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link

**Creating value-based
healthcare organizations**

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Executive digest

Dr. Anna van Poucke

Organizing care to deliver value for patients requires change in five main areas. Start with a clear vision and understanding of what value means and focus energy on cohesive action across all the areas. As one part of the organization starts to move, be aware that other areas need to move with it to keep a well-balanced approach. This might be off-putting at first — seemingly changing everything at once — but it does not have to be as daunting as it sometimes seems. From my work with clients and discussions with providers all over the world, I have drawn the following lessons.

Patients provide your compass

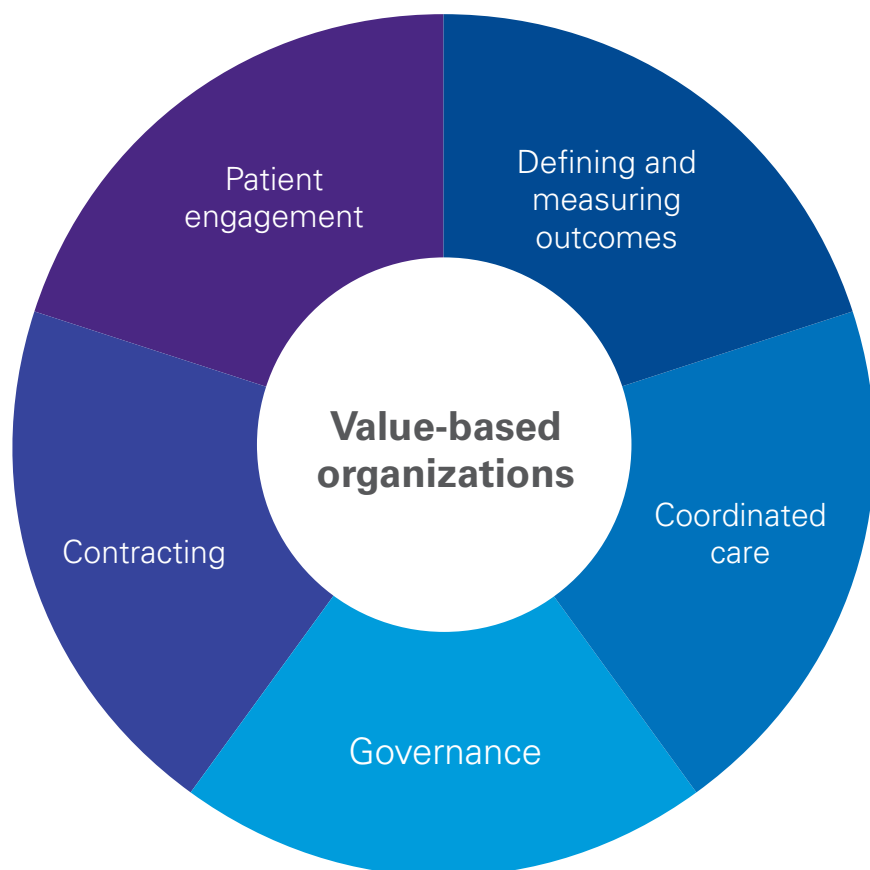
As stated in KPMG International's *What Works: Staying Power— Success stories in global healthcare* (kpmg.com/whatworks), patients are the solution, not the problem. Demographic changes and changing healthcare needs create the case for change. In fact, they are the justification for any healthcare transformation program. Make sure patients and patient representatives (caregivers, etc.) are 'at the table' and not just at the receiving end of visionary documents and practical plans. See to it that they are placed in a position where they define what results they need and can co-create plans to deliver those results. I have seen great examples where patients defined the top 10 priority changes for the care in their health

system for different patient groups (e.g. elderly and long-term conditions) and subsequently played a big role in planning how to deliver the required changes. No professional can deny changes that are at the patients' request.

Visible outcomes can be improved, invisible outcomes cannot

Care providers that are not transparent about outcomes of care to their patients and contractors undermine their future existence. The outcomes you measure should follow directly from what patients need, and therefore be agreed on with patients, their caregivers and professionals. Make sure the focus is not just on the outcomes delivered by your single organization, but take responsibility

Figure 1: Five key characteristics of value-based organizations



Source: *As strong as the weakest link*, KPMG International, 2015

for interfaces with other care providers and the wider care pathway.

Fantastic hip replacement results are great, but if the procedure is followed by a 5-week wait for rehabilitation, the overall outcome for the patient is questionable. I have seen from experience that it's the organizations that are really committed to determine and measure the value they create, that are able to fundamentally improve their service and market share. Do not neglect transparency; it will change the face of healthcare in the coming years.

Define your position in the pathway, find partners you trust

When patients are at the core of the healthcare systems (see KPMG integrated care model page 18), a clear understanding emerges of where your organization is, or should be, positioned in the wider pathway. This will help determine if, for instance, you are looking to create a focused factory or organize coordinated care across tiers of care. The patients you care for are the starting point.

Next, find partners you trust to deliver coordinated care across the whole pathway. Strong health outcomes for patients are not just delivered in hospital, but also in people's homes and in the community by care providers or volunteer organizations. Think about processes of coordinated care delivery, rather than entirely new systems and structures.

Several high performing health systems choose to work with care navigators or accountable lead providers, rather than get stuck in complex discussions of who is in charge of what service (see interview with Dr. Steven Laitner page 25). The value created by working this way can be enhanced by contractors that act as informed and involved partners who contribute to creating a favorable

environment for collaboration that delivers value for patients.

Centralize authority and decentralize decision making

Realizing sustainable change can demand a lot from your organization, especially the simultaneous focus on outcomes and partnership with others in the system. Governance should be focused on delivering outcomes both in isolation and in collaboration with partners. It needs to enable change, so make sure leaders set a clear vision and strategy that will enable transformation.

This needs to be combined with decentralized decision making, empowering professionals across different organizations to continuously improve the way care is delivered. This lower level decision making needs to be supported by accurate (and if possible real-time and cross-provider) information on performance levels, linked to outcome measures. Stimulate professionals to define areas of improvement and take action to improve care delivery on the front line.

Mobilize your contractor, incentives need to change

The contractor is your partner, not your enemy, whether it's an insurer, national government, local authority or clinical commissioning group. Realize that they hold the key for the changes that are needed. Financial incentives that do not reward change are a key blockage in many systems. Find a way to get the gears 'unstuck'.

The approach will differ depending on your system and organization. It can mean making sure the insurer or commissioner are aligned with your goals and shape incentives to drive that change. Or it can mean taking a directive approach yourself, by becoming the lead provider and/or lead contractor in your local health system and taking responsibility for the delivery of integrated care by partnering with other organizations.

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Rethinking value in healthcare

In order to create sustainable healthcare systems it is not enough to make gains in individual treatment areas; real progress can only come from taking a holistic view of the patient. Traditional organizational divisions must be broken down to enable different caregivers to complement each other's interventions, with every contributor to the care continuum sharing a common view of 'value.'

Definitions of value can vary, but in its simplest form it can be described as: outcomes of care divided by the cost of care.

As health budgets come under increasing strain, and care becomes more patient-centered, governments, payers and providers are moving their focus from volume to value. Definitions of value can vary, but in its simplest form it can be described as: outcomes of care divided by the cost of care.

Outcomes are heavily affected by the appropriateness of care, which could in some cases involve a decision not to treat. For example, there is no sense paying for a perfect hip replacement if the patient would have been better off not having the operation in the first place.

To illustrate the different needs of patients, we contrast Mr. Johnson, a 40-year-old with a single condition, and Mrs. Murphy, who is twice his age and suffering from multiple morbidities (see opposite page). The treatment, the outcomes as defined by the patient and the care coordination will all differ significantly.

A single provider should find it relatively easy to calculate value, with quality reflected in a successful outcome of an intervention such as an operation, drug regime or physiotherapy. Several health systems around the world have excellent records for delivering against such goals, thanks to efficient processes and skilled practitioners.

However, more and more patients are now suffering from co-morbidity, as populations age and lifestyle diseases

proliferate. About half of all adults in the US (117 million people) have one or more chronic health conditions such as cardiovascular disease, cancer, diabetes, and chronic respiratory disease.¹

In these instances, the value of a single treatment cannot be viewed in isolation, as it may be dependent upon the success of one or all of the other therapies. Even those with a single disease may receive care from a range of providers, where a weak link in the continuum can damage the final outcome, as a result of hospital-acquired infections, or inadequate physiotherapy, for example.

Important as they are, clinical indicators such as positive blood-test results are too narrow a definition of health outcome. At the highest level, true value is reflected in measures such as the ability to return to work, overall wellness and quality of life — as perceived by the patient — which are influenced by his or her entire journey through the health system.

However, value is also determined by the cost relative to outcomes and can be measured in terms of the efficient use of resources such as operating theatres, successful interventions, patient adherence to treatment and waiting times. Traditional medical boundaries are being stretched to include patients, caregivers and communities, all of whom are playing a more prominent role in care pathways.

1. Ward BW, Schiller JS, Goodman RA. Multiple chronic conditions among US adults: a 2012 update. *Prev Chronic Dis*. 2014;11:130389. DOI: <http://dx.doi.org/10.5888/pcd11.130389>

The changing patient profile and differentiating care demands



Mr. Johnson

Patient with a single health condition

Age: 40

Condition: damaged knee cartilage

Treatment: arthroscopy from a specialist surgeon, physiotherapy

Outcome: able to walk, carry out vigorous exercise and be pain-free

Care type: focus clinic and related physiotherapist both specializing in knee problems



Mrs. Murphy

Patient with multiple health conditions

Age: 80

Conditions: diabetes, cardiovascular disease, colorectal cancer, husband with dementia

Treatment: multiple parties on an ongoing basis including community services for husband

Outcome: dependent upon the patient's expectations, but could include: ability to live at home; fewer or no diabetic episodes; full remission from the cancer; greater personal mobility

Care type: coordinated care between specialist, GP and community services



Patient engagement

Patients can no longer be seen as docile recipients of care, but as active participants that contribute to both the assessment of quality and, more frequently, to the actual design. Patient reported outcome measures (PROMs) are being used by health systems around the world to determine how effectively the treatment improves the quality of life. Patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery with the UK National Health Service (NHS) are invited to complete questionnaires, with results forming part of the measurement of care quality.

PROMs are, however, only a start. Going a stage further, patients are starting to play an active role in the design of care pathways and helping to define desired outcomes and indicators, which form a basis for doctors' pay and bonuses.

Dutch non-profit association Zorgbelang, which lobbies for greater patient involvement in healthcare, argues that there is no such thing as a 'patient,' and that people with diseases or ailments should be seen instead as stakeholders in a system devoted to broad health and wellbeing.

As part of a cultural change program, Zorgbelang has developed a process of care for groups of patients with specific conditions, placing these patients at the center of the care process. Through ongoing dialogue, patients (and caregivers) are encouraged to provide valuable input into the care design for their groups.²

A UK initiative, the Dementia Engagement & Empowerment Project (DEEP), aims to actively engage patients with dementia and representative organizations. In one innovative example, a role-play drama featuring patients with dementia and caregivers, highlighted the unpopular tendency to wheel patients backwards through hospital corridors, creating a sense of disorientation. This practice has now ceased, making a huge difference to wellbeing.³ As health apps, diagnostic devices and remote monitoring improve, self-management will become more common, making patients effectively part of the workforce.

A patient representative taking part in KPMG International's crowdsourcing research, said: "It's important that patients and the public are regarded as part of the

workforce and that they are supported and informed as to what others in the more 'formal' workforce can and cannot do. Healthcare needs to truly learn to hand over responsibility (and risk) to patients in an informed and supportive way."⁴

As the examples demonstrate, engagement will not simply happen by itself; it requires appropriate systems to support shared decision-making and to measure patient input and satisfaction levels. Health leaders need to assess and mobilize the assets and capabilities of patients, caregivers and communities, and ensure that they receive the information necessary to voice informed opinions and take an active role in their care. Patients can also play a vital role in teaching and research.

Informed patients = better choices = improved outcomes

When patients understand their treatment options and potential side effects, there is a strong chance that they may choose an alternative. Patients with benign prostate disease, for example, are typically offered surgery to address urinary symptoms, yet subsequently suffer from post-surgical sexual dysfunction. In one study, the simple act of explaining the risks to patients led to a 40 percent drop in operations, with patients expressing greater confidence in their final decision.^{5,6}

Similar results were seen in female patients with abnormal bleeding from the uterus, where 20 percent fewer chose surgery once made aware of the side effects.⁷ And, in a randomized trial in Toronto, of patients with chest pain diagnosed as stable angina heart disease, one-fifth preferred to avoid surgical treatment.⁸

Convergence: Mount Sinai Hospital's Family Integrated Care Program, Canada

In an inspiring example of collaboration, parents attending the Neonatal Intensive Care Unit at Mount Sinai hospital in Toronto, are supported and educated by nurses to provide much of their babies' care. This promotes bonding, increases skills and confidence and ensures a smoother transition to home life. Babies receiving this type of care gained more weight than those in traditional settings, with four out of five mothers choosing to breastfeed, well above the national average. Parents' stress levels decreased and babies had a lower risk of infection and critical incidents.

Lessons learned:

- guidance from nurses should consist of a 'light touch' and be attuned to parents' needs.

2. Zorgbelang Nederland, <http://www.zorgbelang-nederland.nl/>

3. Mental Health Foundation website, accessed 25 August 2014, <http://www.mentalhealth.org.uk/our-work/research/dementia-engagement-and-empowerment-project/>

4. KPMG International's global healthcare crowdsourcing research project was conducted from March to May 2014, involving 555 healthcare leaders representing more than 50 countries.

5. The effect of a shared decision-making program on rates of surgery for benign prostatic hyperplasia, Wagner E, Barrett P, Barry M, Barlow W, Fowler F, Medical Care, vol 33, no 8, pp 765-70, 1995.

6. Randomised controlled trial of an interactive multimedia decision aid on benign prostatic hypertrophy in primary care, Murray E, Davis H, Tai SS, et al., BMJ.323 (7311):493-6, 2001.

7. Randomized, controlled trial of on interactive videodisc decision aid for patients with ischemic heart disease, Morgan MW, Deber RB, Llewellyn-Thomas HA, Gladstone P, Cusimano RJ, O'Rourke K, Tomlinson G, Detsky AS, Journal of General Internal Medicine, vol 15, no 10, pp 685-93, 2000.

8. Effects of decision aids for menorrhagia on treatment choices, health outcomes, and costs: a randomized controlled trial, Kennedy A, Sculpher M, Coulter A, Dwyer N, Rees M, Abrams K, Horsley S, Cowley D, Kidson C, Kirwin C, Naish C, Stirrat G, Journal of the American Medical Association, vol 288, no 21, pp 2701-8, 2002.

Personal service: Bedfordshire musculoskeletal program, UK

One in ten citizens of the UK county of Bedfordshire experience some form of a musculoskeletal issue. Feedback from local patients and caregivers called for a more integrated approach to care, with locally accessible services tailored around a patient's personal goals.

Truly integrated, patient-centered care

A new partnership of musculoskeletal experts, leading patient charities and local public and private health providers now offer a seamless service. Patients can choose care closer to home and, armed with better information, have a bigger say in their own individual care plans and pathways. With more emphasis upon measurement and outcomes, progress is monitored using patient, caregiver and family feedback, with results published.

Lessons learned:

- use local providers where possible, as they understand the culture and the people
- it is vital to engage with, and influence, general practitioners, to gain their support
- outcome measures, which are defined by bodies that represent patients, legitimize changes in healthcare delivery systems
- the use of internationally agreed outcome measures enables benchmarking and gives credibility to the results.

Participatory health: ParkinsonNet, Netherlands

The Netherlands-based ParkinsonNet has developed regional care communities of healthcare professionals specialized in Parkinson's disease. With a strong focus on evidence-based practice, the network carries out research and provides doctors with training and guidelines. Patients with Parkinson's disease are fully connected and can search the website for advice and liaise with specialists and other patients, holding online discussions.

A new level of engagement

Patients organize their own care, choose physiotherapists and invite professionals and other patients to discuss health issues. Doctors are encouraged to view patients as partners that control their own care, with support from the ParkinsonNet community.

Bringing value into the mainstream

In 2014, ParC (ParkinsonNet's founding provider) was the first medical center in the Netherlands to negotiate a value-based contract with a health insurer, with referral volumes linked to quality indicators. Patient outcomes and satisfaction have improved significantly, with reduced hospital and nursing home admissions and a 50 percent reduction in hip fractures. Savings are estimated at US\$27 million per year across the Netherlands.

Lessons learned:

- doctors must view patients as partners rather than as subjects of care
- by measuring outcomes to show improvements at lower cost, ParC was able to negotiate a value-based contract with a major healthcare insurer
- ParC initially involved only those healthcare professionals that wanted to take part; the rest followed once they saw the impressive results.

Defining and measuring outcomes

Health systems can only deliver excellent value by systematically measuring outcomes, in order to spot high and low performers, benchmark against best practices and gauge improvements over time. As payers become more active, they are linking rewards to positive results, with outcomes reflecting all the interventions in the continuum. Health professionals cannot be content with simply completing their treatment; there must be an improvement in the longer-term outcome, which becomes the responsibility of all providers. This notion of a continuum of care is particularly relevant to the increasingly complex management of care for chronic conditions.





There is a wide range of desired outcomes, from absence of complications after interventions, to longer-term rehabilitation of functions and total recovery of patients. As patients exert more influence on what is measured, goals relating to quality of life, general wellness and emotional wellbeing have been introduced. These form a continuum of outcomes, which starts with the basic resolution of a condition and ends with longer-term goals such as resuming a normal life or living without pain. For a patient with a stroke, the continuum might follow this path:

Short-term outcome: immediate stroke care, followed by a return home within 6 months, with minimum loss of functionality.

Long-term outcome: prevention of further strokes within 2 years, with the patient gaining full independence and returning to work.

In an outcome-driven system, health professionals make better decisions that are more likely to improve the patient's overall quality of life. Surgery and subsequent recovery may be an appropriate path for Mr. Johnson, the healthy 40-year-old with knee cartilage damage. For Mrs. Murphy, the 80-year-old with multiple health conditions, however, the same surgery could supersede any benefits and may be approached more effectively with physiotherapy (see page 7).

Defining outcome indicators

1. Define the outcome that you want to measure (for example the increase in function after a knee replacement).
2. Select the instrument for measuring the outcome; the Oxford Knee Score, or a patient reported outcome measure (PROM) or patient reported experience measure (PREM).

3. Set the outcome measure (e.g. the difference between a pre- and post-score), the inclusion and exclusion criteria and, if relevant, the impact on patients with different combinations of disease/conditions.

For an Oxford Knee Score, the outcome indicator may be the percentage of patients that improve by more than two-to-ten points. The acceptable 'norm' could mean 90 percent or more of patients reaching this indicator, with targets to beat this average.⁹

The quality of an outcome indicator is determined by its relevance to the patient group, the quality of the measuring instrument and the reliability of the data measured.

When outcome measurements are plotted over time, a pattern of patient value starts to emerge. Many current outcome measurements only cover the short-term effects of care, whereas ParkinsonNet measures both short- and long-term outcomes of care delivery, which is more representative of the total value for patients. The four key measures are:

- Patient experiences measured via surveys, based around customer quality.
- The number of hip fractures per patients with Parkinson's disease.
- The percentage of patients admitted per year into hospital and/or long-term care.
- Quality of life assessment: prevention of deterioration of the condition, as reported by the patient.

Striving for continuous improvement

The more standardized the measurement, the easier it is to compare outcomes between patients,

clinicians, institutions and entire health systems. The Oxford Knee Score¹⁰ is a 12-item, patient-reported questionnaire to assess function and pain after total knee replacement surgery. It is short and easily replicated worldwide, and because it is completed by the patient, it minimizes any possibility of bias in the assessment. Questions cover physical capabilities such as: Could you kneel down and get up again afterwards? Have you been limping when walking, because of your knee? Could you walk down a flight of stairs?

Broad, global benchmarks challenge an organization to improve the quality of its care. By setting tough targets, and making results freely available, providers can encourage a culture of excellence, knowing that patients will choose doctors, clinics and hospitals with the best track records, leading to a survival of those people and organizations best able to adapt. Such 'health Darwinism' may appear brutal, but can play an essential part in raising standards in the health system.

Sweden has a long history of quality registries, collecting comprehensive, reliable data and following outcomes of patients with similar conditions and/or medical procedures. In recent years, these measurements have been enhanced with patient input, with reports published, to ensure transparency for taxpayers and patients, promote quality improvement and to share best practice. Despite spending less than half per capita on healthcare than the US, health outcomes are far better in Sweden along virtually every dimension, with an infant mortality rate of less than half that of the US.¹¹ Professor Jörgen Nordenström shares lessons from Sweden on organizing value-based healthcare on page 21.

Evolving the measurement of outcomes

Within a continuum of care, communicating the final outcomes to the various providers will improve the understanding of how each set of interventions affects the quality of care. For example, midwives and gynecologists could review the measures associated with complications in pregnancy or childbirth. Physiotherapists and orthopedic surgeons can collaborate similarly to help improve mobility after hip replacements.

As this type of thinking becomes more commonplace, organizations start to look beyond single or even multiple interventions toward measuring the longer-term effects of care. This could include outcomes such as a patient's independence, ability to undertake specific activities or return to work. For patients with co-morbidity, care coordinators are needed, with the capability to steer patients across different providers or systems, to achieve the best possible outcomes.

Over time, wider health trends can be tracked by making all outcomes public, to compare providers and chart the effectiveness of preventive care programs that prevent obesity, heart disease, smoking and diabetes.

9. National Quality Forum (www.qualityforum.org)

10. Dawson J, Fitzpatrick R, Murray D, Carr A. Questionnaire on the perceptions of patients about total knee replacement. *J Bone Joint Surg Br.* 1998 Jan;80(1):63-9

11. *What Sweden Can Tell Us About Obamacare*, New York Times, 15 June 2013.

A passion for excellence: Sun Yat-sen Cancer Center, Taiwan

An example of single disease integration is the Sun Yat-sen Cancer Center, which formed multidisciplinary cancer teams, mostly focused on a particular type of cancer. The teams included nurses and clinical support staff, and evolved to include care managers, with appropriate technicians included when needed. Teams meet at least twice per month to review new cases and discuss existing patients' care, and every team member knows patients' names and medical circumstances.

Embracing new payment models

Reimbursement was seen as the catalyst for reform, along with quality measurement. The Center introduced pay-for-performance, in collaboration with Taiwan's Bureau of National Health Insurance. Providers received retrospective quarterly capitated payments for each patient, supplemented by performance bonuses based on patient survival rates.

The Taiwanese system had previously lacked comprehensive clinical information (such as health outcomes) and did not report results at the individual provider or physician level. The Sun Yat-sen Cancer Center established patient electronic medical records that included physician order entry, copies of x-rays and other images, lab reports, surgical records, outpatient physician notes, and scheduling.

Data related to quality measures was entered every day by care managers into patients' medical records, and patient safety measures were also tracked, along with patient satisfaction, which was used to inform areas for improvement.

Raising the bar

The center's 1-to-5-year breast cancer survival rates exceeded all hospitals in Taiwan, and adherence to all 10 quality indicators was significantly associated with better overall survival and progression-free survival among patients. Patient safety rates, such as hospital-based infections were also the lowest in Taiwan.

Lessons learned:

- it is not enough to introduce measurement; all staff must be encouraged and incentivized to methodically record outcomes, with penalties for non-compliance
- individual clinicians should be measured on quality indicators including survival rates
- contingent reimbursement schemes reinforce adherence to outcome improvements, while outcome related bonuses could help improve outcomes.

Coordinated care: Delivering greater value

As patients with multiple conditions becomes more common, patients risk becoming lost in different parts of the care system, with each provider concerned only with its own narrow parameters of success. True value is determined by the total outcome as a result of all the care received, which may require considerable coordination, to ensure that providers are aware of and complementing each other, and assuming collective accountability for outcomes. Without such joined-up thinking, value can 'leak' out of the system. For example, if a patient has a hip replacement operation and the initial physiotherapy sessions are delayed, the hip can lock, leaving the patient far less mobile and comfortable.



No single system is best suited to achieve value for all patients in all settings. The appropriate approach will depend upon the patient, his or her social group, the disease segment and, to some extent, the geography.

Value is typically achieved over a longer period, measured by indicators of the quality-of-life outcome, including life expectancy. Patients with multiple chronic conditions should, where possible, be cared for at home — or close to home — embracing self-care and encouraging more independent lives.

Where this is not feasible, they are best served in integrated units responsible for their total care. These teams consist of clinical and non-clinical personnel that treat the diseases and all related conditions, working together toward a common goal to maximize outcomes.

For chronic conditions, these goals are, more often than not, related to the patient's quality-of-life rather than their medical state. For certain complex conditions, it may be prudent to bring in, or cooperate with, super-regional providers possessing high degrees of specialization. Frequent formal and informal meetings enable participants to exchange and review vital information and build an atmosphere of trust.

This is harder than it sounds, given the fragmented state of many healthcare systems. Even in single, public health systems such as the UK's NHS, administrators struggle to pull together different parts of the care continuum. Lack of interoperability is one of the biggest barriers; without technical standards, organizations struggle to share and make sense of data in a standard format.

Concerns over information security and privacy have further slowed progress, while different payment schemes must somehow be sufficiently aligned to ensure common goals. And of course, clinicians may not always be accountable to the same leaders, and could be more loyal to their own group and organization than to a patient that crosses different provider boundaries.

Adapting the degree of integration to the circumstances

No single system is best suited to achieve value for all patients in all settings. The appropriate approach will depend upon the patient, his or her social group, the disease segment and, to some extent, the geography. Coordinated care is more common where there are perceived problems with continuity of care, as well as with groups such as long-term care patients and the elderly. Those requiring elective or acute cardiovascular care will benefit from a more specialized approach, calling for single care pathways.

Patients with single conditions may be better served in integrated 'focus clinics' that specialize in one health condition and pool their expertise toward fast, efficient care. The Sun Yat-sen Cancer Center in Taiwan (see page 14) is focused solely on cancer and brings together a diverse range of specialized clinicians in medicine, surgery, pathology, radiology, nuclear medicine, radiation, oncology, medical physics, psychiatry, anesthesiology, gynecology and rehabilitation medicine.

All processes and innovations are geared toward developing the highest standards of cancer care, with patients able to move seamlessly between different specialists in the same building.

A third option is embedded care, used by regional hospitals with limited services, who work with the most appropriate (and often supra-regional) provider to augment their own care, using shared, integrated pathways. The most complex care, such as diagnostics and/or interventions, is often outsourced to the specialized, supra-regional provider.

Embedded strategies

Regional health systems, especially those on the periphery of a county, may struggle to provide coordinated, often complex, care for their patients. Although patients can be referred to other systems for the entire treatment process, they would have to travel to each consultation, and the local hospital would lose vital income, which could threaten its entire existence.

In the Netherlands, one regional hospital chose an 'embedded' strategy for prostate cancer care, working together with a specialist provider as the preferred, subcontracted supplier. In this form of alliance, clinical pathways are integrated, and diagnostics and aftercare take place in the local center. The intervention is carried out in the specialized center and the outcome of the total pathway is measured. Such an arrangement enables patients to receive most of their care close to home.

Disease programs offer a manageable entrée into coordinated care, dividing patients into segments and developing pathways for these groups that cross different providers, with agreed outcome scores. At a more mature level of integration, the system forms managed clinical networks with formalized governance treatment, research and education, and joint development of care pathways. Patients are under the wing of care coordinators, who take overall responsibility for their welfare throughout the pathway.

The most advanced practice involves formal clinical networks or integrated care organizations, with official contracts between contractors and subcontractors, or even totally integrated organizations.

In the US, accountable care organizations (ACOs) have emerged, featuring a group of health providers working together for a defined population of patients. Reimbursements are closely tied to measure the quality of care, using a variety of payment models including capitation and fee-for-service. The ACO is ultimately accountable to patients and payers.

Rather than formally 'integrate,' systems could instead agree upon contractual relationships with contractors and subcontractors, with bundled payments based upon their expected costs. Such a route gives the commissioning party greater choice of contractor, thus preserving competition.

Cancer, elective care, maternity care and acute cardiovascular care are all potential candidates for bundling. Even the much-maligned fee-for-service approach can be fully value-based for preventive interventions with a proven record of delivering value.

Assertive Community Treatment (ACT)

In this intensive and highly coordinated approach to community mental health, an interdisciplinary team consists of a psychiatrist, one or more nurses, social workers, substance abuse specialists, vocational rehabilitation specialists, occupational therapists and certified peer specialists. This team is jointly responsible for all its patients, whether they are outpatients or in psychiatric hospitals. The whole team works under the supervision of a qualified mental health professional.

Three levels of integration

Focus clinics — patients with a single health condition (Mr. Johnson — see page 7).

Embedded structures — regional care providers work with preferred, subcontracted suppliers to coordinate care for certain types of health conditions.

Coordinated care — patients with multiple health conditions and chronic diseases (Mrs. Murphy — see page 7), where different organizations align their operations, in some cases, choosing to fully merge.

More evidence is needed on what is working, why it is working and how models can be scaled.

Clinically integrated care offers great promise.

The current payment model remains substantially volume-based and fee for service oriented. In fact, few health systems have transitioned into two-sided financial risk models to date.

However, Centers for Medicare & Medicaid Services (CMS) in the US recently stated its intent to have 50 percent of Medicare payments in alternative payment models by 2018, and a shift from a volume-based payment system to a value-based payment system is occurring.¹²

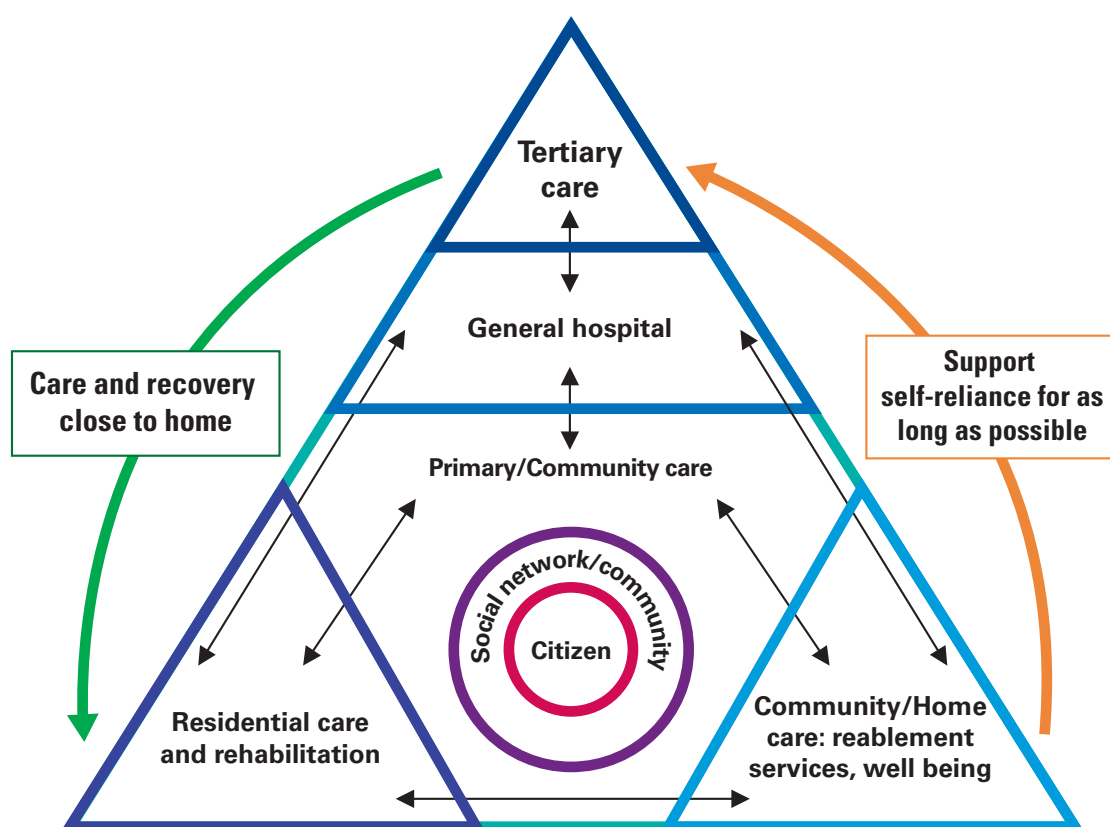
As payment models evolve, new tools, technology and talent, as well as new governance structures will be required to accommodate a risk-based environment. Consolidation of both

health systems and health plans in the US will likely continue in anticipation of changing payment models that reward both quality and efficiency and lead to better population health management.

In addition, physicians will be impacted under new legislation recently passed (Medicare Access and CHIP Reauthorization Act of 2015), incentivizing alternative payment models, which will begin in 2019.

More evidence is needed on what is working, why it is working and how models can be scaled. The shift from volume to value has proven to be real, but CMS and other payers need better ways to assess and promote real and sustainable value, including aligning incentives to link primary and community care to achieve true population health.

Figure 2: KPMG's integrated care model



Source: *As strong as the weakest link*, KPMG International, 2015

12. U.S. Department of Health & Human Services, <http://www.hhs.gov/news/press/2015pres/01/20150126a.html>

Governance

Maintaining a focus on value

In a value-based organization, excellence is planned, rather than accidental, thanks to a strong culture of measuring outcomes, and a commitment to quality at every level, not just among individual clinicians or quality managers. Where several institutions form part of an integrated care network (such as an accountable care organization), this commitment must be present across every entity, with managers providing the appropriate organizational and clinical governance.

At the highest level of maturity, high-value care may be achieved either through vertically integrated health systems, or alternatively via clearly defined contracts between contractors and subcontractors.

Governing a system differs from governing an individual hospital, as the network must often accomplish a variety of objectives through several different organizations, all operating within a rapidly changing healthcare and regulatory environment. With multiple parent and subsidiary boards, it is essential to arrive at a unifying definition of the integrated system that is shared by all the boards and associated members. Many successful healthcare systems have reduced autonomy in their subordinate boards, and given greater authority and accountability to the system board, including oversight of quality and patient safety.

One of the mantras of effective, value-based organizations is: centralize authority and decentralize decision-making; leaving more granular decisions to appropriate subordinate boards. For example, the system board would set the policy for quality and the strategic direction for the entire system, while specific decision-making responsibility for medical staff would rest with individual hospital boards.

Clinical governance levels can vary widely, depending upon the formality of the structure and the relationships within the integrated care network. As health systems evolve, organizations and individuals follow a journey. From a position of high individual autonomy, health professionals start conforming more closely to rules and guidelines. Continuous improvement and accountability become part of the culture, with a rising awareness of

the need to deliver value across the care continuum — and not simply in single interventions. Measuring and monitoring become second nature, as the different providers work closely together to address agreed segments of patients, with clear outcome targets such as reduced readmissions, shorter hospital stays and lower costs.

At the highest level of maturity, high-value care may be achieved either through vertically integrated health systems, or alternatively via clearly defined contracts between contractors and subcontractors. In cases where public or private healthcare organizations subcontract care to providers, hospitals or practitioners, intermediate contracting bodies can assume responsibility for the key outcomes. Day-to-day goals will remain the domain of the subcontractor.

Integration is by no means a prerequisite for quality. Certain types of patients are best served by dedicated groups of specialists in areas such as hip or knee replacements, cancer or elderly care, contracted to deliver ‘meaningful units of care.’

Care pathways cover the entire patient experience as he or she moves through the system, with an emphasis on prevention and wellness through care in the community. Well-coordinated teams are responsible not just for their own areas of treatment, but also for the ultimate outcomes.

Asking tough questions — Georgina Black, Partner, KPMG in Canada

Boards are ultimately accountable for the performance of an organization and its employees, and should not hesitate to question management about the decisions they are taking and their performance, including:

- Who is accountable for oversight of quality and patient safety?
- What mechanisms are in place to ensure that management produces appropriate and accurate information?
- What are stakeholders' expectations of quality and patient safety?
- How does the organization, its staff, patients and the community define quality and patient safety?
- What metrics are used to measure progress towards quality goals?
- Does the organization have the skills to achieve its quality objectives?

Lessons from Sweden — Prof. Jörgen Nordenström

International rankings, national polls and surveys both tend to look favorably on the Swedish health system. Sweden offers arguably the best model of how a local authority-led approach could be structured. It has over 70 disease and patients registries in place, containing outcome measures that enable comparison between (groups of) providers — including primary and community care — and different regions. Prof. Jörgen Nordenström, professor of surgery at Karolinska University Hospital for over 15 years and author of the recently published *Value-based Health Care: are we as good as we can be?*, shares four practical lessons from his research and experience with organizing value-based healthcare.

Use structure and process measures to compliment outcome measures

Outcome measures by themselves do not provide the full story. If you want to organize value-based healthcare, you need to understand what is causing good or bad outcomes of care to identify improvement areas. This requires the identification of measurements of process and structure that are closely linked to measurements of outcome.

Be your own fiercest competitor

Urge care providers to be their own fiercest competitor. Demographic differences, socio-economic status, specific local circumstances, quality of primary care providers in the region or availability of community services, can distort comparisons between providers and regions. Instead, compete with yourself over time to improve your results every month and year.

Commit to continuous improvement, adhere to evidence-based best practices

Karolinska University Hospital uses effective lean production techniques to systematically improve disease pathways. Find the tools and techniques to support a commitment to improvement befitting your organization then make sure you adhere to evidence-based best practices. The latest best practices should be the standard you adhere to and the starting point for the next round of improvements.

Communicate in terms of quality

Organizing value-based healthcare needs to be underpinned by a fundamental belief that increasing care quality leads to reduced overall costs. All changes need to demonstrate improvements to quality, access and affordability of care. A compelling story about change conveys that message to engage patients, staff and other stakeholders to help drive change.



Contracting

Assuring value

Contracts are a powerful and often under-utilized way to shape healthcare delivery. They must be adapted, depending upon the level of coordination and the outcomes being sought. New contractual arrangements can drive a more patient- and outcome-based approach, as providers have little alternative but to comply. Once a health system is oriented toward patient-centered outcomes, contracts can help to sustain this approach, by incentivizing the desired behavior to reward activities that create value, rather than simply reimbursing costs. Contract discussions should not be adversarial, and present an opportunity to align the values of payers and providers, and keep expenditure under control.

In integrated systems, payments start to cross organizational boundaries. Purchasers such as insurance companies, commissioners or government agencies could agree to payment, based upon a set of outcomes for a given population. For chronic conditions, this may be a fixed sum per patient per year (assuming outcomes are met); for elective care, the payment would be episode-based. Primary care professionals, on the other hand, could receive a fixed sum per enrolled patient, partly subscription-based, but also partly based on the measured health outcomes for these patients.

Toward value-based contracting

As performance-based contracts start to replace traditional fee-for-service contracts, healthcare organizations are now looking to introduce contracts that reward value.

By rewarding action, case-based payments can generate unnecessary interventions in order to increase income. Primary care in particular, population-based payment, or capitation, is an alternative and potentially more appropriate way to maximize preventive care, with the added advantage of a fixed cost that eases budgetary planning.

Capitation is most effective when a system measures its outcomes. Without such monitoring, physicians may feel they can spend the entire allocated budget by referring the most costly patients to other types of care — rather than focus on high quality primary and community care. Capitation also puts

a lot of pressure on providers to work within a finite budget, which could be challenging when treating high-risk conditions such as cancer.

An innovative example of contracting is alternative quality contracts, developed by Blue Cross Blue Shield Massachusetts in the US, which align the incentives of hospital providers with primary care doctors, to halt the growth in medical expenditure (see page 24).

Providers are rewarded by retaining a share of any savings for achieving quality and efficiency targets. Since the contracts were introduced in 2009, providers have delivered higher quality improvements and cost savings.

The UK Bedfordshire musculoskeletal program (see page 10) also involved capitation-based funding (producing a fixed budget), with contractors taking a share in the gains or risks, based upon patient outcomes and cost savings. Some of the project measures include innovative use of technology, quality of patient experience, level of integrated care, and annual reports including stakeholder feedback and improvement plans.

The danger of changing too quickly

A sudden shift from fee-for-service to bundled services could result in local health providers receiving significantly lower incomes, placing entire clinics or hospitals at risk. Given the unfamiliarity of new reward systems, a transitional period of 1-2 years should enable providers gradually to reduce unused capacity and adjust to the new model. During this period, income would remain stable.

Capitation is most effective when a system measures its outcomes. Without such monitoring, physicians may feel they can spend the entire allocated budget by referring the most costly patients to other types of care — rather than focus on high quality primary and community care.

The power of new contracts: Blue Cross Blue Shield Massachusetts and Harvard Vanguard Medical Associates, US

Through the introduction of an alternative quality contract (AQC), physicians and hospitals entered into a voluntary global payment model where financial incentives are linked to clinical quality, patient outcomes, and efficient use of resources. These doctors and hospitals were also responsible for the full continuum of care, including cost and quality, across all settings.

The contracts, which included a per-patient global budget, may be solely with physician groups or could also include hospitals. The AQC applied only to members of certain health insurance plans with primary care organization Harvard Vanguard Medical Associates.

An adaptive approach

This arrangement encouraged primary care physicians to seek the same quality hospital care at lower-cost. As the main contractor, Harvard Vanguard hired part-time specialists that could perform small interventions within the primary care center (preventing unnecessary referrals), and selected referral partners based upon their outcome to cost ratio, which helped to break up pushed up prices.

The availability of treatment and outcome variations stimulated a change in behavior, while the long-term nature of the contracts encouraged investment in the partnership. In future, new insurance products will emerge that incentivize members to choose high-value care, and actively participate in discussions with doctors. Critically, spending levels were not reduced immediately but brought down over time, enabling providers to adjust to the new regime.

Low-cost, high-quality care

Quality has improved significantly, while the rate of cost increases are set to halve within 5 years, all without abolishing fee-for-service payments. Any share of surpluses in budgets will be dependent upon performance quality.

Lessons learned:

- the system covers patients in every care setting, encouraging primary care physicians to seek the lower-cost hospital care without sacrificing quality
- five-year contracts stimulate long-term partnerships between providers and payers.

Promoting true value: HealthSouth, US

HealthSouth, a provider of inpatient rehabilitation services based in Birmingham, Alabama, US, was perceived to be more expensive than its competition (predominantly skilled nursing facilities). However, management believed that its standardized care management protocols actually delivered superior outcomes. To prepare for the move to value-based contracting, the organization wanted to calculate the total cost and outcomes of care, including pre-operative, inpatient and post-operative programs.

A clearer picture of value

Gathering data from multiple health plans and clinical sources, HealthSouth demonstrated that its overall cost of care was less than other providers, and is using these findings to build its relationships with health plans, and improve financial performance through better contracting arrangements. Readmission rates are half of competitors, and acute bed days are considerably lower, bringing considerable savings.

Lessons learned:

- it is critical to communicate value in a clear, understandable way
- existing data may be inadequate, so organizations may need to invest in data mining and analysis.



Exploring value:

Dr. Steven Laitner

As an independent healthcare consultant and general practitioner, Dr. Laitner discusses value-based organizations with Anna van Poucke.

Dr. Laitner has helped a number of UK healthcare organizations become more value-based, by introducing the concept of the 'Accountable Lead Provider' (for a 'Program of Care') which has proven to be an effective way of applying many of the principles discussed throughout this report.

Anna: For a majority of patients in many countries, care starts with the general practitioner, but once an individual is referred to an in- or out-patient facility, the process can become complicated, especially in the case of co-morbidities; a lack of coordination between providers, with patients shuttled between different specialists and caregivers.

Steve: I agree. Neither GPs nor hospitals are currently capable of providing the complete pathway of care, and GPs who hold commissioning powers in the UK do not really have the skills or time to micro-manage all the elements of complex healthcare systems and pathways. I think to do so, is neither right nor possible. One alternative is to follow the lead of other industries and contract with a lead provider to manage the entire continuum for a particular program of care such as musculoskeletal conditions, diabetes, and the frail elderly. This idea is at the heart of the Accountable Lead Provider model (see opposite).

Anna: This is like having a hub at the center of the system — but these contractors do more than just oversee care.

Steve: Absolutely. That is why I call them 'Accountable Lead Providers,' who provide a substantial amount of community-based specialist services as an alternative to hospital outpatients, and, where necessary, will subcontract the in-patient part of a patient's pathway care. They also hold responsibility for the total budget for a program of care, such as respiratory health, or a care group, such as the frail elderly. They are fully accountable for both the quality and the cost of the entire patient pathway across primary, community and acute care. They are ideally placed to work with all stakeholders to define the standard

pathway and manage the gateways through the tiers of care. The key activities they provide include support for case management, care navigation, shared decision-making, personal health planning, support of self-care and also importantly caregiver support.

Anna: In this report we mention the importance of outcomes, and the need to link these to care planning and measurement. How can an accountable lead provider ensure a strong focus on outcomes?

Steve: Care planning must be linked with outcome development and measurement. Therefore, the methodical use of care plans is part of the contract between the commissioning group and the lead provider. The contracts should be fully or partially outcome-based with a capitated payment, of which a proportion would be based upon outcomes. There is usually a sweet spot of contract elements related to outcomes, which in my experience lies around 5-10 percent of the contract value. However, rather than focusing on a specific percentage, make sure the amount is large enough to drive change but small enough to make sure providers do not fixate on just the outcomes that are stipulated.

Anna: There are a number of good outcome measurements. For musculoskeletal conditions, the Oxford Hip and Knee Score has proved reliable. For patients with respiratory diseases, a reduction in the number of people smoking or a fall in hospital admissions are also positive outcomes.

Steve: And patients have to play a part in defining and reporting outcomes, to ensure that they reflect what is really important to them as human beings. In addition to existing PROMs, you can think of so-called 'patient defined outcomes' on an individual basis. These measures will vary according to an individual's personal goals, whether it's the desire to hold a pen and write a letter, or walk to the shop for groceries, or take a week's holiday with the family, or simply enjoy a pain-free night's sleep.

Anna: What is the role of the GP in this model?

Steve: The GP will remain the first point of call and will initiate a referral to the hub when they feel a patient would benefit from multidisciplinary specialist services. The aim is to avoid unnecessary referrals or treatment, and provide care in the most appropriate setting. What the most appropriate setting is will depend on the individual's needs and preferences at that time.

Anna: For this model to work, we will need a new type of coordinating professional that understands the different parts of the care network and can work with health professionals and patients. Potential candidates could be a GP, nurse, community geriatricians or general hospital physician. One of their most important tasks, besides delivering care to patients, is to manage individual care pathways and support GPs and specialist providers with patient referrals.

Steve: This is a key role and careful thought needs to go into their remit and skills and who may fulfill that role. The role of the key worker, case manager, care navigator, care planning support worker are all essential and may not all have to be health or care

professionals, peer support can play a key role. The accountable lead provider may wish to create some form of joint venture between provider partners such as social care, third sector organizations and independent providers, or alternatively it may simply manage subcontractors. In the case of frail elderly services, it is likely to be dually commissioned by health and social care.

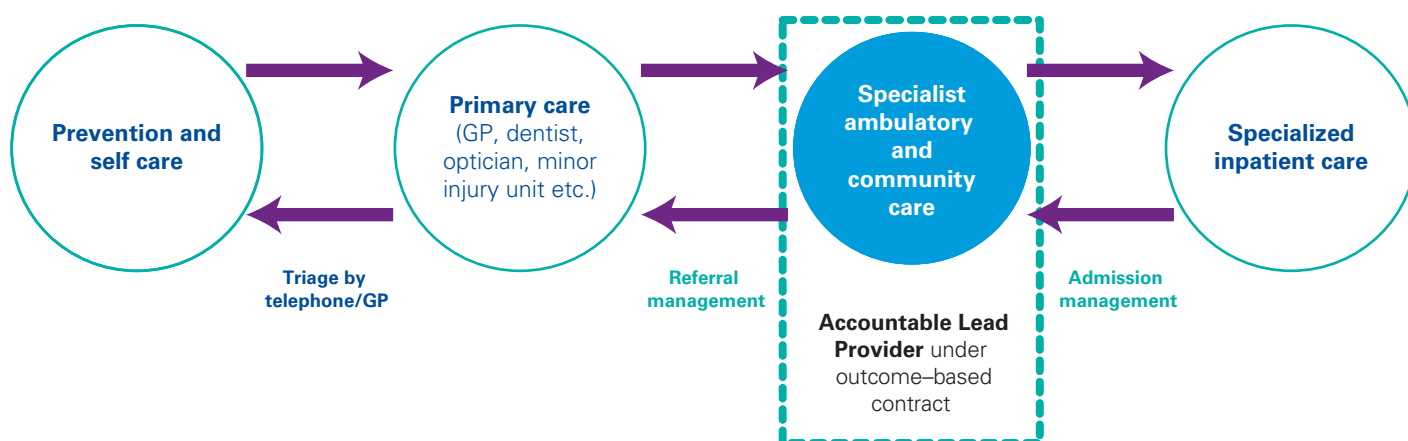
Anna: In addition to joint ventures, the provider may enter into special purpose vehicles, alliances, partnerships or loose federations, but the key constant is that there is a single, accountable governing body, whose activities are fully transparent, in order to maintain a steady focus on outcomes.

Steve: That focus is critical. And, because the contractor is both providing and sub-contracting, it has a strong incentive to manage complex and long-term conditions more effectively, and strive for earlier and cheaper interventions, including self-care and even prevention. The structure of the contract gives providers a real incentive to improve patients' lives, including solutions that may lay outside the health system, in what I like to term a 'biopsychosocial' model of care.

Accountable Lead Provider model

The accountable lead provider, under the outcome-based contract with the contracting party (clinical commissioning group, insurer etc.), delivers the bulk of specialist ambulatory and community services for that specific program of care. It works with patients and all care providers involved to manage the boundaries between tiers of care (⇌) and shift care to the most appropriate setting, incentivizing a 'shift left' through the tiers of care.

Figure 3: Accountable Lead Provider model



Source: Dr Steven Laitner, 2015

Conclusion: Mobilizing for value

As many healthcare systems have discovered, the road to value is paved with hazards and obstructions. KPMG's maturity matrix on the following pages presents achievable targets for becoming more value-oriented. Providers and payers can use the matrix to assess their current positions, strengths and weaknesses, and monitor progress toward value maturity.

Payers tend to be the driving force for change, but providers will also have to transform their approach to healthcare to become more outcome-oriented. Patient representative organizations can also be influential, by demanding patient-defined outcomes, self-care and accountability.

Most of the elements in the matrix (see page 29) are interdependent, so progress in one area needs to be supported by advances in another. As health systems reach the higher levels of maturity and achieve integrated care, the buy-in of local politicians, patients and community groups can accelerate the transformation and aid wider strategies for public health.

A blueprint for change: evolution not revolution

- The five elements of the KPMG value maturity matrix must progress concurrently. Failure to do so could hold back the move to a value-based organization. For example,

value-based contracts cannot be achieved without accompanying measurements of outcomes. Many organizations choose to start small, transitioning some of the care for one disease or patient group, requiring amendments to part of the contract.

- The objectives of payers, providers and patients should be aligned, to ensure a common understanding of value and a willingness to work together. Governance and contracting provide the glue to make such partnerships stick, by rewarding/penalizing the right/wrong behavior.
- Change cannot happen overnight and financial provisions need to be made for providers or individuals as they adapt to new targets, to ensure that income does not suddenly fall dramatically. Although competition should raise quality standards, it is important that entire hospitals do not suddenly fail, as this would jeopardize care provision.
- Contracting should similarly evolve slowly, by adapting certain parts of the agreement, such as a modest (5 percent) shared bonus for meeting new outcome targets. Over time, incentives must constitute a larger proportion of payments, in order to truly incentivize significant improvements.

KPMG value maturity matrix

(5=high; 0=low)

Maturity level	5	4	3	2	1	0
Patient engagement	Patient as co-creator <ul style="list-style-type: none"> integrated shared decision-making systems for individual patients across the care cycle patients co-design care in the care cycle and for specific segments, using resources to add value in the local health system 	Patient as partner <ul style="list-style-type: none"> patients empowered for self-care patient experiences and reported outcomes are part of performance management and subsequent payments 	Patient as valuable source <ul style="list-style-type: none"> patient representative organizations co-design care pathways patient-preferred outcomes used for design of care pathways 	Patient as soundboard <ul style="list-style-type: none"> patient-representative organizations provide input for outcome indicators patient-reported outcomes used as quality indicators 	Patient as client <ul style="list-style-type: none"> patient opinions expressed by traditional representative organizations quality indicators based on some patient data 	No patient involvement <ul style="list-style-type: none"> patients are not involved in care design
Defining and measuring outcomes	Population health-based <ul style="list-style-type: none"> population health outcomes based on aggregated data from all providers, communities and patients outcomes made public indicators based on latest priorities 	Long-term outcome-based <ul style="list-style-type: none"> focus on prevention and wellness across the value chain risk-adjusted outcome goals public sharing of results, internal performance monitoring and ongoing improvement programs 	Outcome-based <ul style="list-style-type: none"> outcome indicators are comparable and transferable to other providers in the care continuum indicators aligned with global best practice real-time measurement results shared with payers, clinicians and other providers in the care continuum 	Partly outcome-based <ul style="list-style-type: none"> patient experiences (patient reported outcome measures — PROMS) incorporated into targets clinical indicators partly based on outcomes 	Process/structure measure-based <ul style="list-style-type: none"> basic clinical outcomes agreed in single provider organizations clinical indicators based on process and structure measures 	Input-based <ul style="list-style-type: none"> no outcome targets; just measurement of inputs no metrics for outcomes no learning
Defining and measuring outcomes	Community-based coordinated care <ul style="list-style-type: none"> integrated care plans with links to the wider community, aimed at prevention and wellness strong role for patients in co-designing individual care pathways recognition that value is created by a strong care chain 	Segment-based coordinated care <ul style="list-style-type: none"> integrated care plans for specific groups and segments managed coordination and integrated interventions aimed at 'end-of-care-cycle' outcomes and prevention recognition that value is created by coordinating care 	Segment-based multidisciplinary care <ul style="list-style-type: none"> formalized multidisciplinary meetings for specific groups and segments adjustment of interventions between different providers to improve outcomes recognition that failure to 'link up', causes loss of value 	Provider-based multidisciplinary care <ul style="list-style-type: none"> regular multidisciplinary meetings some care coordination on specific groups or segments, and a recognition that value is jointly created by several organizations 	Fragmented care with basic data sharing <ul style="list-style-type: none"> basic data sharing individual providers focus on quality of care 	Fragmented care <ul style="list-style-type: none"> care provision organized around the needs of the different organizations

Maturity level

5

4

3

2

1

0

	Contingent contracts	Coordinated contracts	Bundled payments with shared savings	Bundled payments	Pay-for-performance	Fee-for-service
Contracting	<ul style="list-style-type: none"> contingent contracts for the local health system (partly capitation, partly bundled and coordinated) aggregated outcome-based payments or capitation for patient segments, with differential payments based on outcomes 	<ul style="list-style-type: none"> coordinated contracts (with one contractor for the system) differential payments based on outcome shared savings and shared losses 	<ul style="list-style-type: none"> bundled payments per provider (partly) based on outcomes, with shared savings for the whole health system 	<ul style="list-style-type: none"> bundled payments per provider with outcomes/indicator-based controls per episode 	<ul style="list-style-type: none"> pay-for-performance and additional bonus for achieving quality indicators 	<ul style="list-style-type: none"> fee-for-service payment for fragmented delivery by single providers
Governance	<p>Vertically integrated governance</p> <p><i>Process</i></p> <ul style="list-style-type: none"> appropriate governance structures formalized system for continuous outcome measurement and improvement <p>Coordination</p> <ul style="list-style-type: none"> integrated care pathways based on prevention and wellness 	<p>Coordinated governance</p> <p><i>Process</i></p> <ul style="list-style-type: none"> coordinated governance between providers within the care system, jointly focused on outcomes and results <p>Coordination</p> <ul style="list-style-type: none"> coordinated care pathways 	<p>Single provider: coordinated governance</p> <p><i>Process</i></p> <ul style="list-style-type: none"> single provider-based governance structures formalized outcome monitoring and improvement processes <p>Coordination</p> <ul style="list-style-type: none"> some coordination over the way that outcomes are defined, measured and improved within the care system 	<p>Single provider: quality-based governance</p> <p><i>Process</i></p> <ul style="list-style-type: none"> single provider-based governance structures formalized quality monitoring and improvement processes 	<p>Single provider: ad hoc quality-based governance</p> <p><i>Process</i></p> <ul style="list-style-type: none"> single provider-based governance structures emergence of processes to monitor and improve quality 	<p>Single provider: no clinical governance</p> <p><i>Process</i></p> <ul style="list-style-type: none"> Single provider governance structures covering each aspect of fragmented care traditional management principles <p>Coordination</p> <ul style="list-style-type: none"> no coordination with other parties

How KPMG can help organizations become more value-based

KPMG's network of healthcare professionals have extensive experience in both public and private sector health systems, and many have initiated and managed major organizational transformations to delivered significant value improvements. We work with payers and commissioners of care and provide practical, hands-on advice and support.

Our teams work can help with care system redesign, working across regional health ecosystems to rethink patient pathways and shift the provision of care to more appropriate settings. Our healthcare professionals expertise covers programs with both payers and providers, as well as combined programs, to accelerate the development of high value healthcare, including:

- developing and implementing integrated care pathways
- restructuring of regional healthcare systems, including the underlying business cases

- designing and implementing new forms of contracting
- creating appropriate governance structures
- helping professionals through the various steps in in their path toward better healthcare delivery.

Our network of healthcare IT specialists are able to leverage enabling technologies and enhance performance through systems selection, implementation project management, controls assessments, business process improvement, and change management services.

Working with boards, our teams help build the right skills, capabilities and information to lead effectively, increase confidence in systems and processes, and improve data accuracy to improve governance. For more information visit kpmg.com/healthcare or email healthcare@kpmg.com

What Works: A series of thought leading reports from KPMG Global Healthcare

The need for change in healthcare is well understood. There is also an increasing consensus about what needs to be done to address these challenges:

- a focus on quality, safety, controlling costs and improving population health
- a move from the emphasis being on the volume of treatment toward ensuring high value care
- activist payers working with patients and providers to reshape the system
- the development of new models of delivery including increasing

convergence between healthcare payers, providers and the life sciences industry

- reaching out to patients and communities in new ways.

The question is how to make these changes happen. We argue that there are a number of changes of both mind-set and capability that are required across a number of areas. These include:

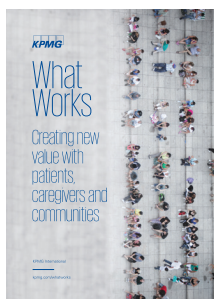
- systems to drive clinical and operational excellence
- new partnerships and networks

- new models for coordinated care and population health

- the ability to contract for value.

This report looks at the last of these and makes a strong case that there is a long journey for some healthcare organizations to become true value-based healthcare systems.

For more information, or to reserve your copy of future **What Works** reports, please contact your national partner, see back cover, or email; healthcare@kpmg.com. Visit kpmg.com/whatworks for the latest report.



What Works: Creating new value with patients, caregivers and communities

Globally some parts of healthcare are beginning to make the changes that will involve patients, caregivers and communities more fully in their own healthcare. Using our experience across the world, this report outlines the answers that you need to fully realize the value inherent in better patient involvement and communities to improve care.

kpmg.com/patientvalue



What Works: Partnerships, networks and alliances

As hospitals and healthcare organizations around the world struggle to address growing volumes of patients, reduce per capita costs, and improve the patient experience of quality and satisfaction, consolidation in healthcare has accelerated significantly. This report highlights six practical tips that together help organizations realize long-term success.

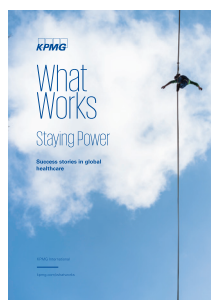
kpmg.com/partnerships



What Works: Paths to population health — Achieving coordinated and accountable care

Health needs are changing fast, but systems are simply not keeping up. It is clear that organizations are struggling to convert theory into practice. This report describes the practical steps that organizations need to go through to reshape themselves and their services.

kpmg.com/pophealth



What Works: Staying Power — Success stories in global healthcare

KPMG gathered together 65 healthcare leaders from 30 countries across 6 continents to discuss effective strategies for successful transformation. These discussions were centered around 7 key themes ranging from population health and accountable care to clinical and operational excellence. This report summarizes the insights shared between organizations, cultures and countries.

kpmg.com/stayingpower

Contributors



Gary Belfield, Associate Partner, KPMG in the UK

Gary is a recognized national leader on commissioning development with health experience across a range of organizations. He created national commissioning policy as a member of the NHS Management Board. In working with multi-disciplinary teams throughout his 20 years of management experience at the NHS, including Chief Executive of Acute NHS Trust and Deputy CE of Community and Mental Health NHS Trust, he successfully improved patient care, primary care, community services, and focused on system redesign for long term. He is committed to sharing his learnings with organizations to improve health outcomes for patients and local communities.



Georgina Black, Partner KPMG in Canada

Georgina works closely with boards, executive teams and diverse stakeholder groups to develop strategies to improve performance. Throughout her career, she has led several transformational projects (mergers and acquisitions, restructuring, governance and program reviews, shared services and organizational design) in the public sector to improve effectiveness and efficiencies within complex stakeholder environments. Through her work with provincial, local governments, not-for-profits and healthcare organizations, she brings a systems perspective to identifying and addressing cross function, organization and sector opportunities. Georgina is an Advisory Partner in Canada, national Sector lead for Health and member of KPMG's Global Healthcare Steering Committee. She has 20 years of experience advising organizations in the areas of executive governance and leadership, strategic planning, performance improvement and complex organizational change.



Malcolm Lowe-Lauri, Partner, KPMG in Australia

Malcolm has been at the forefront of the NHS's modernization efforts, having helped several UK healthcare authorities deliver change and improve performance, successfully working with multiple stakeholder groups. Most recently Malcolm was CEO of University Hospitals Leicester (NHS) Trust, England's third-largest university hospital trust with \$1 billion turnover and 11,500 employees, where he turned around a failing asset renewal program. A prominent national and international figure, he has chaired the UK CEO's Research Forum and was a member of the NHS Future Forum, advising the UK Government on health legislation. Malcolm is currently an Advisory Partner in Australia and is part of KPMG's Global Healthcare Center of Excellence. One of his areas of expertise is the development and implementation of new care delivery models to achieve cross-organizational change.



Scott Maslin, Associate Director, KPMG in the UK

Scott focuses on care system redesign and value-based commissioning, supporting the development of high quality and effective services that are aligned with population need and fit for the future. Scott has led strategic health and social care system redesign for the governments of Northern Ireland and Jersey, Channel Islands, as well as in a number of large and complex care systems across England. Scott joined KPMG in the UK from the NHS where he had a background in service redesign and quality improvement.



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