Delivering value-based healthcare

Victoria's HealthLinks experience: early successes, learnings and achieving scale

Tanya Sewards
Department of Health and Human Services, Victoria

Jo Stevens
Barwon Health

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Presentation overview

1. **HealthLinks – aiming to deliver greater value**
2. **Implementation experience from a system-manager perspective**

   Tanya Sewards

3. **Delivering value-based reforms within a health service level : Barwon Health's experience**

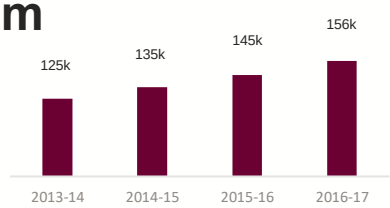
   Jo Stevens

4. **Next steps to scaling value-based models of care**

Challenges facing Victoria's healthcare system

Pressures to Victoria's health system

Health expenditure in Victoria has risen by an average 6.6% annually over the last decade



Chronic conditions occupy an increasing proportion of Victoria's burden of disease

$200 million is spent on avoidable hospital admissions every year

Challenges with existing funding models

Reward volume of healthcare, not the value added to patients - the system incentivises invasive and high-cost interventions

Can impede the provision of high value care - Clinicians need flexibility to coordinate and deliver the interventions that matter to patients, in the most efficient way

The logic of HealthLinks

Activities

- Identify highly complex and chronic patients on arrival at hospital
- Stream patients to the right interventions
- Support self-management
- Create incentives to reduce avoidable hospital care

Changes expected

↓ Unplanned admissions and ED presentations

↑ Increased provision of services in lower cost, home and community settings

↑ Patient experience and outcomes

Long-term outcomes

- Patients get the right care
- Better patient experience
- Better value care and more effective use of available resources

VALUE BASED HEALTHCARE

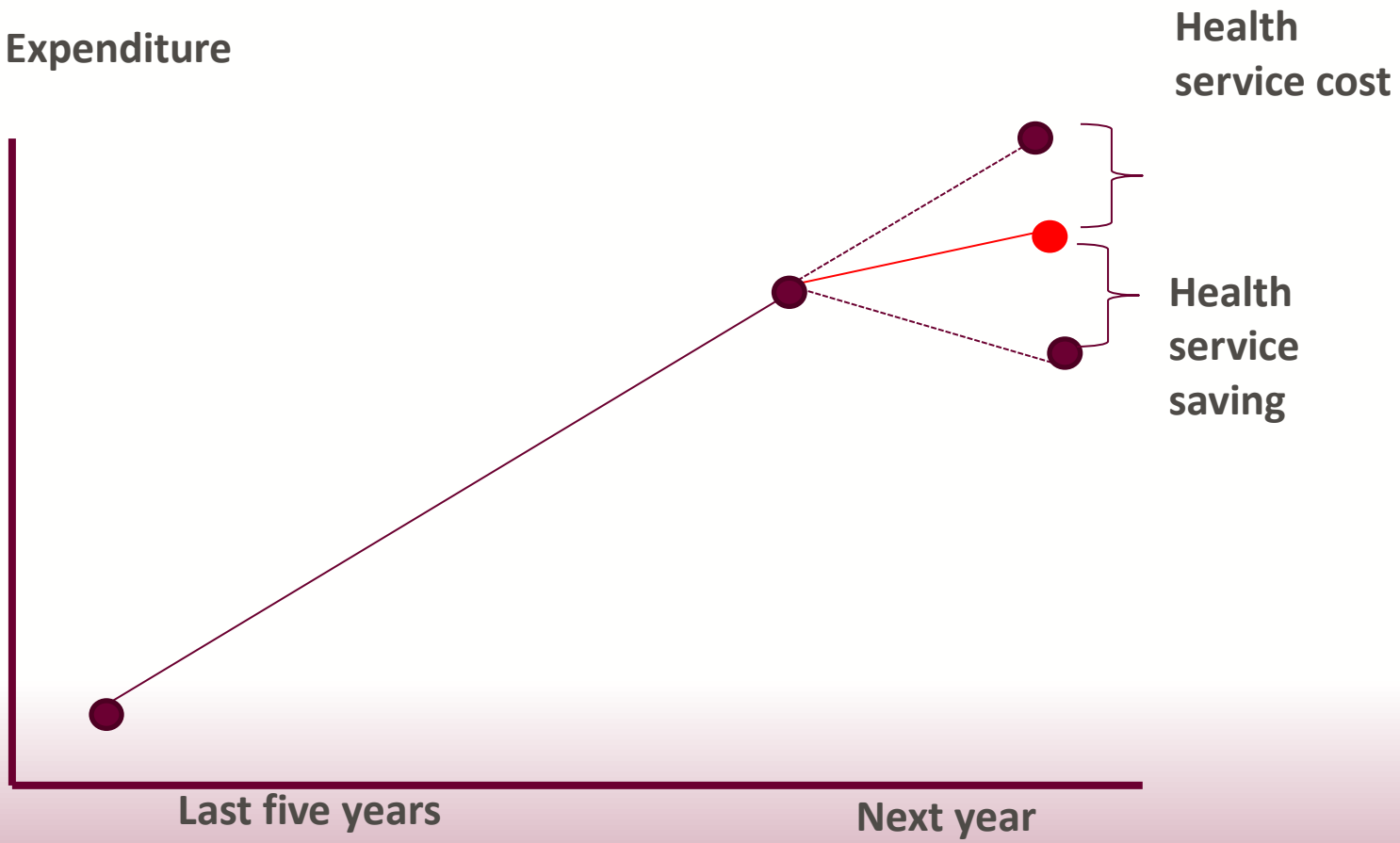
How HealthLinks works

- An algorithm identifies patients who are at high risk of multiple unplanned admissions.
- Most of these patients have multiple chronic and complex conditions.
- Patients can remain enrolled for up to four years, unless they meet an exclusion criteria or die.
- 1/3 of patients are ‘true patients – will go on to have multiple admissions.

- A portion of funding is converted to a capitated grant, for every enrolled patient.
- Any savings from reductions in inpatient care can be reinvested in program enhancements.
- Encourages health services to avoid wasteful and unnecessary care and focus on delivering services that make a difference to patient outcomes.

- Health services can develop their own interventions and determine which patient cohort to focus on.

HealthLinks funding incentive

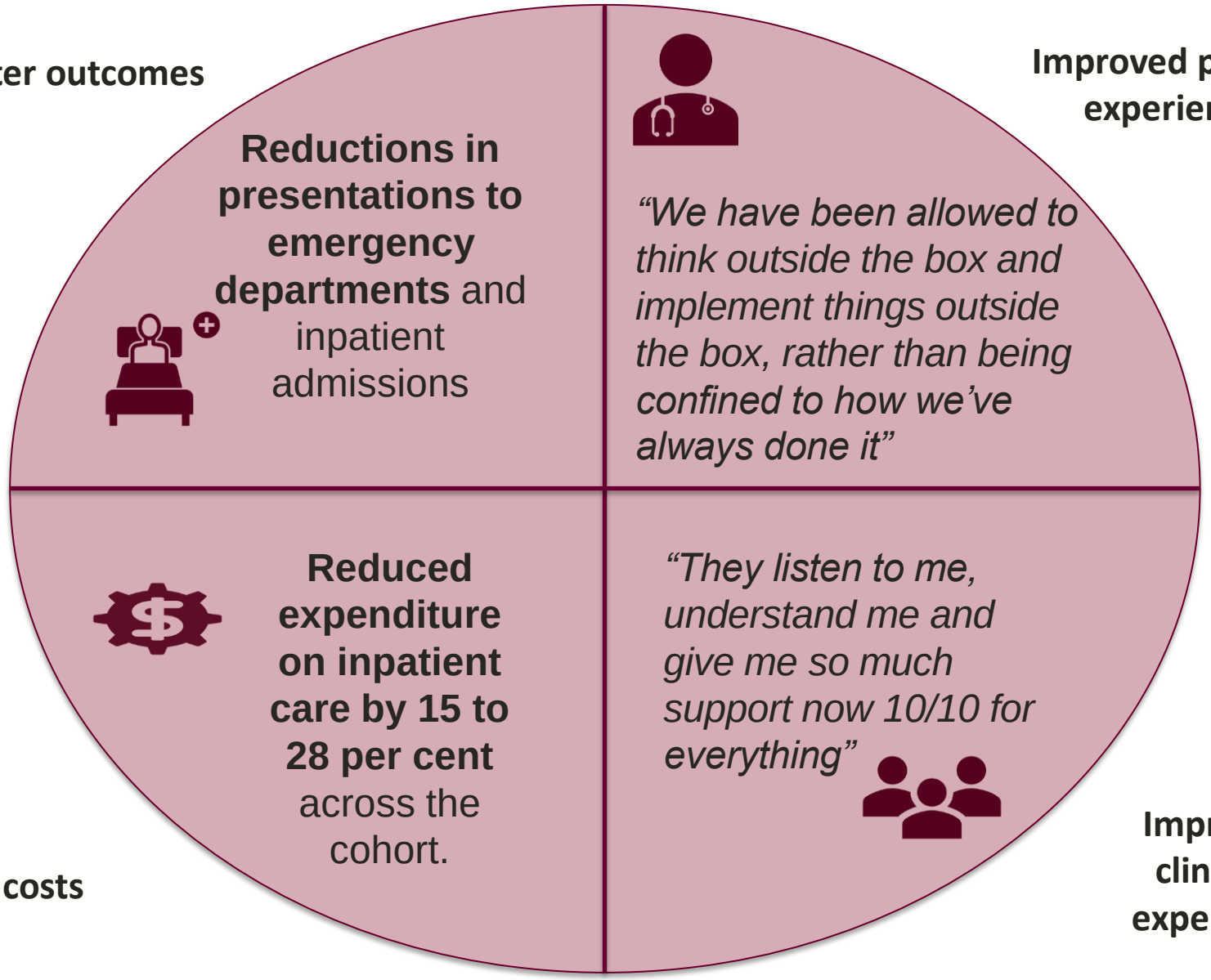


Source: adapted from Harvard TH Chan School of Public Health

The journey so far

- Currently four health services participating in HealthLinks – flexibility to design interventions and target specific patient groups
- Over 40,000 patients have been enrolled in HealthLinks across the four sites
- Average enrolment period of 2 years
- Common care elements emerging:
    - Regular telephone coaching/telehealth monitoring of patients at home
    - Follow-up support post discharge to arrange appointments, connect patients with general practitioner and other service providers.
    - Facilitated and direct access into existing hospital and community health and social services
    - ‘Other support’ - transport, heating, cleaning etc.
- Clinical Collaborative Group to share best practice approaches and resources to managing complexity– 10 health services participating
- Independent evaluations and system level evaluation underway

Early successes



Challenges in implementing value-based care models - for system managers

- Designing funding models that incentivise delivering value
- Understanding what patients value and the interventions that work
- Measuring value - currently geared towards measuring throughput, not quality or value of care from the perspective of a patient
- Changing health service behaviours – accepting possible reductions in revenue over time
- Building a system of care that can deliver value across different providers
- Determining value in a shared funding environment
- Timeframes for results - changing consumer behaviour can take longer than the time allowed for evaluating impact
- Consumer perceptions and trust as changes in care are implemented
- Changing workforce configurations and building different types of skills – planning for the future workforce

Barwon Health

HealthLinks

Jo Stevens Manager Chronic and Complex Care

(Service Improvement Lead HealthLinks)

Barwon Health Victoria

The primary catchment for Barwon Health has a population of 253,000. Some tertiary services extend to the South Australian boarder extending the serviced population to 500,000.

Rapid urban growth, predicted to be 28% by 2036 and an aging population pose challenges

Barwon have a full spectrum of services, emergency, acute, mental heath, primary care, community health, community nursing, aged care and rehabilitation.

There are 1033 beds and service delivery takes place across 22 sites

Barwon Health

Capability to provide specialty services resulting in 90% self sufficiency

Geographically the only public hospital

Preventing hospital admission through services such as HITH, Community Nursing , HARP, enhanced Pall@home, GEM@home programs and *HealthLinks*.

What is Home Monitoring 2016

Barwon Health

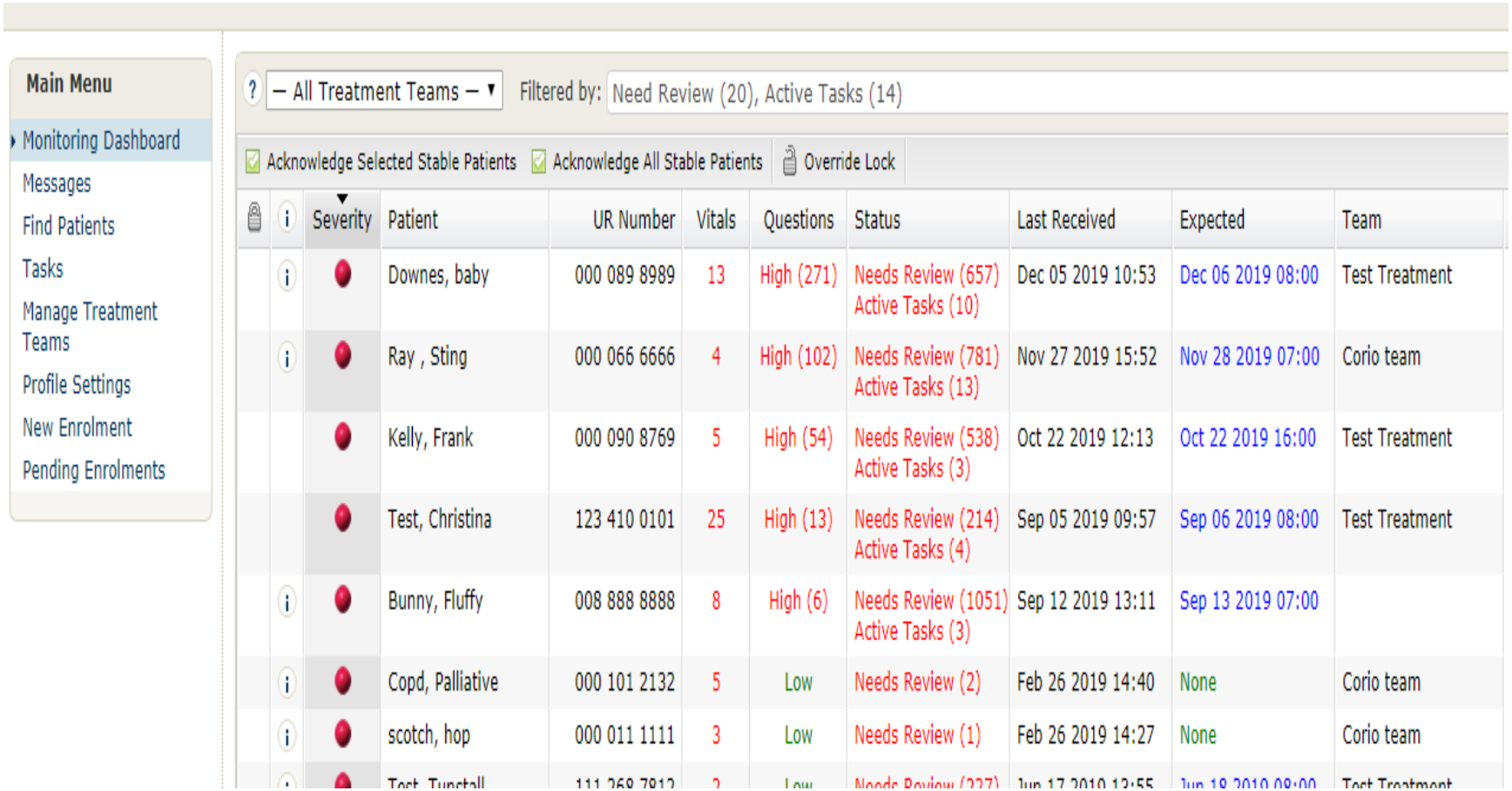
Provide advice or recommendations for action

Refer patient to appropriate health service

Seek further advice from on-call consultant

Remote Patient Monitoring

Barwon Health



Severity	Patient	UR Number	Vitals	Questions	Status	Last Received	Expected	Team
	Downes, baby	000 089 8989	13	High (271)	Needs Review (657) Active Tasks (10)	Dec 05 2019 10:53	Dec 06 2019 08:00	Test Treatment
	Ray , Sting	000 066 6666	4	High (102)	Needs Review (781) Active Tasks (13)	Nov 27 2019 15:52	Nov 28 2019 07:00	Corio team
	Kelly, Frank	000 090 8769	5	High (54)	Needs Review (538) Active Tasks (3)	Oct 22 2019 12:13	Oct 22 2019 16:00	Test Treatment
	Test, Christina	123 410 0101	25	High (13)	Needs Review (214) Active Tasks (4)	Sep 05 2019 09:57	Sep 06 2019 08:00	Test Treatment
	Bunny, Fluffy	008 888 8888	8	High (6)	Needs Review (1051) Active Tasks (3)	Sep 12 2019 13:11	Sep 13 2019 07:00	
	Copd, Palliative	000 101 2132	5	Low	Needs Review (2)	Feb 26 2019 14:40	None	Corio team
	scotch, hop	000 011 1111	3	Low	Needs Review (1)	Feb 26 2019 14:27	None	Corio team
	Test, Tunstall	111 268 7812	2	Low	Needs Review (227)	Jun 17 2019 12:55	Jun 18 2019 08:00	Test Treatment

Individualised Care

Barwon Health

- Monitoring plan that can be modified to meet the patients individual needs
- Health coaching approach fortnightly via video conferencing facilitated by scheduled and opportunistic expert nurse intervention
- Support for patients in the use of the system

Research Findings for RPM

Broader paper published in 2017
Economic Evaluation submitted for publishing 2020

Barwon Health

- Statistically Significant
  - Reduction in LOS by 3.9 days
  - Improvements In Health Literacy scores
  - Improvements In Quality of Life scores
  - Reduction in Anxiety and Depression scores
- Suggested reductions in Hospital presentations and Emergency Presentations
- Economic evaluation cost neutral model
- Qualitative review of the patient experience identified improved health literacy and a sense of safety
  http://www.youtube.com/watch?v=4UCrA36LF5s

HealthLinks

Barwon Health

HARP Review

Pathways developed for referrals with priority access to Community Health and Rehabilitation services

Intake model designed and tested

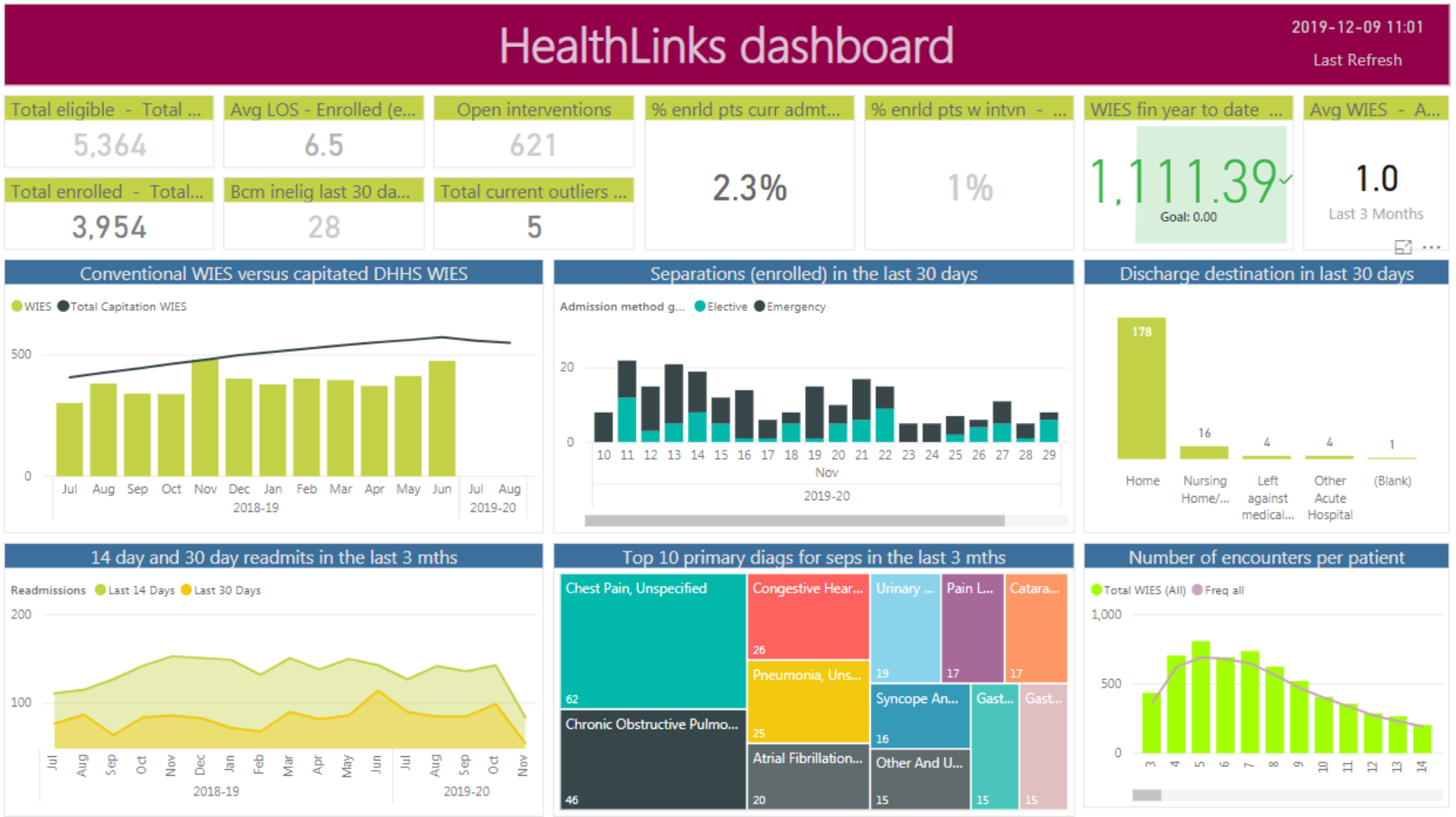
Barriers to care identified

Reporting and identification

Secondary screening questions at bed side

HealthLinks Identification and Reporting 2018/19

Barwon Health



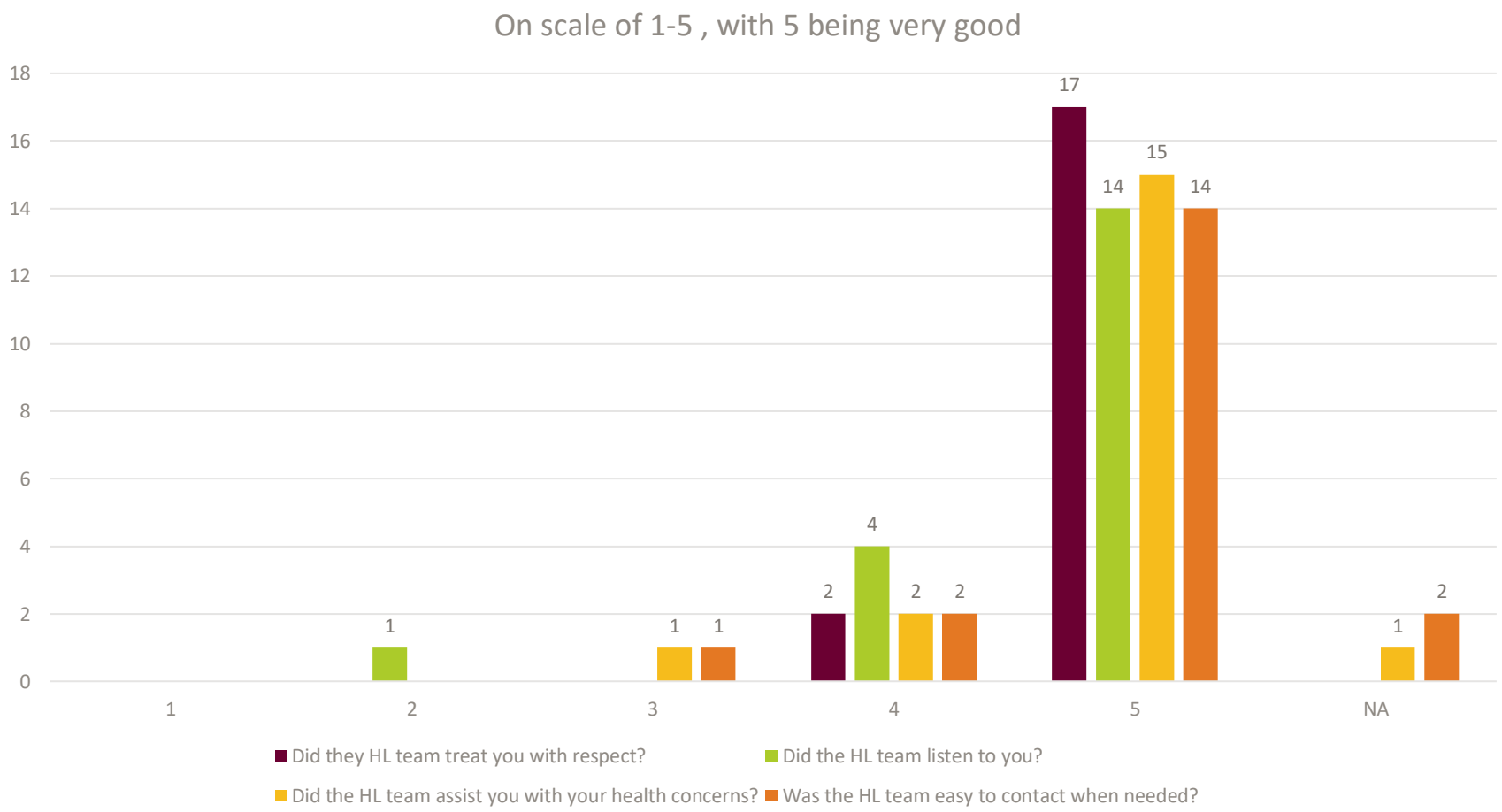
OUR VALUES / RESPECT / COMPASSION / COMMITMENT / ACCOUNTABILITY / INNOVATION

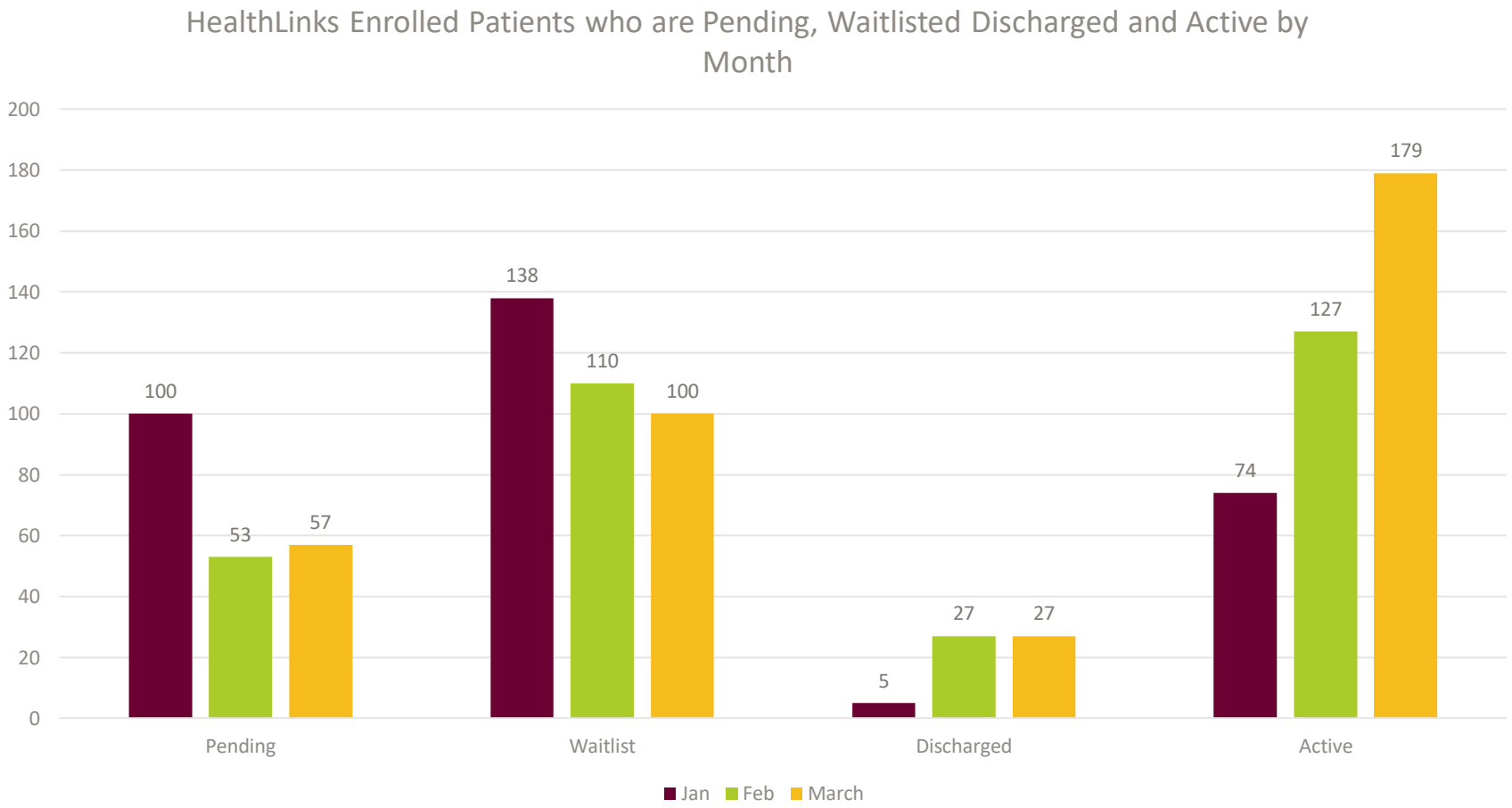
CHF Model 2019/20

Barwon Health

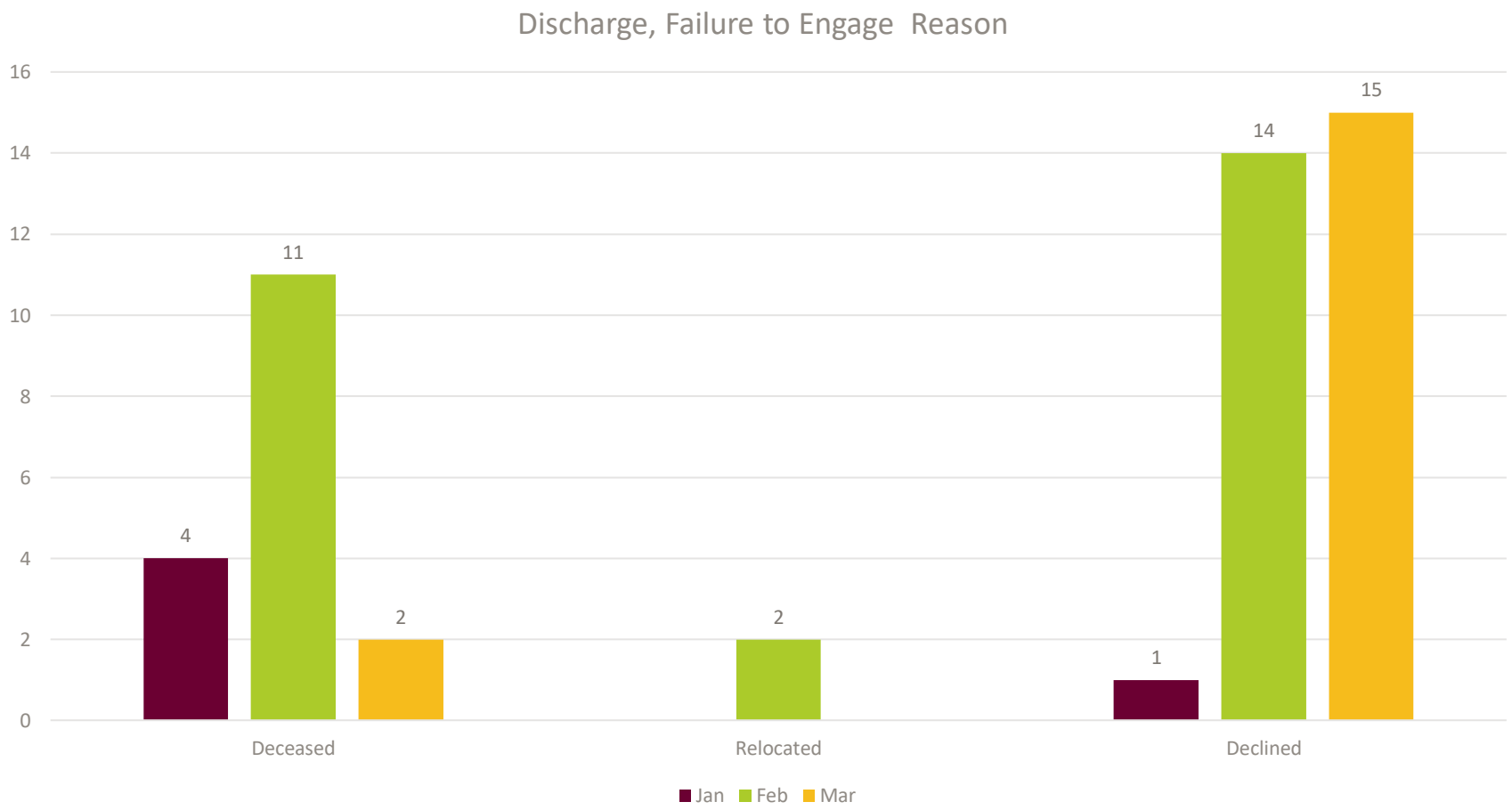
- New service commencement January 2020
  - Follow up post discharge within 48 hrs
  - Extension of current Barwon HARP model
  - CHF patient
  - Bed side intake, risk stratification
  - Monitoring RPM and step down phone support
  - Care escalation to CNC and NP, HITH and Cardiology
  - Liaise with GP

Patient Survey




HealthLinks Enrolled Patients who are Pending, Waitlisted Discharged and Active by Month
200
180
160
140
120
100
80
60
40
20
0
100
53
57
138
110
100
5
27
27
74
127
179
Pending
Waitlist
Discharged
Active
Jan
Feb
March

Discharge , Failure to Engage



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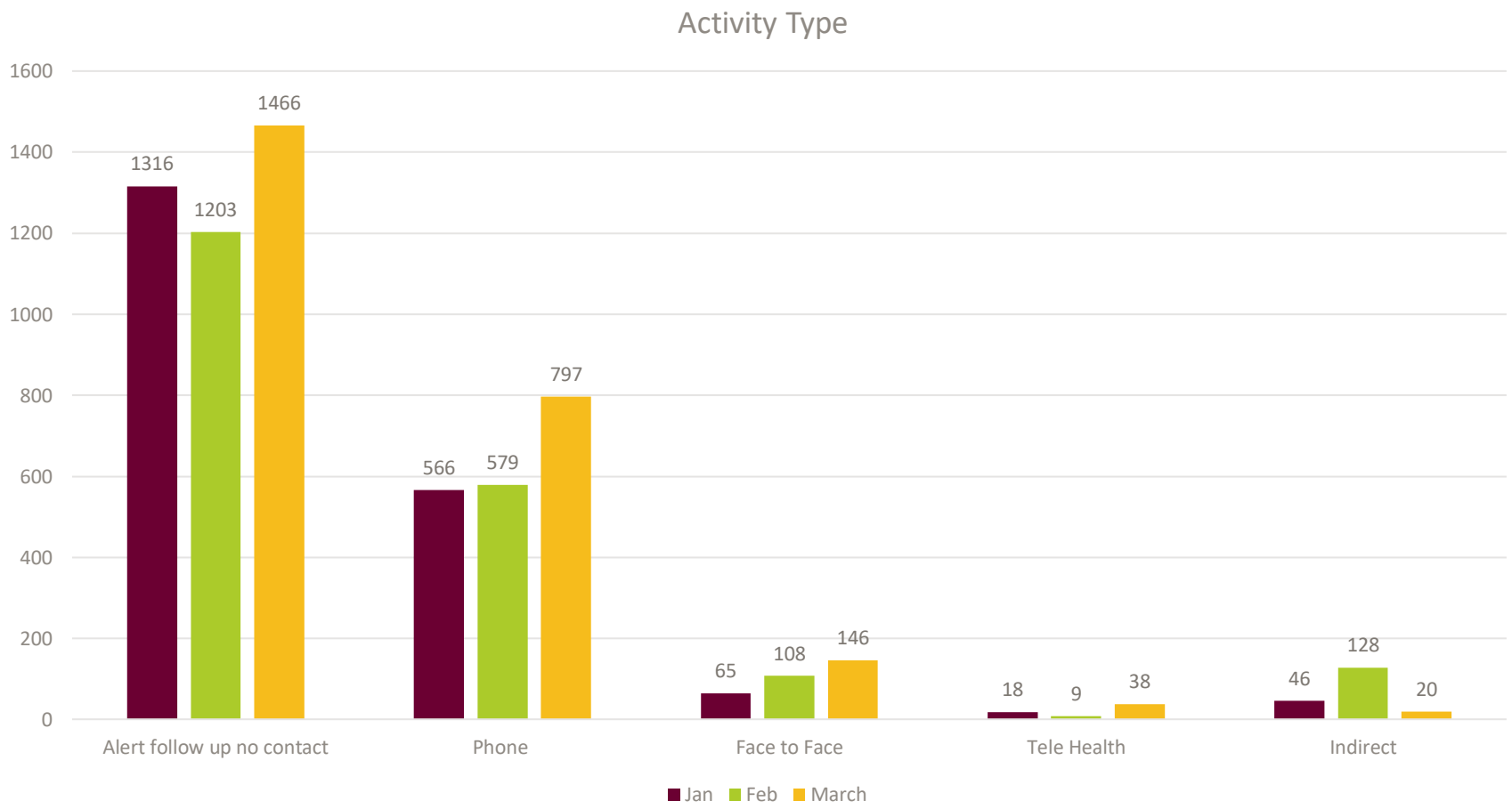
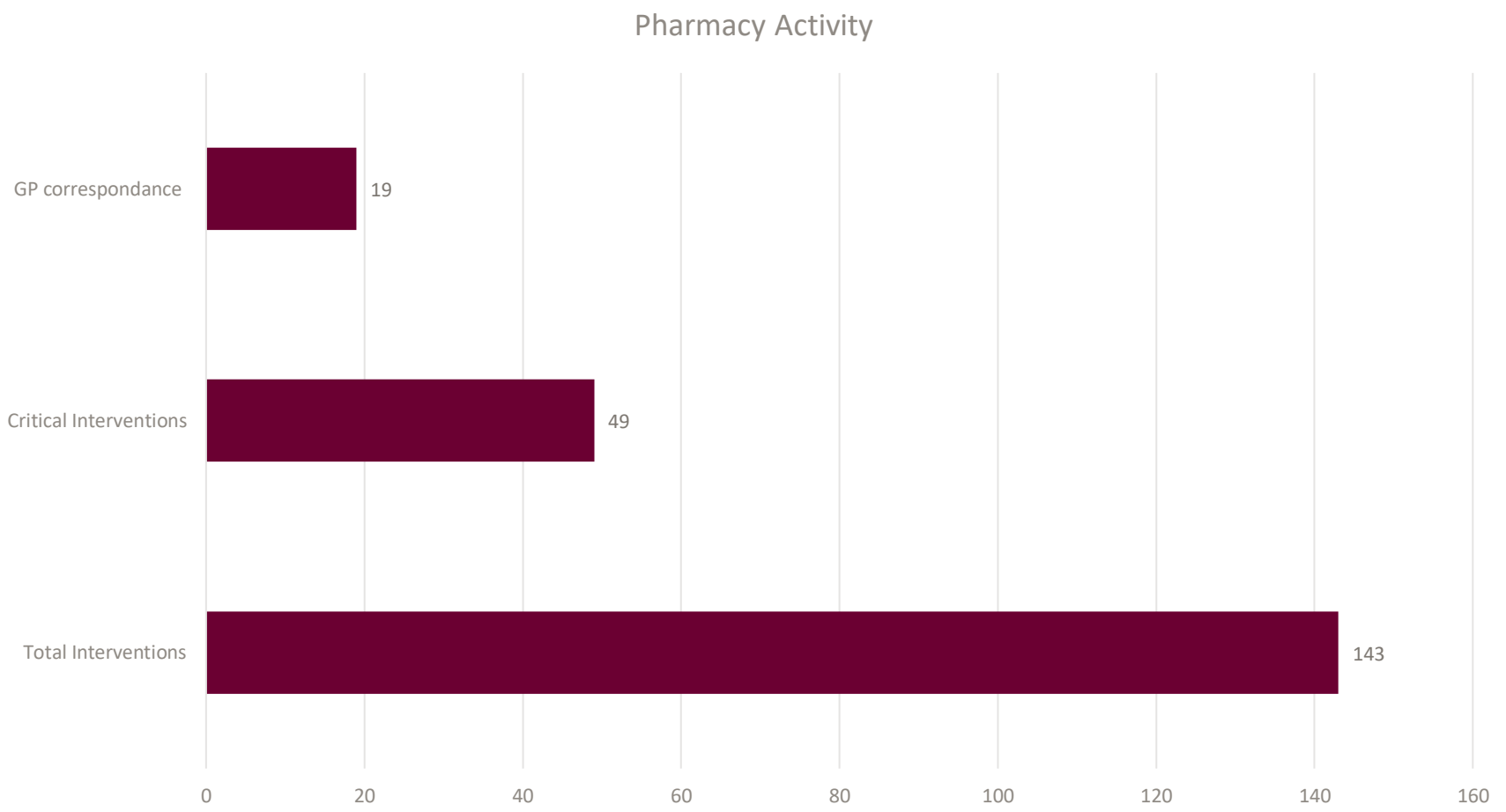


Pharmacy Interventions in 3 months



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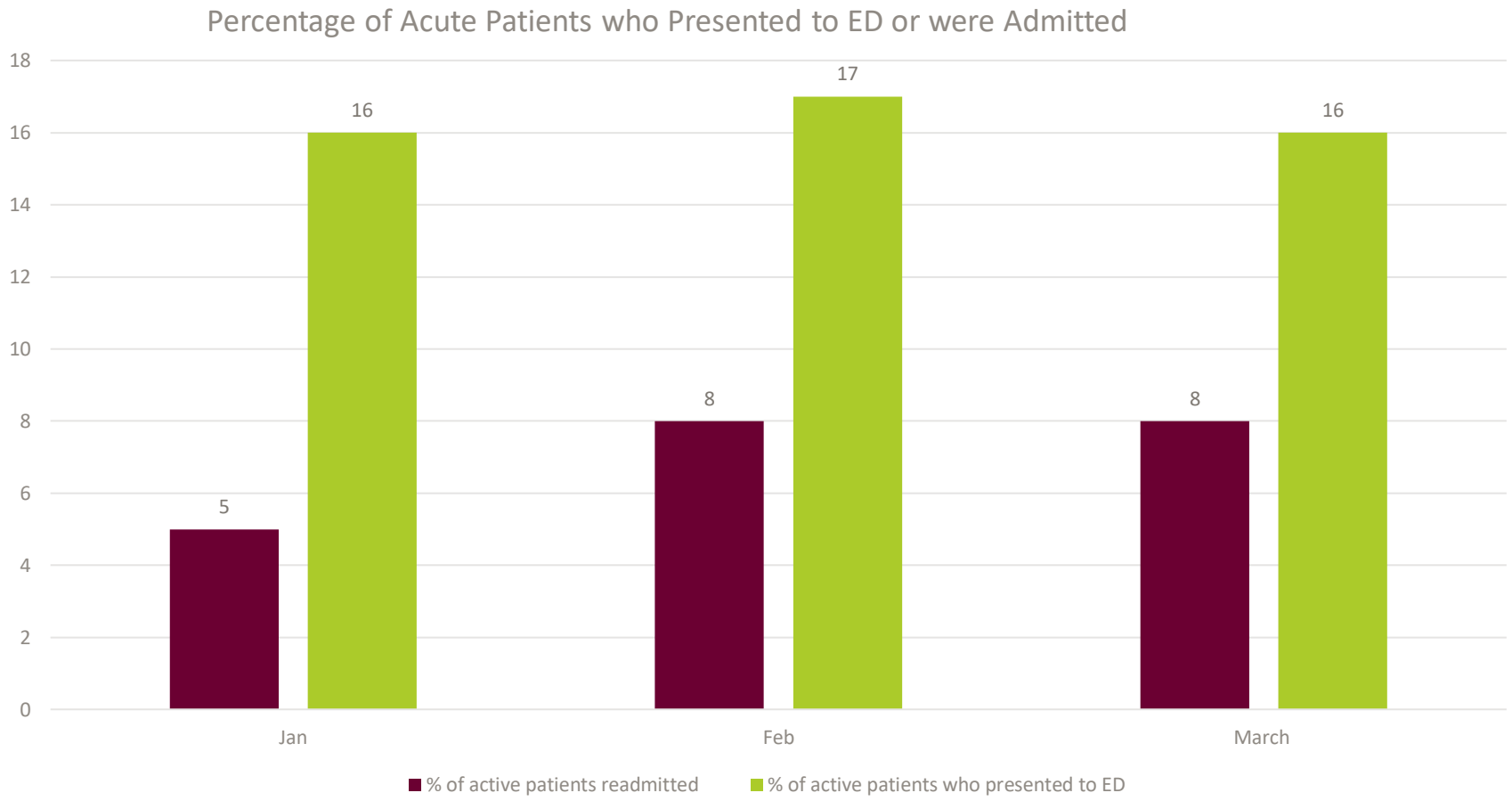

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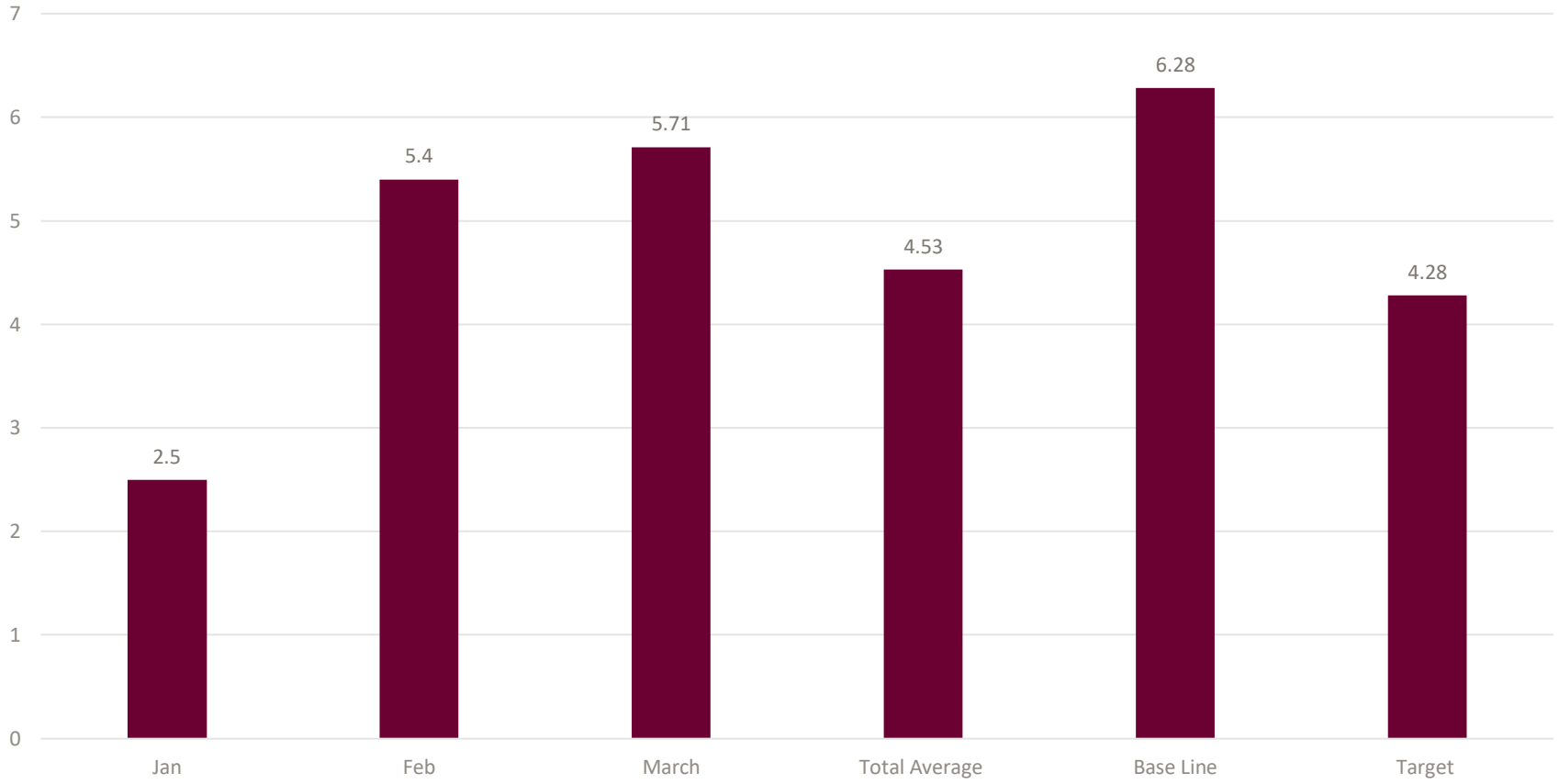
Days Average LOS, Base Line LOS and Target LOS



Key learnings

- For system managers
  - Long term view required
  - Shared trust and common goals between policy makers and implementers
  - Data systems and consistent measures underpin value based care

- Implementers
  - Executive support is vital
  - Needs to be adequately resourced (e.g. funding systems, workforce, IT systems)
  - Partnerships with other providers key to holistic care

Achieving scale

Adopting value-based care models dependent on:

better data and digital systems to assist decision-making in care and clinical improvement

accountability frameworks that are based on outcomes rather than outputs, robust outcome data and digital analytics

Developing optimal models of care that we know are effective and involving consumers in the design of these models.

information sharing and collaboration across the system s

leadership at the system level and at the local level

Questions

Thank you

Tanya Sewards
Principal Policy Officer
Health and Wellbeing
Tanya.sewards@dhhs.vic.gov.au

Jo Stevens
Manager, Chronic and Complex Care
Barwon Health
Jo.stevens@barwonhealth.org.au