UBC CENTRE FOR
HEALTH SERVICES AND
POLICY RESEARCH

# Value Judgements

## Focusing on patients' health and health care outcomes

### Conference Summary

June 2023

CHSPR 2023 HEALTH POLICY CONFERENCE

Kate Redfern MSc
Mackenzie Moffet BSc
Micah Mizushima BSc
Michael Bond MD MHSc
Michael Guo MD
Jason Sutherland PhD

THE UNIVERSITY OF BRITISH COLUMBIA

*Value Judgements: Focusing on Patients' Health and Health Care Outcomes—Conference Summary was produced by:*

UBC Centre for Health Services and Policy Research
The University of British Columbia
201–2206 East Mall
Vancouver, BC V6T 1Z3
Phone: 604-822-4969
Email: chspr.reception@ubc.ca

You can download this publication from https://chspr.ubc.ca/

# Contents


3 About CHSPR

3 CHSPR's Health Policy Conferences

4 About the Conference

4 Supporters and conference organization

6 Opening Keynote

6 Value judgements: Outcomes, populations, and relationships within a value context
Speaker: Scott Wallace, Managing Director, The Value Institute for Health and Care, University of Texas, Austin

8 Access to Primary and Secondary Care: A Long-Standing Problem

8 Access to primary care – A long journey
Speaker: Mylaine Breton, Associate Professor, Dept. of Community Health Sciences, University of Sherbrooke

9 25 years on access to scheduled services: Anything learned; anything changed?
Speaker: Tom Noseworthy, Professor Emeritus, Department of Community Health Sciences, University of Calgary

10 An Outsider's Perspective on the Insider's Problems in Improving Value in Health Care

10 Québec's Health and Welfare Commissioner: A unique role in improving value in health care
Speaker: Joanne Castonguay, Health and Welfare Commissioner, Province of Québec

12 Using Evidence to Drive Policy Decision-Making

12 Physician and patient sex and impact on outcomes
Speaker: Angela Jerath, Scientist, Sunnybrook Research Institute

13 Values, value and equity
Speaker: Irfan Dhalla, Vice President, Care Experience and Equity, Unity Health Toronto

14 Mental Health and Policy-Making to Improve Value

14 Why the value of mental health care often lags below physical health care, and what we could do about it
Speaker: Michael Schoenbaum, Senior Advisor for Mental Health Services, Epidemiology, and Economics, National Institute of Mental Health (USA)

15 Leveraging an established provincial programmatic approach to support the development of a mental health system in Ontario
Speaker: Paul Kurdyak, Psychiatrist, Centre for Addiction and Mental Health (CAMH)

16 Day 1 Summary

16 What we've learned: How different approaches to value-based health care can lead to change
Speaker: Carly Weeks, Health Reporter, The Globe and Mail

16 Anne Crichton Lecture
17 A health economist's perspective on value-based health care in Canada
Speaker: Fiona Clement, Professor, Department of Community Health Sciences, University of Calgary

18 Adopting Principles of Value-Based Health Care in Provinces
18 Deriving value from the hospital electronic patient record
Speaker: Trevor Jamieson, Chief Medical Informatics Officer, Unity Health Toronto
19 Operationalizing value-based decision making in the largest health authority in Canada
Speaker: Anderson Chuck, Chief Health Economist, Alberta Health Services
20 How Pacific Blue Cross works to remove barriers to health equity
Speaker: Sarah Hoffman, President and CEO, Pacific Blue Cross

21 Summary and Closing Remarks
21 Value-based health care: Through an industry lens
Speaker: Neil Fraser, Health Care Director, Advisor and Consultant, and Former Medtech Executive

22 Thank You to Our Sponsors
22 Gold sponsors
22 Silver sponsor
22 Bronze sponsors

# About CHSPR

The Centre for Health Services and Policy Research (CHSPR) is an independent research centre based in the School of Population and Public Health at the University of British Columbia (BC). Our mission is to stimulate scientific enquiry into health system performance, equity, and sustainability.

Our faculty are among Canada's leading experts in primary health care, health care funding and financing, variations in health services utilization, health human resources, and pharmaceutical policy. We promote inter-disciplinarity in our research, training, and knowledge translation activities because contemporary problems in health care systems transcend traditional academic boundaries.

We are active participants in various policy-making forums and are regularly called upon to provide policy advice in BC, other provinces, and abroad.

Our research is primarily funded through competitive, peer-reviewed grants obtained from Canadian and international funding agencies and commissioned research projects.

For more information about CHSPR, please visit https://chspr.ubc.ca/.

# CHSPR's Health Policy Conferences

CHSPR's annual health policy conference is an opportunity for those interested in health policy issues to hear about emerging research and participate in interactive dialogues with experts in thematic areas shaping Canada's health system. This long-standing conference draws together leaders, researchers, policy-makers, academics, health care providers, and patients, from universities, governments, industry, health authorities, and national organizations across BC, the rest of Canada, and internationally.

This report presents highlights from the 2023 conference. For summaries of past conferences, please visit http://chspr.ubc.ca/conference/past-conferences/.

# About the Conference

CHSPR held its 35th annual health policy conference on March 9 and 10, 2023. The conference was held in an in-person format at the Pinnacle Hotel Harbourfront in Vancouver, BC. The theme was assessing progress and future potential for value-based initiatives in health and health care services. The movement to increase value from health care is gaining momentum and related initiatives are flourishing. For many, value from health care means measuring patients' health relative to the costs incurred to achieve their outcomes. However, this concept over-simplifies the complex processes of generating or maintaining health. Focusing on patients' health and health care outcomes means improving access and quality of care, appropriately targeting interventions, and understanding the effects of health inequities, social determinants of health, and systems of health care delivery.

Speakers were drawn from the research community, health care providers, and patient participants from a number of settings and contexts. The objective of the conference was two-fold: to draw in health policy leaders, researchers, patients, and students engaged in value-based initiatives, and to facilitate discussions regarding value-based initiatives pertinent to provincial health care delivery systems.

This report is a summary of the talks presented at the conference and the ensuing panel and audience-based questions and deliberations. A detailed conference program and conference materials can be found at https://chspr.ubc.ca/conference/.

## Supporters and conference organization

This conference was possible because of the financial support of generous supporters, including the Canadian Institutes of Health Research Institute of Health Services and Policy Research, the BC Ministry of Health, the BC Patient Safety & Quality Council (now Health Quality BC), Michael Smith Health Research BC, the Canadian Institute for Health Information, the Institute of Health Economics, and Providence Health Care. This report was possible through support from Health Canada.

Dr. Jason Sutherland of CHSPR chaired the program committee. Committee members included:

- Colin Busby, Director of Policy and Outreach, Institut sur la retraite et l'épargne (retirement savings institute), HEC Montréal
- Fiona Clement, Professor, Department of Community Health Sciences, University of Calgary
- Meghan McMahon, Associate Scientific Director, CIHR Institute of Health Services and Policy Research
- Gary Redekop, Neurosurgeon, University of BC
- Carly Weeks, Health Reporter, The Globe and Mail

Dawn Mooney and Joyce Huang of CHSPR and Sally Clelford of Face2Face Events Management led the planning committee.

We acknowledge that the conference venue is situated on the traditional, ancestral, and unceded territories of the Musqueam, Squamish, and Tsleil-Waututh people.

DAY 1 | SESSION 1

# Opening Keynote

The Value Institute for Health and Care at the University of Texas, Austin, is at the forefront of developing, measuring, and evaluating value-based health care through leadership in scholarship, patient-centred engagement, and education. The efforts of Managing Director Scott Wallace, Executive Director Elizabeth Teisberg, and their team, have led to transformations in health care strategy, organizational culture, and measurement around the globe, including in Canada.

## Value judgements: Outcomes, populations, and relationships within a value context

### Speaker: Scott Wallace, Managing Director, The Value Institute for Health and Care, University of Texas, Austin

Scott Wallace began by describing the current environment for health care service provision:

- Many providers are experiencing large fiscal deficits;
- There are severe shortages of skilled labour, acute for nurses and allied health professionals;
- Cost increases for drugs are very high and far exceed medical inflation;
- The complexity of patients continues to increase.

Mr. Wallace argued that in order to reduce cost growth of health care services, new approaches to health care delivery, outcomes, and financing are needed. He used several case studies of value-based care to articulate the failings/limitations of the current health care delivery model, including a hemophilia care example from St. Paul's Hospital in Vancouver, where interventions have been successful in decreasing the number of bleeds, and an example from North Carolina where allied health services were restructured to reduce kidney failure rates. He also discussed a prostate cancer case study from the Martini Klinik in Germany, in the context of focusing on outcomes that matter most to patients, even though patients' survival outcomes were similar between the Martini Klinik and peer clinics.

Through the case studies, Mr. Wallace emphasized that the goals of value-based initiatives were not solely focused on costs, but rather on what outcomes were important to patients (e.g., asking patients what they would like to change). This reframing identified processes that needed to be improved and were consistent with patients' health care objectives. Mr. Wallace then described the '3C' approach the Value Institute uses to assess patient-centred care: Applying the value-based principles to specific settings and clinical contexts, is the health care delivery model asking the following of its patients:

- Capability (can you do the things that matter the most to you?)
- Comfort (is your suffering reduced?)
- Calm (are you feeling as calm as possible?)

Mr. Wallace then posited that a population-health approach to improving health outcomes may not align with patients' perspectives of their health, health care, or outcomes. He posited that the 'right' questions were not being asked of patients and that the 'right' data is not being collected (e.g., patient-reported outcomes). He concluded with a number of takeaways, including opportunities for closing the 'gaps' for some groups (e.g., race-based differences in outcomes); developing structures/institutions that facilitate clinicians building relationships with their patients; developing the 'right' team that supports the health outcomes the patients prefer; and identifying/measuring what's important to patients.

Audience questions for Mr. Wallace focused on the applicability of the value-based initiatives from other countries to provincial health care delivery systems. Mr. Wallace described opportunities in Canada to address gaps in the data needed to measure value. One specific example focused on the opportunity to measure value by systematically collecting cost data attributed to clinical processes.

DAY 1 | SESSION 2

# Access to Primary and Secondary Care: A Long-Standing Problem

For decades, provinces have struggled with mixed results to provide timely access to primary and secondary care. The talks in this session featured cutting-edge research and policy analyses that shed light on barriers to improving access to care.

## Access to primary care – A long journey

### Speaker: Mylaine Breton, Associate Professor, Department of Community Health Sciences, University of Sherbrooke

Mylaine Breton identified access to primary health care as a major policy issue across provinces, stating that only 41% of Canadian have same/next day access to primary care compared with 58% of residents of other countries with similar health systems. Dr. Breton described that delays in accessing primary care were attributable (somewhat) to residents' inability to find a family physician and lack of 'attachment'. She then outlined the negative health effects of lack of attachment.

Dr. Breton outlined two potential solutions for improving attachment and subsequent access to primary care. The first solution she described is 'centralized wait lists', an initiative that has shown some success in Québec. Centralized wait lists in Québec have been used in conjunction with assessment centres that match patients with a range of health care providers (e.g., pharmacist or nurse) based on the nature of the health problem or condition. Dr. Breton outlined how the funding model in Québec has changed to support centralized wait lists for primary care.

The second potential solution described by Dr. Breton is based on applied principles of industrial engineering. This multi-modal intervention includes a number of dimensions/attributes: retain some flexibility in scheduling to see urgent patients; increase the supply of providers when demand is expected to increase (e.g., flu season); implement online appointment systems for patients; have nurses support chronic/complex patients on an ongoing basis; and use interdisciplinary coaches for continuous improvement in primary care clinics.

Audience questions for Dr. Breton focused on the specific indicators that her team extracted from primary care physicians' electronic medical records (EMR), such as the third-next available appointment. Discussion focused on the fact that BC lacks a standardized EMR for primary care and that benchmarking initiatives in BC, such as those presented by Dr. Breton, would take time and significant policy support to develop.

## 25 years on access to scheduled services: Anything learned; anything changed?

### Speaker: Tom Noseworthy, Professor Emeritus, Department of Community Health Sciences, University of Calgary

Tom Noseworthy presented a retrospective analysis of the past 25 years of access to scheduled health care services (e.g., diagnostic imaging and elective surgery). He summarized strategies to improve access including: reduce demand; maximize appropriateness (of the health intervention); increase the rate of utilization (by being more technically efficient); match supply with demand (e.g., capacity, capital equipment, and health human resources); triage based on urgency; and apply single-entry models (i.e., centralized waiting lists).

Dr. Noseworthy described that provinces have done very little in terms of the factors known to be effective at improving access or reducing wait times. He noted that provinces have made little to no progress in reducing demand through population-health interventions or measuring or triaging patients based on appropriateness, and very little progress on implementing system-wide single-entry models.

Drawing from over two decades of experience, Dr. Noseworthy described how Federal Wait Time initiatives (and funding) have succeeded in making wait times observable. He argued that observable wait times are a positive and necessary step for transparency regarding access to scheduled services. He also argued that in order to 'fix' the problem, governments need to establish policies that:

1. Present firm guidelines pertaining to wait times for access and hold health care organizations accountable for meeting the timelines;
2. Adopt single entry models;
3. Use health care delivery models that apply triage processes effectively; and
4. Use private infrastructure and access to capital to expand delivery within the context of the single-payer model.

Questions and discussion on wait times were focused on 'how can we make changes?' Dr. Noseworthy's responses noted that there are effective strategies for reducing wait times and improving access, but provinces have not supported the necessary policy changes needed to implement the strategies. He opined that without provincial health systems making changes to the policies described above, meaningful changes to access were unlikely to occur.

DAY 1 | SESSION 3

# An Outsider's Perspective on the Insider's Problems in Improving Value in Health Care

The provinces have created frameworks and implemented initiatives to improve value from health care spending. As Health and Welfare Commissioner (Québec), with the dual role of informing government and the public, Joanne Castonguay has unique perspectives regarding tensions and opportunities for improving value from health and social care.

## Québec's Health and Welfare Commissioner: A unique role in improving value in health care

### Speaker: Joanne Castonguay, Health and Welfare Commissioner, Province of Québec

Joanne Castonguay began by describing the role of Québec's Health and Welfare Commissioner in evaluating the performance of Québec's health and welfare system. The Commissioner's role, within the context of a provincial health and welfare system with limited resources, is to provide advice to government and the public pertaining to sustaining a system that is agile and evolves with the needs of the population, while maintaining values of transparency, impartiality, equity and inclusiveness.

Ms. Castonguay identified elder care as one of the Commissioner's priorities. To move forward on the Commissioner's mandate to measure, evaluate and recommend changes to government regarding elder care, she described a need to: define the parameters of the elder care system, describe the current state, describe attributes of high-quality elder care, identify where improvements were most needed, and articulate possible policy options. Within this scope, the Commissioner's activities include: developing health system performance measures,

leading policy innovation, communicating with government, and engaging with the public to determine citizen priorities.

Ms. Castonguay described the special mandate recently given to the Commissioner by the Québec government. She described that the government expectation of the Commissioner was to measure performance/effectiveness of public health, nursing home management, and health system governance and services for elders. In her interim analyses, the Commissioner argued that the Ministry of Health and Social Services had not been effectively governing the health system—rather the Ministry had been operating the health system (not governing)—and were ill-equipped/skilled to do so. The Commissioner recommended that the government play a more active role in the governance of health care delivery.

The presentation concluded with a demonstration by Ms. Castonguay's associate, Ms. Genevieve Ste-Marie. She presented the Commissioner's recently published health system performance indicators. Consistent with the government's mandate, the indicators focused on the long-term care and home care service sectors. Four domains of measures were included: appropriate care, patient-centred care (e.g., number of days spent at home in the last year of life), continuity and coordination of care, and security. Then, the Commissioner discussed their role in evaluating progress on each of the domain's measures—the measures were coloured 'red' or 'poor' and she noted that substantial progress/improvement in performance in the domains was needed in the region's elder care.

Discussants John Sproule (Senior Policy Director, Institute of Health Economics) and Tom Noseworthy noted the complexities of performance measurement and inter-regional comparisons. They also noted that Québec's health system had been a hub for innovation that the rest of Canada often hears little about. Their final comment regarding the Commissioner's presentation highlighted the uniqueness of her role and that other provinces do not have independent evaluative organizations.

DAY 1 | SESSION 4

# Using Evidence to Drive Policy Decision-Making

A rich history of Canadian evidence has highlighted significant opportunities for improving health and well-being. The talks in this session focused on disparities in health and health care and future opportunities for improving value in our publicly-funded health care system.

## Physician and patient sex and impact on outcomes

### Speaker: Angela Jerath, Scientist, Sunnybrook Research Institute

Angela Jerath presented research and policy implications of provider-patient sex discordance and patient outcomes. Her talk drew from a body of peer reviewed research reporting on patients' outcomes when their care provider was a different sex. Based on large sample population-based data, she noted that research has consistently found small, but measurable, better outcomes with female physicians. She noted that similar results have been reported across a number of jurisdictions.

Focusing on surgical care, Dr. Jerath cited a number of possible factors associated with the findings, including surgeon-related factors regarding: background knowledge, technical proficiency, communication (female surgeons have been found to spend more time with patients), judgement; and context-specific factors such as surgical volume, team dynamics, and health system factors. Other patient-related factors may have also affected the findings, including age, comorbidities, cultural barriers, risk behaviours and socioeconomic status.

Dr. Jerath closed with a number of policy-relevant points to reduce disparities in surgical outcomes, including: universities to increase the number of females in higher faculty/academic levels, admission committees to improve diversity of surgeons, provinces to track patient-centred outcomes, and hospitals and clinical departments to support career development through mentorship and sponsorship. She concluded that progress and opportunities to reduce gender bias in surgical outcomes will be slow and involve structural characteristics of provincial health systems.

## Values, value and equity

### Speaker: Irfan Dhalla, Vice President, Care Experience and Equity, Unity Health Toronto

Irfan Dhalla opened by drawing on two patients' experiences with health care delivery, access to care and insurance. Overall, his talk focused on contrasting different health outcomes when health care structures are viewed through the lenses of 'equality' and 'equity', noting that equity can be improved through non-financial and financial incentives such as focusing on barriers to access for those with disabilities or complex chronic conditions.

Dr. Dhalla discussed policy remedies that are available to improve equity, including: increasing the diversity of health care providers to align with the characteristics of the patients they serve (more females and visible minorities), changing medical education processes so that trainees perceive the same issues as patients, tailoring professionals' skills that are associated with improving patients' experiences with care, and focusing on improving health outcomes and health care in rural and remote communities. He reiterated that opportunities for improving equity should be focused on certain under-served populations and patients with different backgrounds (e.g., new immigrants and low socio-economic status populations).

Audience questions for Dr. Dhalla and resulting discussion addressed a number of policies and features of provincial health systems, including the unknown impact of the new generation of health care providers and the long-term effects of the scarcity of health professionals in rural and isolated communities.

DAY 1 | SESSION 5

# Mental Health and Policy-Making to Improve Value

There is strong evidence that existing mental health care policies can be strengthened to improve health and well-being and value to the health care system.

## Why the value of mental health care often lags below physical health care, and what we could do about it

### Speaker: Michael Schoenbaum, Senior Advisor for Mental Health Services, Epidemiology, and Economics, National Institute of Mental Health (USA)

Michael Schoenbaum presented statistics showing that physical health care needs are much more commonly met than mental health care needs; further, only a small proportion of patients actually receive the mental health care treatment/services they need even when they access mental health care services.

He described some of the challenges associated with providing appropriate mental health care treatments aligned with patients' needs. Among them, he noted that there were no biomarkers for personalizing mental health care, as there are for some physical health conditions, a fact that inhibits diagnostic certainty, matching patients with treatments, and documenting improvements in symptoms.

Dr. Schoenbaum proposed options available to policy-makers, including: (1) identifying condition-based treatment plans and (2) tracking progress on treatment plans and outcomes of treatment. He noted that strong patient-reported outcome measures are available to measure progress on treatment plans for behavioural health problems. He noted that larger-scale issues were more complex to address, such as standards of training and practice for mental health conditions, financing mental health treatment and providers, and an inadequate number of qualified professionals to deliver mental health care. His responses to questions regarding the inadequacy of mental health treatment noted that the National Health Service (UK) and the Veteran's Health Administration (USA) have made meaningful progress on standardizing treatment for mental health conditions, enforcing standards, and measuring improvement/performance.

## Leveraging an established provincial programmatic approach to support the development of a mental health system in Ontario

### Speaker: Paul Kurdyak, Psychiatrist, Centre for Addiction and Mental Health (CAMH)

Paul Kurdyak began by arguing that there is no mental health care system in Ontario and cited some statistics regarding lack of access to psychiatric care.

Dr. Kurdyak then proposed that developing a mental health care system in Ontario could follow the lead of other sectors: identify who is not accessing mental health care in order to understand who should be receiving care; measure how long people are waiting to access care; measure whether people are receiving care that is concordant with standards of care and best evidence; measure whether people respond to treatment; and measure whether people are receiving stepped care for treatment-resistant mental health conditions.

Dr. Kurdyak described that there is no infrastructure for treatment of common mental health disorders. He offered that a mental health care system could start by focusing on depression and anxiety-related disorders since they are so prevalent and costly from a societal perspective. Then he rank-ordered conditions that could follow: schizophrenia and psychosis, eating disorders, and substance use disorders. He presented the attributes of a 'roadmap to wellness' for mental health care, which include: expanding services and access, improving quality, and implementing innovative solutions.

Dr. Kurdyak outlined the broad parameters of a mental health care system that would include elements of: performance measurement, evidence-based clinical model of care, access or system navigation, stakeholder engagement, collection and use of data, and a digital strategy.

In the discussion, Dr. Kurdyak offered that mental health care needs an empirical basis, such as that used by other sectors, to provide robust 'business cases' to government to attract meaningful funding. He highlighted that provincial health systems were 'political' and that the sector needed to overcome the stigma associated with it. He concluded the discussion by advocating for an increased use of collaborative care models for mental health treatment, whose primary care-focus would consult psychiatrists as needed.

DAY 1 | SESSION 6

# Day 1 Summary

## What we've learned: How different approaches to value-based health care can lead to change

### Speaker: Carly Weeks, Health Reporter, The Globe and Mail

Based on her analyses of the first day of presentations and deliberations with policy-makers, providers and patients, Carly Weeks opined that it was hard to see how the health system is going to shake off its stasis and 'get better.' Ending on a positive note, she offered that there were bright spots in the health care system, including care navigators working to help homeless people in Toronto and nurses providing wound care in homeless shelters.

DAY 2 | SESSION 1

# Anne Crichton Lecture

The Anne Crichton Lecture was supported by the University of BC's Crichton Health Systems and Policy Learning Fund. This new fund was created in honour of Dr. Crichton, a passionate health care advocate and former professor in the Department of Health Care and Epidemiology at the University of BC and her decades-long contributions to the well-being of Canadians through health systems research. The fund honours Dr. Crichton's commitment to improving BC's and Canada's health care systems by funding an annual prize and lecture by an outstanding scholar, and whose content would focus on health system and policy challenges that remain key to health promotion and the prevention of illness.

Fiona Clement of the University of Calgary delivered the inaugural lecture. Recognizing that provinces have been halting in their adoption of value-based frameworks that use patient and economic data in their decision-making, Dr. Clement discussed current decision-making and options for moving value-based initiatives forward.

## A health economist's perspective on value-based health care in Canada

### Speaker: Fiona Clement, Professor, Department of Community Health Sciences, University of Calgary

Drawing parallels with Dr. Anne Crichton's research several decades earlier, Dr. Clement lamented that the same problems that existed decades ago still persist in provincial health systems—chief among them: access and funding. Dr. Clement noted that the *Canada Health Act* is not aging well and that spending tends to focus on acute care rather than on maximizing the health of the population.

Dr. Clement transitioned to discussing potential opportunities to improve value, including: listening to communities/populations that the system is intending to serve and collecting data that measures costs and outcomes of health care (e.g., patient-reported outcomes, patient-reported experiences with care, and measures of equity). Then, she opined that policy-makers could make decisions on what matters to people based on evidence regarding spending and benefits.

Dr. Clement then discussed whose responsibility it is to improve value. She offered that while provinces are the operators of their health systems, federal intervention could help with funding and cross-provincial standardization.

There were a number of questions for Dr. Clement following her presentation. The audience asked why the *Canada Health Act* hasn't been updated, how data collection for Indigenous communities might move forward, how to manage physician burnout, and how Health Canada can ensure accountability if the provinces refuse to share critical data. On each of these questions, Dr. Clement described possible options for governments, health systems and providers.

DAY 2 | SESSION 2

# Adopting Principles of Value-Based Health Care in Provinces

This cross-country panel of speakers brought their unique perspectives of health care to point to opportunities for health systems to develop and implement policies to improve value by overcoming persistent barriers.

## Deriving value from the hospital electronic patient record

### Speaker: Trevor Jamieson, Chief Medical Informatics Officer, Unity Health Toronto

Trevor Jamieson began by presenting statistics regarding how electronic medical record (EMR) systems have not 'lived up to the hype' regarding cost or efficiencies. He also described that there is not a strong body of research supporting that EMRs automatically improve quality of care. Possible reasons that EMR use has not achieved these objectives include: blunt approach to understanding workflows in clinical settings, social aspects of health care delivery are ignored, and EMRs cause information overload in some clinical settings.

Dr. Jamieson opined that effective EMRs should be core to health care delivery and that they should make the 'right stuff easy' and the 'wrong stuff hard,' noting though that health care can be viewed as a complex adaptive system where technology is only one component (other components include personnel, workflow, and communication.) He noted that attributes more likely to be associated with effective use of EMRs include solutions that address the following challenges: techno-complexity (learning new skills); techno-uncertainty (learning to manage uncertainty); techno-overload (more data than time); techno-insecurity (discrimination based on lack of tech skills); and techno-invasion (expectation of longer hours).

Dr. Jamieson noted that some key challenges include the need for strong governance, interoperability, and standardized measures of care processes and outcomes. He then discussed opportunities to address these challenges, including improving patient access to health information and offering secure data access/sharing. He concluded with a recommendation to view EMR adoption as a quality improvement exercise.

Following the presentation, there was discussion with the audience regarding the lack of progress on EMR interoperability within and between provinces.

## Operationalizing value-based decision making in the largest health authority in Canada

### Speaker: Anderson Chuck, Chief Health Economist, Alberta Health Services

Anderson Chuck described the framework for assessing value for projects/investments that Alberta Health Services (AHS) has developed and implemented. The framework has been applied to resource allocation and investment decision-making.

The value framework provides for a sequence of steps to be followed. First, all projects assessed with the framework should carefully define 'value' for their project. This may include: quality, cost-effectiveness, feasibility, and/or equity. Then, the framework assesses projects on the following domains: whether the environment was conducive to improvement of value (as defined by the project); whether the project has a suitable accountability structure; whether the project has a lifecycle; and whether the project provides significant detail regarding how it integrates its activities across providers/sectors. All projects assessed through the value framework also must include an evaluation plan, although evaluation has been managed externally for validity purposes.

A key question from the audience to Dr. Chuck was: What aspects of the health system and political policy-makers facilitated development and adoption of the value framework by AHS? Dr. Chuck answered that support from physicians and key opinion leaders was instrumental in the development and eventual adoption of the framework by AHS. A second question asked whether the decision-making process through the value framework was transparent to the public. Dr. Chuck outlined that some important milestones of the process were observable, though progress through the framework was not made public.

## How Pacific Blue Cross works to remove barriers to health equity

### Speaker: Sarah Hoffman, President and CEO, Pacific Blue Cross

Sarah Hoffman led by discussing the role/operations of Pacific Blue Cross in the insurance market in BC as a health benefits provider. She then focused on Pacific Blue Cross's 'fit' within the health care ecosystem and its activities relative to the Ministry of Health, regional health authorities, and the Provincial Health Services Authority.

Ms. Hoffman described how Pacific Blue Cross has been working with its clients and partners to impact social determinants of health through income and social perspectives. She described the details of two initiatives: menstrual inequality and access to services in First Nations communities. Regarding the former, she described a partnership between Pacific Blue Cross and BC Women's Health Foundation. On the latter, she described Pacific Blue Cross partnership with the First Nations Health Authority.

Ms. Hoffman concluded with remarks regarding the important roles of private insurers in a mixed public-private health care services market, such as exists in provinces and territories. She noted several key challenges for non-governmental health and health care organizations: cybersecurity, health literacy, and providing access to services for new immigrants—issues not specific to Pacific Blue Cross, but relevant to public and private insurers in general.

Ms. Hoffman received questions from the audience regarding how the health system (all of its parts) can help to build health literacy, how patients can access their data online, and how private health care organizations (including health benefit insurers) could fit within future versions of the *Canada Health Act.*

DAY 2 | SESSION 3

# Summary and Closing Remarks

## Value-based health care: Through an industry lens

### Speaker: Neil Fraser, Health Care Director, Advisor and Consultant, and Former Medtech Executive

Neil Fraser, former President of Medtronic Canada, provided a wrap-up for the two days of the conference. Mr. Fraser reiterated some of the major challenges regarding implementation of value-based initiatives faced by provinces, including a lack of cost and outcomes information, and a recognition of the role of the private sector.

He reflected on experiences with value-based projects in a number of countries, noting that Canada's health care system is ill-equipped to adapt to new innovations; electronic infrastructure is not modern and lags peer countries; many senior health care executives eschew risk; and that 'change' in the health care system has not been prioritized by senior decision-makers and politicians.

Drawing from some international examples, including in the Netherlands, Mr. Fraser described some common themes of successful value-based initiatives, including front-line engagement with clinicians, publication of results to support transparency and legitimacy, diversity of skill sets, and facilitation of competition among private providers.

Mr. Fraser concluded his summary of the conference with comments noting that value-based initiatives were needed, though the initiatives will need engagement/involvement of health care providers, funders and payers (private insurers or commercial providers); and that success begets success.

# Thank You to Our Sponsors

## Gold sponsors

## Silver sponsor

## Bronze sponsors

Providence Health Care

How you want to be treated.

## Advancing world-class health services and policy research and training on issues that matter to Canadians

**UBC Centre for Health Services and Policy Research**
The University of British Columbia
201-2206 East Mall
Vancouver, BC Canada V6T 1Z3

Tel: 604.822.4969
Fax: 604.822.5690
Email: chspr.reception@ubc.ca

**www.chspr.ubc.ca**