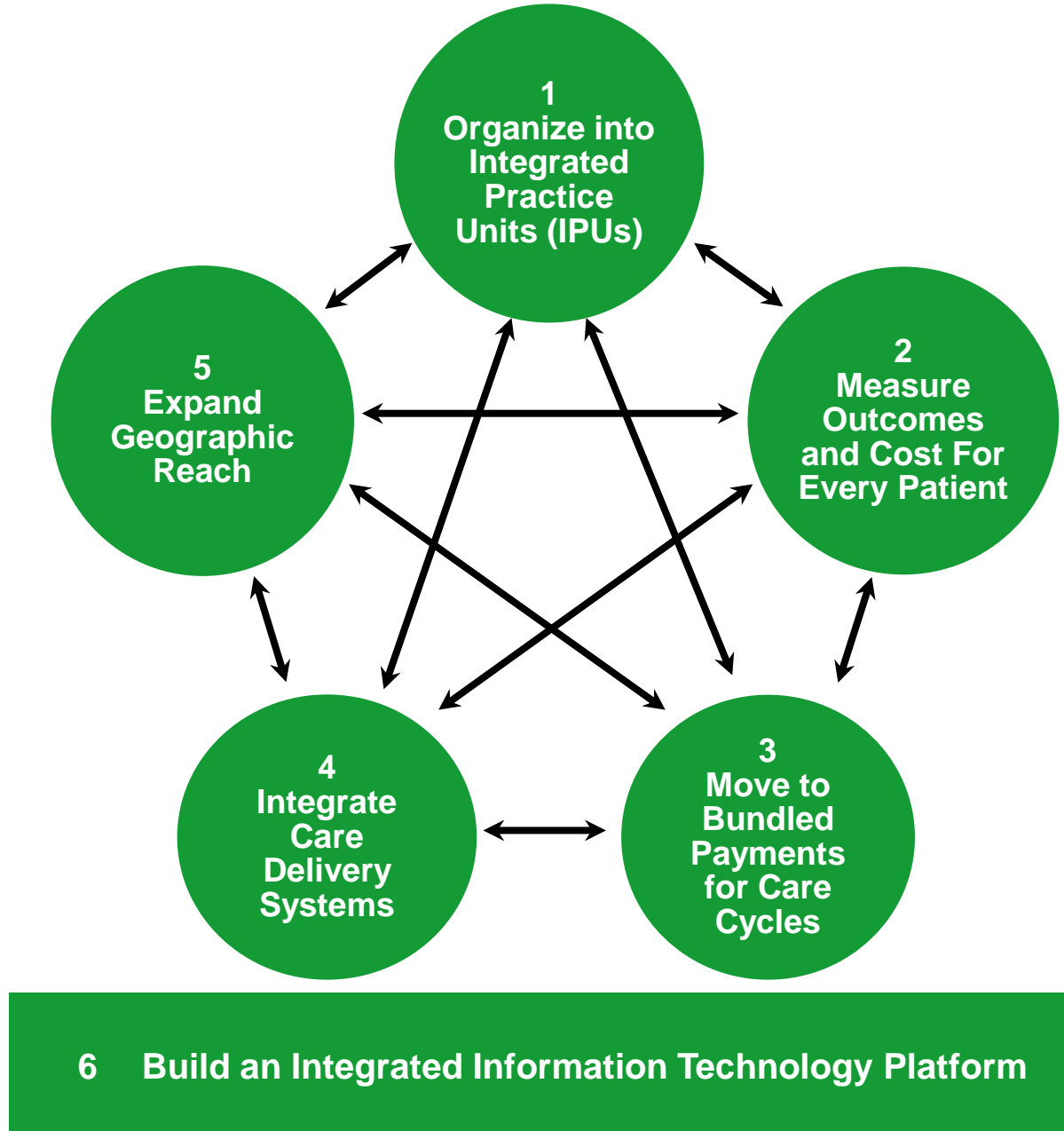


Build an Enabling IT Platform

Attributes of a Value-Based IT Platform

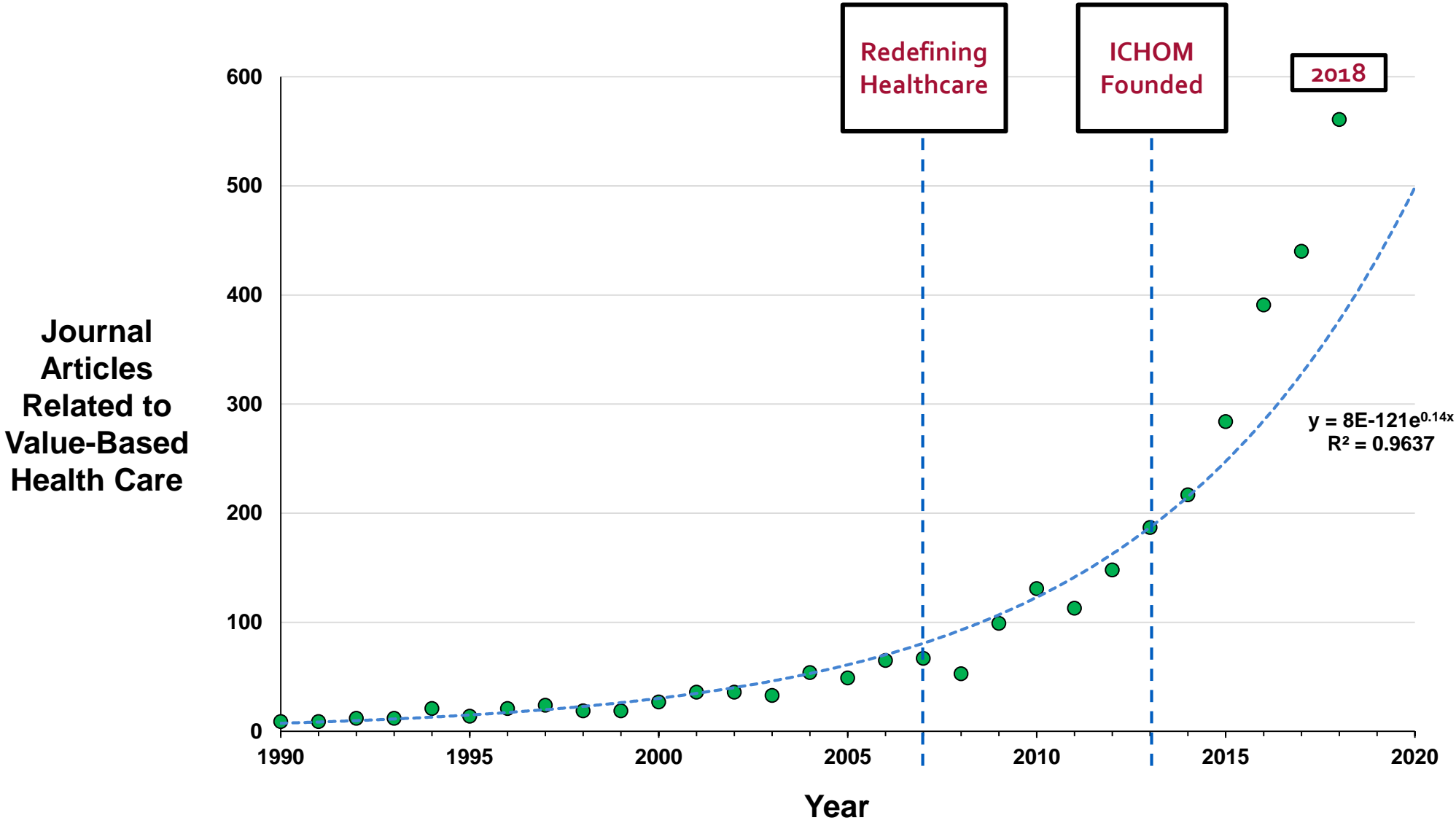
1. Combines **all types of data** for each patient across the full care cycle (notes, lab tests, genomics, imaging, costs) using standard definitions and terminology
2. Tools to capture, store, and extract **structured data** and eliminate **free text**
3. Data is captured in the **clinical** and **administrative workflow**
4. Data is stored and easily extractable from a common warehouse. Capability to **aggregate**, **extract**, **run analytics** and display **data by condition** and **over time**
5. **Full interoperability** allowing data sharing within and across networks, EMR platforms, referring clinicians, and **health plans**
6. Platform is structured to enable the capture and aggregation of **outcomes**, **costing** parameters, and **bundled payment** eligibility/billing
7. Leverages **mobile technology** for scheduling, PROMs collection, secure patient communication and monitoring, virtual visits, access to clinical notes, and patient education

A Mutually Reinforcing Strategic Agenda



Value-Based Health Care Thinking and Practice Are Rapidly Diffusing

Peer Reviewed Literature 1990-2018



From: Science Direct; accessed December 2018, Patrick Clapp, Baker Research Services, Harvard Business School

NEJM Catalyst Innovations in Care Delivery is a new digital, peer-reviewed journal from NEJM Group, the publisher of The New England Journal of Medicine.

Publishing six issues each year, NEJM Catalyst Innovations in Care Delivery aims to accelerate health care delivery transformation by publishing real-world examples and practical solutions so that health care leaders can address today's urgent care delivery challenges and shape the future of health care delivery across the globe.

Editorial Leadership:



Co-Chair and Editor-in-Chief —
Tom Lee, MD, MSc, Chief Medical Officer, Press Ganey; Professor, Harvard Medical School, TH Chan School of Public Health; Internist, Brigham & Women's Hospital



Co-Chair —
Michael Porter, PhD, Bishop William Lawrence University Professor, Harvard Business School

Quick Facts:

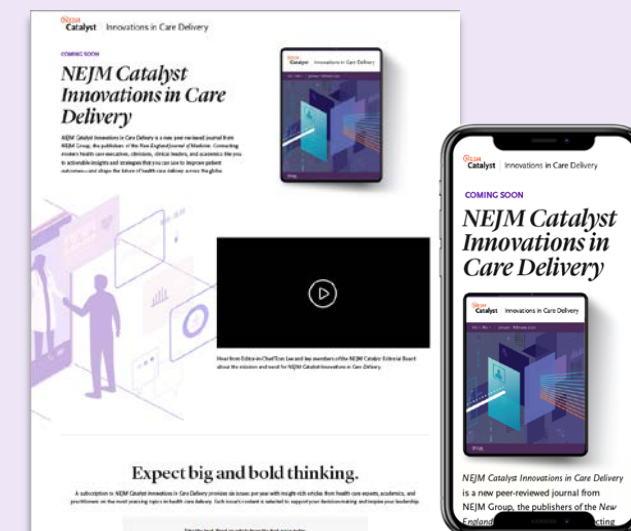
Frequency: Bimonthly (6x/year)

Launch Date: January 2020

Format: Online only

Indexed: Anticipate indexing in PubMed and MEDLINE

Audience: Health care executives, clinical leaders, clinicians, academics, industry analysts, consultants, policy makers, government officials



The Health Care Transformation is Well Underway

- We **know the path** forward
- **Value for patients** is True North
- **Value based thinking** is restructuring care organization, outcome measurement, payment models and **health system strategy** across multiple countries
- **Standardized outcome measurement** and new **costing practices** are beginning to accelerate value improvement
- **Employers**, **suppliers**, and **insurers** can be the next accelerators
- **Government policy** is beginning to reinforce value improvement



- We are anxious to **work with all** of you in accelerating this transformation

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- Websites Including Videos
 - <http://www.isc.hbs.edu/>
 - <https://www.ichom.org/>
 - Case studies and curriculum guide available at: <http://www.isc.hbs.edu/resources/courses/health-care-courses/Pages/health-care-curriculum.aspx>

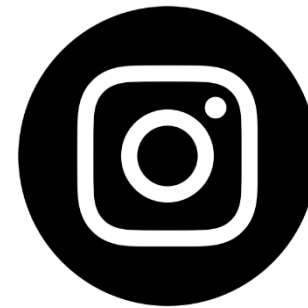
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CanREValue Collaboration

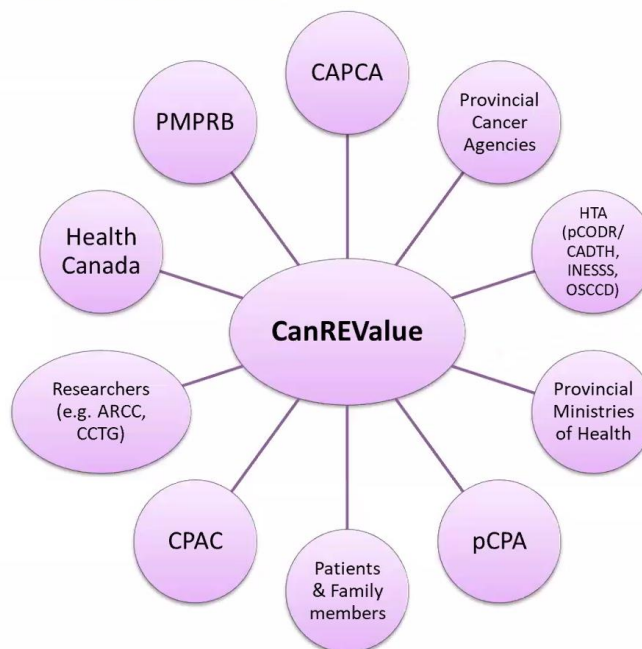
Purpose: To develop a framework for Canadian provinces to generate and use RWE for cancer drug funding decisions in a consistent and integrated manner

Potential System Impact

- Reassessment of cancer drugs by recommendation-makers
- Refinement of funding decisions or renegotiations/disinvestment by decision-makers/payers across Canada

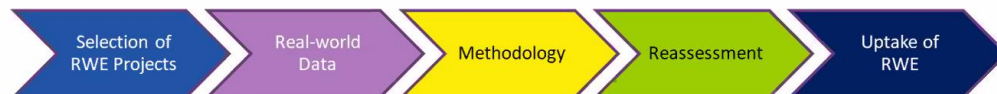
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CanREValue Members



5

CanREValue Working Groups



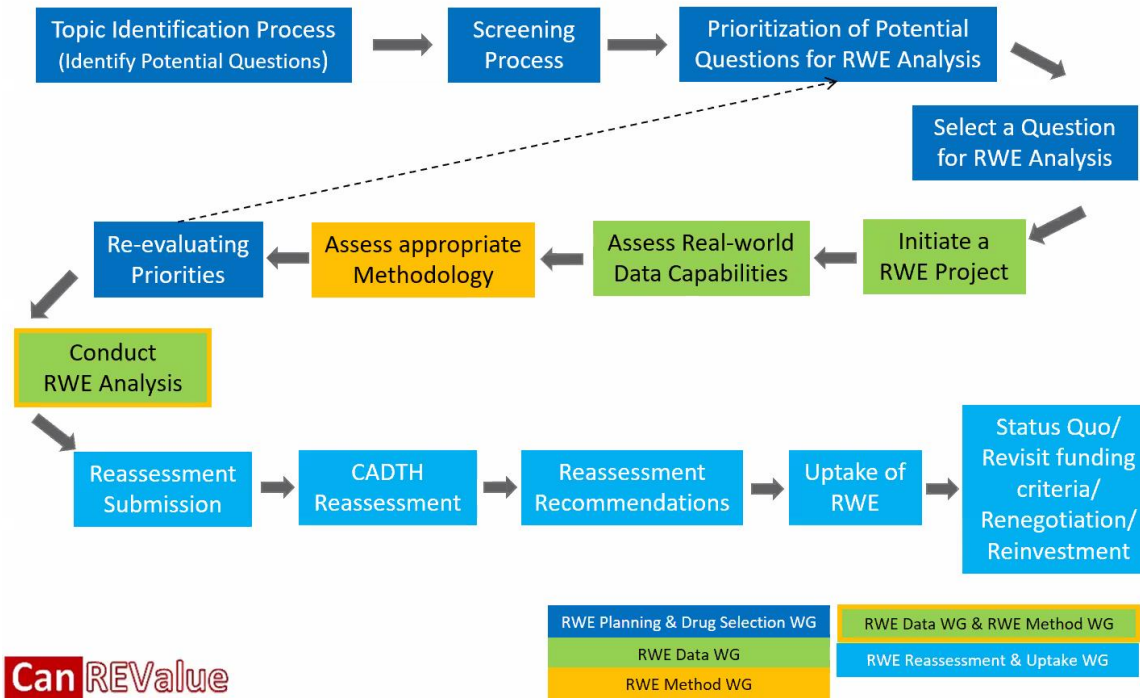
6

Framework Development

- The five Working Groups are tasked with developing the framework
- Through multiple teleconferences and two in-person meetings, the Working Group members have drafted a preliminary framework
- The findings from each Working Group are summarized in interim reports for stakeholders consultation
- Based on the inputs from the stakeholders, the Working Groups will update the preliminary framework through an iterative process

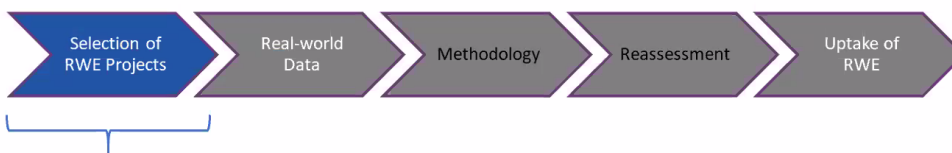
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CanREValue Preliminary Framework



Planning & Drug Selection Working Group

Chair: **Scott Gavura**, Director, Provincial Drug Reimbursement Programs (Cancer Care Ontario)

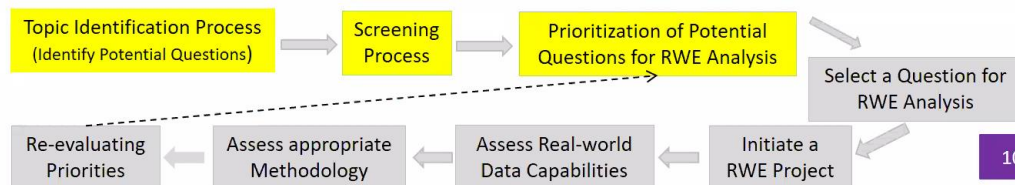


RWE Planning and Drug Selection WG

To develop criteria to identify potential drug candidates for real world evaluation and establish provincial infrastructure for RWE

Developing the framework component

- From Jan 2018 to Oct 2019, the WG members have completed:
 - 5 teleconferences
 - 2 annual in-person meetings
 - 6 surveys
- The working group members have
 - Developed a topic identification process
 - Applied it to identify 3 potential candidate drugs for RWE evaluation
 - Consulted with experts regarding prioritization process development
 - Identified multi-criteria decision analysis (MCDA) approach to priority-setting
 - Established a plan to develop and incorporate an MCDA based tool



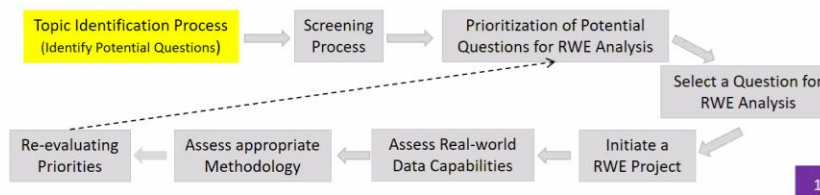
Framework will ultimately be prospective

MCDA work is still underway

Topic Identification Process

Triggers of potential RWE questions:

- Trigger 1: Uncertainties in the clinical benefit and/or alignment with patient values.
- Trigger 2: Uncertainties in value for money or feasibility of adoption of the drug
- Trigger 3: The uncertainties identified in triggers 1 & 2 are not expected to be resolved by evidence from future planned studies



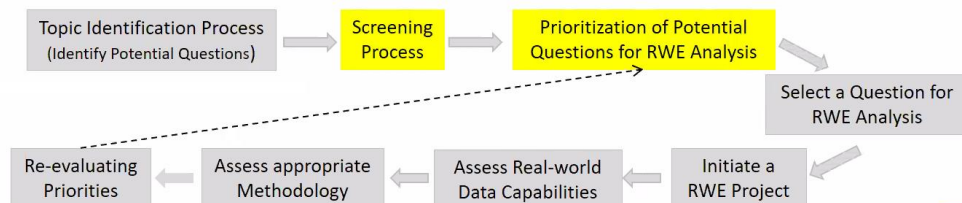
Trigger 2: CE, long-run CE

Trigger 3 “inherent” unknowns

Screening & Prioritization Process

Screening & Prioritization Process – under development

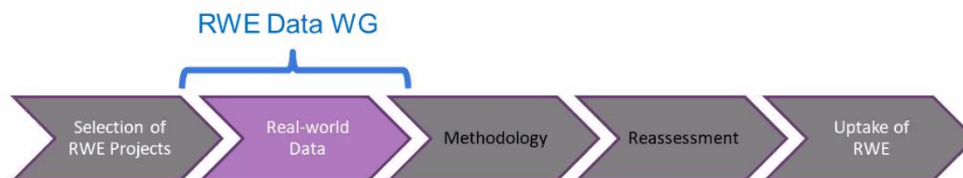
- WG members will develop a multi-criteria decision analysis based rating tool for prioritizing RWE questions
- Two sets of criteria are being considered for prioritization:
 - ✓The importance of the uncertainty identified
 - ✓The likelihood of resolving the uncertainty identified using administrative data



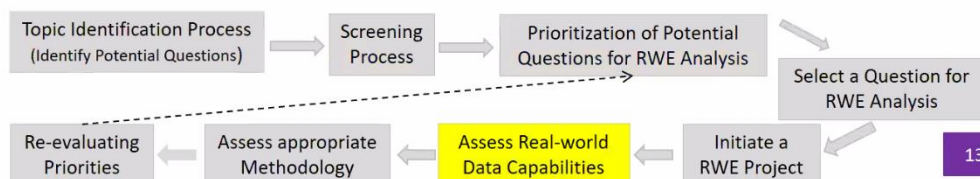
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Data Working Group

Chair: **Dr. Claire de Oliveira**, Associate Professor, University of Toronto; Health Economist, Centre for Addiction and Mental Health



To identify strategies to access data across provinces and harmonize data elements relevant for RWE studies



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Data holding across provinces

- Data experts from the ten provinces were iteratively consulted from March 2018 to September 2019 to complete the asset review via
 - 4 teleconferences
 - 2 in-person meetings
 - Two surveys
 - Multiple iterative exchanges via emails
- A survey was circulated to identify the main data custodians in each province and the available databases held by each jurisdiction.

Example: Survey on Data Holding

Province	Data Holder	Databases	Date Range	Update Frequency	Notes
Province	Custodian name	Database name	Year – Mar 2019	E.g. annual	
		Database name	Year – to date	E.g. real time	

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Data elements held in databases

- Within each database, we requested information on the name of each data element and descriptions.
- Data experts were asked to assess whether the data elements were available and linkable, and any limitations in coverage and/or completeness.

Example: Survey on Data element

Province	Data Element	Description	Database Name	Available & Linkable	Notes
Province	Age	Patient age	Cancer Registry	Green	
Province	Drug cost	Cost of drug	Treatment database	Yellow	



Data available and linkable
 Data available and linkable with caveat
 Data not available or linkable

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Capability to conduct real-world analyses

- Data experts from each province was asked to assess their capability to conduct a real-world study on different outcomes of interest
- Capability for conducting a RWE study varies by:
 - Type of outcome examined
 - Type of oncology drug (based on route of administration)
 - Province

Intravenous Cancer Drug Analysis		BC	AB	SK	MB	ON	QB	NB	NS	NL	PEI
Effectiveness (survival)											
Safety & Toxicity											
Budget Impact (payer's perspective)											
Cost-Effectiveness Analysis											
PROs/QOL (e.g. ESAS)											
Oral Cancer Drug Analysis		BC	AB	SK	MB	ON	QB	NB	NS	NL	PEI
Effectiveness (survival)											
Safety & Toxicity											
Budget Impact (payer's perspective)											
Cost-Effectiveness Analysis											
PROs/QOL (e.g. ESAS score)											

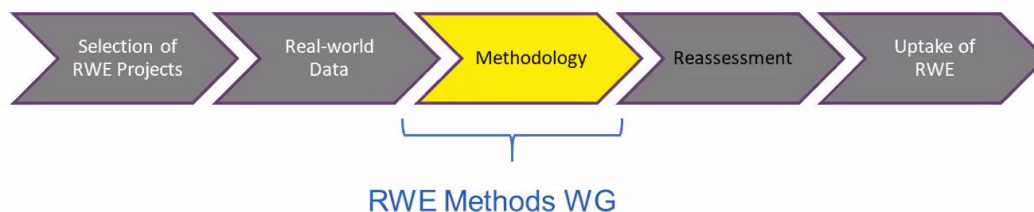
 Analysis can be completed
 Analysis can be completed with caveat

16

Red = analysis will be challenging?

Method Working Group

Chair: **Dr. Jeffrey Hoch**, Professor and Chief, Division of Health Policy and Management, Department of Public Health Sciences, UC Davis;
 Associate Director, Center for Healthcare Policy and Research

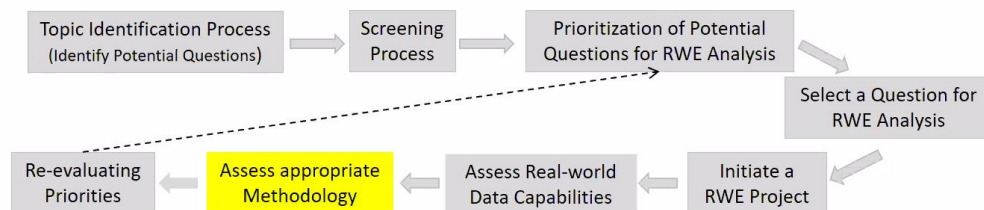


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Generating RWE from RWD

Two stages of analysis must be conducted to generate RWE from RWD

1. Adjusting for biases between exposure and controls
2. Statistical analysis to examine associations between exposure and outcome



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Paper 1 almost done; paper 2 sketched out

Identifying the appropriate methods

- The WG has held 2 teleconferences and 2 in-person meetings
- The group has adopted an outcomes-focused approach
 - Papers will focused on methods to evaluate different outcomes (e.g. survival)
- We have a paper exploring different approaches for survival analysis

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Adjusting for biases – checklist of methods

- ☐ Multivariable-based regression
- ☐ Propensity score related analysis
- ☐ Instrumental variable methods
- ☐ Other methods

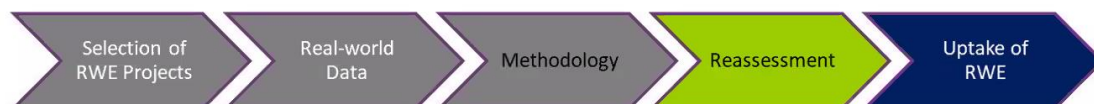
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Reassessment & Uptake Working Group

Co-Chairs:

Erica Craig, Provincial Pharmacy Director, New Brunswick Cancer Network

Brent Fraser, Vice President of Pharmaceutical Reviews, Canadian Agency for Drug and Technologies in Health



RWE Reassessment and Uptake WG

To develop strategies for implementing RWE results for HTA reassessment and policy making decisions

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Brent: objective= Develop a preliminary reassessment framework –

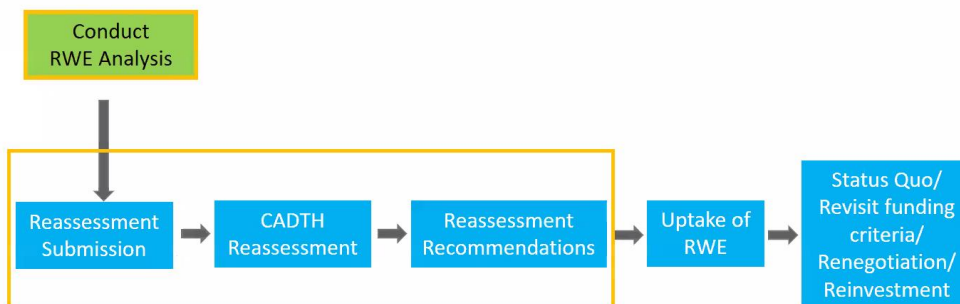
Developing the framework component



- Between Jan 2018 to October 2019, the working group members have completed:
 - 4 teleconferences
 - 2 annual in-person meetings
 - 4 surveys
 - 1 mock reassessment session
- The working group members have
 - Developed a draft reassessment process
 - Evaluated the process by conducting a mock reassessment session
 - Members were presented with real-world evidence from a funded cancer drug and were asked to
 - I. Deliberate upon the evidence presented and make a recommendation
 - II. Evaluate the reassessment process (e.g. what type of evidence is needed during a reassessment)

22

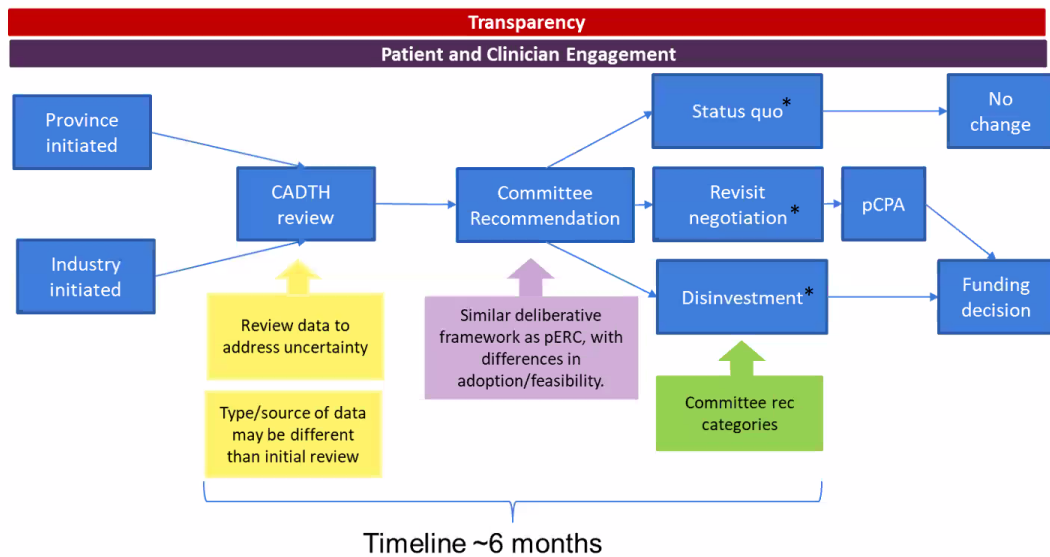
Reassessment Process



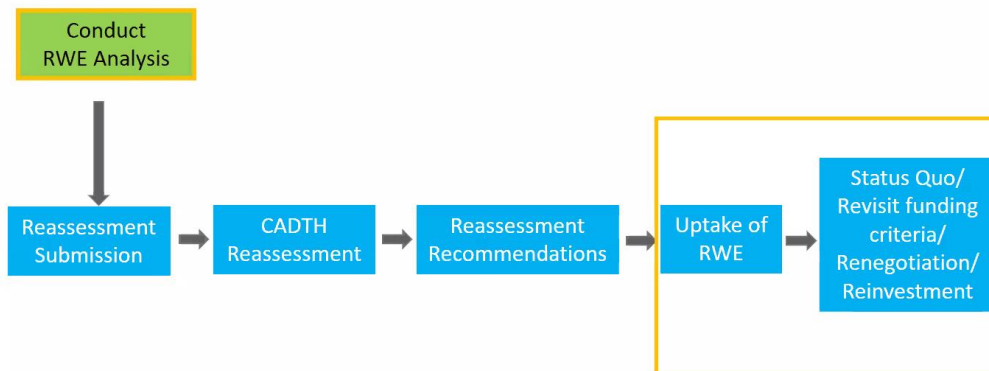
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Would go to pERC – similar to new submission; Unique challenge of in-market products– may require changes to funding criteria; re -negotiations

Reassessment Process



Uptake of RWE

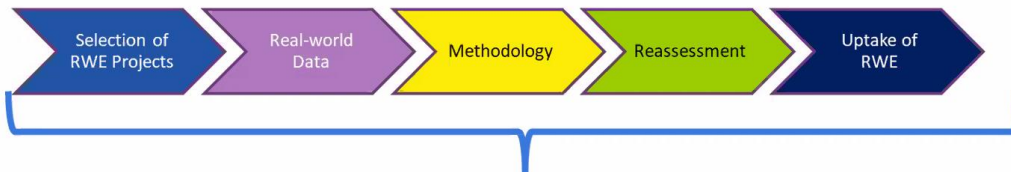


Re-investment may be possible

Dr. Bill Evans not online - Mina Tadrous filling in

RWE Engagement Working Group

Chair: **Dr. Bill Evans**, Medical Oncologist, Professor Emeritus,
McMaster University



Engagement Working Group

To ensure appropriate input from key stakeholders cross-jurisdictionally, at all steps of the framework development

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Stakeholder Consultation

- We aim to seek inputs from the public and all stakeholders on the preliminary framework process
- A series of interim reports were drafted to outline the different components of the framework
 - ☐ Report 1: Interim Data Report
 - ☐ Report 2: Interim Policy Report
 - ☐ Report 3: Interim Method Report

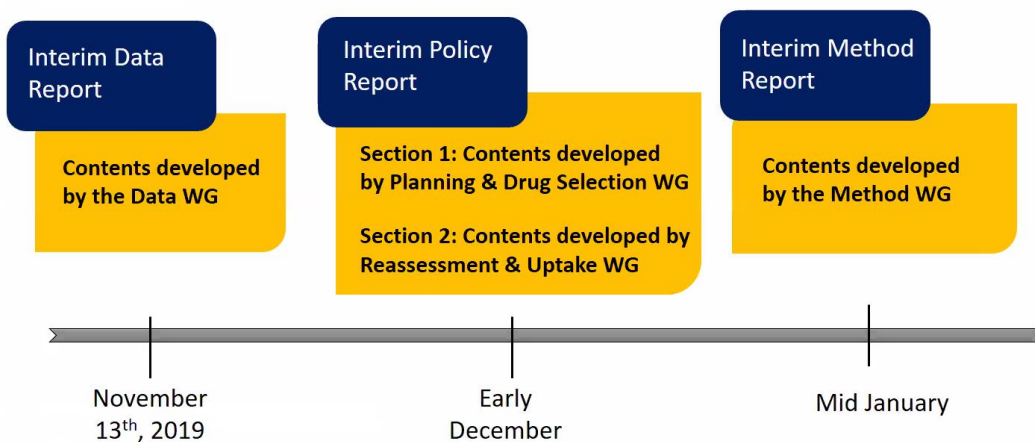
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Feedback Process

- Interim Report can be accessed via:
 - I. CanREValue Website
 - ❖ Reports will be posted on the website: <https://cc-arcc.ca/canrevalue-kt>
 - ❖ Under the tab labelled "CanREValue Working Group Reports"
 - II. Register with CanREValue mailing list
 - ❖ Sign up at: CanREValue@cc-arcc.ca or follow @CanREValue
 - ❖ Reports will be send out to the mailing list
- Feedback can be provided in the feedback form
 - Feedback forms will be included with the report
 - Accept feedback from all stakeholders through written submission
 - Feedback (maximum 5 pages) will be accepted for 1 month after release of draft report
- Updated report will be released with reply to all feedback
 - All replies and comments may be made public

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Timeline for report release



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Questions?

Reports can be accessed one of the following ways:

- Register for the CanREValue mailing list (CanREValue@cc-arcc.ca)
- Visit the CanREValue website (<https://cc-arcc.ca/canrevalue-kt>)

