Conference Series 2020 Resources

Webinar 2

Question and Answers

A Value Based Approach to Healthcare Leadership

1. Right now, many leaders are saying "I don't have time for outcomes; I have to deal with Covid." How would you respond to these statements?

COVID-19 is an excellent example of why tracking outcomes matters. Value-based healthcare allows for data-driven changes in care and policy in a responsive and efficient way. ICHOM is in the process of quickly developing a standard set for patients with COVID-19, which we hope will allow providers and registries to track the outcomes that matter most to patients and to use these data to inform their guidelines. In addition, it will be crucial to examine the outcomes of all those patients whose care has been suspended as a result of the pandemic. This will be important in preventing any further unnecessary damage.

2. How long after treatment do you ask patients how their quality of life has been improved?

This varies according to condition and context. ICHOM produce a timeline of standardised collection points with their standard sets. This is important when comparing outcomes, particularly after a procedure like cataract surgery, for instance.

3. How can a patient, who is considering treatment, access the patient outcomes you have been collecting with the system you have implemented in your hospital?

This will depend on the local system in place and how this links to the patient's medical records. However, patient data will always be available to the patient and this is also true for outcomes data.

4. What is the evidence that listening to patients through taking up the information provided by patients in the first -Q1 - PRO survey, can lead to improved outcomes?

This is an idea that is just being explored. At MSKCC, we just completed PCORI-funded RCT of 2600 patients randomized to receive feedback and resources about symptoms management after ambulatory cancer surgery. We are analyzing the data now. ClinicalTrials.gov Identifier: NCT02700256.

5. Would you prefer to use PREM individually (feedback doctor/team-patient) or aggregated and transparent for other (future) patients, or both?

Both, but it's important that PREMs are seen and therefore acted upon quickly and therefore need to be embedded in operational management. Also important to note that good PREMs do not guarantee high value. Far from it.

6. How do you find what to measure as PROs when you do not have the ICHOM standard set as the baseline?

If you are aiming to implement something in a particular context, at the local level, you may want to gather a group of experts locally to determine the PROs that need to be collected in your patient population. The ICHOM Standard Sets have the advantage of being a globally-representative list of outcomes shortlisted by an international expert group. ICHOM is always interested in launching new projects to develop standard sets of outcomes, so you are welcome to get in touch to let us know that there is a condition that you think should be prioritised.

7. COVID-19 has clearly exposed health disparities that exist in healthcare globally. How can measuring outcomes help reduce those disparities?

Measuring outcomes, particularly when using standardised sets of outcomes, allows providers to compare performance and to learn from each other. Our hope is that this can serve to inform the changes needed to improve care for those who need it most. ICHOM standard sets include a list of case mix factors, which are clinical, demographic and risk-adjustment factors. This means that the data can highlight the roots of disparities, which should help to drive change.

8. The other issue is that physicians are losing revenue given changes to their practice, loss of income from elective surgeries — even when there is a compass towards value-based care, it is quite difficult to ignore the realities of salary cuts & other physician disincentives. How are we positioning ICHOM in this conversation?

We cannot deny that the pandemic has had an impact on physicians as well as patients. Value-based healthcare and measuring outcomes should help drive care improvement and performance in the medium- to long-term. In the case of elective surgeries, for example, value-based care will highlight the importance of these for the patient, who will likely report improvements in PROs. This can serve as an incentive for such treatments to move forward when there is discussion over what needs to be prioritised.

9. How do you approach measurement? Where would someone get started?

Implementing collection of PROs will depend somewhat on the local context and the systems used. ICHOM has partnered with specialists in implementation to support providers wishing to begin this journey. You can get in touch with the relevant partner for your region to discuss where to start. In addition, ICHOM is in the process of developing a tiered approach to standard sets, so that those wishing to implement a standard set for the first time can begin with a subset of data collection before implementing the standard set in its entirety.

10. What is the status of the development of the CAT method to collect PROMs in a more intelligent way?

- CAT methods are gaining traction but there is still barriers to scoring (ie need to be connected to servers etc)
- This is a very important question but we are not yet close to this in Wales. As more and more people have a focus on PROMS, this as well as harmonisation will be important to reduce the burden of measurement on patients.
- This is a great method if you have the ability to use it, but it can be burdensome as it requires additional setting up and high-quality systems in place.

11. You mention innovation at speed. Would you concur that a more pragmatic (and patient-centric) attitude to data security has been applied, (e.g. "how we can have access to data" as opposed to "these are the reasons why you can't")?

Yes, I definitely recognise this as a feature of the pandemic, and hope that some of this is maintained for the future, whilst maintaining a focus on good information governance.

12. What digital technologies have you found most effective in collecting PROs?

Anything linked to enhanced remote digital communication with a patient (2 way). Also when it is personalised e.g. a text saying, Dr X would like you to complete this assessment that is important to your care. Using a word like assessment instead of 'survey' or 'questionnaire' is also helpful.

13. Has anyone published on M&Ms of non-COVID patients facing delays & cancellations of care due to COVID-19?

Several preliminary studies have been published assessing the indirect effects of the pandemic on patient care, particularly in emergency care, oncology, otolaryngology and surgery. However, it is likely that these results only begin to scratch the surface and there is much work to be done to prevent further morbidity and mortality secondary to this crisis.

14. How do you build resilience of health care workers who are taking risks/working hard, only to see colleagues laid off and costs being cut?

Times like these can certainly be very difficult, particularly for healthcare workers in these situations. When taking a value-based approach, cost cutting should only be driven by data and should serve the interest of the patient as well as the providers and payers.

15. Who is responsible for collecting PROs? Is this done by the program itself (i.e. surgical program) or a centralized measurement group in your organization?

I think this varies enormously according to the healthcare system that you are in. Good clinical and patient engagement are the foundations of this work but it can't be done without some dedicated project and informatics support to get it off the ground. Early attention to data extraction and flow is also necessary.

16. Value-Based Health Care Delivery and ICHOM's work make strides in our communities, however, we all suffer on the "information technology" front- as highlighted by Porter in the 1st Webinar. Are any of the tools discussed here today available under open software licensing-at least in some limited realistic testing capacity?

Interoperability is a major headache. This is why we are creating the National Data Resource in Wales, which will enable us to link data from different sources ahead of analysis.

17. How do we develop tools to actually collect, aggregate and analyse the outcomes? A key issue to me in scaling up value-based healthcare is interoperability…

A large part of the work to be done in implementation is exactly on these points. Our Implementation Partners can help with these steps, offering options best suited to your local needs.

18. How many and which ICHOM Standard Sets do you have currently implemented and running (globally, if healthcare provider is global)?

Dr Sally Lewis: Heart failure, lung cancer, cataract, stroke, hip and knee (not ICHOM) Parkinson's and dementia (one health board)…and some other non-ICHOM sets.

19. How did you align the incentives of your organisation to focus on what matters to patients instead of what matters to clinicians or shareholders?

This a very complex question and could be the focus of a whole webinar so I won't attempt to answer here. Basically there has to be something in it for everyone.

20. Do you think that in the near future, HTA will include what matters to patients on its recommendations?

Dr Sally Lewis: I sit on the special interest advisory group for medical devices at HTAi…this is certainly our wish and something we would wish to encourage through our work.

21. I understand that the PROMs are enterprise wide in the sense applicable to geography. How have the PROMs that are being utilised been localised to each geographical location given that locus of control varies across regions which are shaped by internal and external factors which will be different such as knowledge, beliefs, attitudes, education, etc to name a few (social determinants)? Take Framigham risk assessment model for example, this is more appropriate for some ethnicities than others due to the baseline utilised to develop the risk model.

This is an excellent question and would agree that PROMs analysis is often over-simplified. Variation in PROMs is driven by many things as the questioner highlights. This is why we have employed an expert PROMs research team to ensure that we do not draw erroneous conclusions from our analyses. Much more research is needed in this area around PROMs utility and also in involving more patients in PROM development.

22. Which specific steps does the healthcare leadership need to take to enable the implementation of VBHC ? How can healthcare leadership be convinced to adopt VBHC?

The selling point in VBHC is that it should serve the interests of all stakeholders. Initiating to outcome measurement and switching to value-based payment models, for instance, these are key steps to enabling this approach.

23. What are some practical steps to engaging patients? Hospital leaders may often say there isn't enough time, or I have to focus on COVID-19. How do we reconcile these time pressures with a changing healthcare ecosystem?

Creating a way for patients to report on their outcomes remotely may be key in this sort of situation. This has worked very well in some contexts, especially when this can happen before the patient sees the clinician, so that the data collection is already done and can lead to an informed discussion between the provider/clinician and the patient.

24. Some of the experiences from COVID-19 would suggest that VBHC based systems have been more resilient. Yet, many efforts in this direction eg. in the US have lost momentum. What do you think is needed from HC leaders to secure that we progress at higher speed and not fall back?

It is important for examples of VBHC approaches that have been successful through this crisis to be shared and published, so that the evidence can drive further engagement in this field and revert this loss of momentum.

25. There's an emphasis on telehealth and virtual health care tools, but populations who normally have poorer outcomes and are disproportionately impacted by COVID-19 are often the same ones that do not have internet, money for technological devices, and who may have poor literacy or require translation services. How much are these tools going to help marginalised communities and/or those in rural/remote areas with poor internet infrastructure?

This can be an issue, and it is important that an alternative be made available in every case. For instance, if a patient is expected to be submitting PROM responses before an appointment, there should be an opportunity to do so on arrival at the clinic, rather than having to do so at home.

26. Socioeconomic determinants highlighted by Covid-19. What should healthcare leaders do to address this - which is typically seen as "someone else's problem"?

If we are able to monitor outcomes and collect case mix data in the process, it will be invaluable to look at the data and assess exactly where these issues lie. And this should be a driver of transformation in care provision. This is our hope, and ICHOM is in the process of harmonising the case mix data that should be collected for every standard set.

Wed 27th May

May Webinar

ICHOM BOARD:
ICHOM Strategy & VBHC in a Global Pandemic

15:00 BST / 10:00 EST / 16:00 CET
(45-60 minutes)

24th June

June Webinar

A Value Based Approach to Healthcare Leadership:
Preserving the value thought in a pandemic
Why Outcomes Measurement is critical
Innovations in PROMs Collection

(45-60 minutes)

29th July

July Virtual Conference

The Healthcare System of the Future
Exploring the importance of VBHC
The role of VBHC in Virtual Medicine

(3 hours)

23rd Sept

Sept Webinar

Shared Decision Making in Practice
Co-producing Healthcare with Patients

(45-60 minutes)

16th – 18th Nov

November Conference

Patient-Centered Healthcare and the Value Based Approach
Making Change Happen

(2 days)

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