Health services management (FS-14)

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FOCUSED SYMPOSIUM
Health Services Management

Managing Information and Measurement to Achieve Excellence in Service Provision

2 May 2015
Managing Information and Measurement to Achieve Excellence in Service Provision

Symposium Overview

Dr. Robert Jones – Symposium Convenor
Introducing the Symposium Team

Robert Jones (UK)
Fiona Jenkins (UK)
Janice Mueller (New Zealand)
Ina Diener (South Africa)
Carolyn Oddo (USA)
To understand how data, information, measurement and service analysis are essential to, and impact on the management and provision of physiotherapy services in, for example, patient care, business cases, performance management, staffing levels, resource use, activity, outcomes, R&D, staff deployment and to consider some uses and application of data and information.
Format

- Presentations
- Discussion and Questions
- Summing up and Conclusion
Some definitions

- Data
- Information
- Metrics
Information, Data and Metrics

- Timely, accurate, relevant
- Reliable and valid
- Key performance indicators
Information and the role of the manager

- Nerve centre – key informational link
- Managing the data collection process
- Interpretation – data to information
- Monitor
- Planning
- Dissemination and transmission
- Spokesperson/presenter
- Mastery of big picture and detail
- Accountability
Where do we use information?

1. Strategy
2. Patient and service user experience
3. Clinical excellence
4. Finance
5. Information and Metrics
6. Activity
7. Staff resources
8. Staff management and development
9. Service improvement and re-design
10. Leadership and management development
11. Risk management
12. Corporate governance
13. Communications and marketing
14. KPIs
What data do we need?

- Patient (individual and aggregated)
- Population
- Staffing
- Activity
- Unmet need
- Financial
- Clinical outcomes
- R&D – Evidence base
Why do we need it?

- Clinical and patient care
- Service planning and commissioning
- Service development
- Performance management
- Service excellence
- Benchmarking
- Ensure continuing professional and personal staff development
- Value for money for commissioners and service users
Examples of useful data: Staff caseloads

<table>
<thead>
<tr>
<th>Grade</th>
<th>Patients</th>
<th>Contacts</th>
<th>Clinical Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 WTE Podiatrist</td>
<td>475</td>
<td>654</td>
<td>Out-patients (medicine)</td>
</tr>
<tr>
<td>0.2 WTE SLT</td>
<td>63</td>
<td>289</td>
<td>General Medicine</td>
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<tr>
<td>1 WTE SLT</td>
<td>235</td>
<td>992</td>
<td>In-patient (medicine)</td>
</tr>
<tr>
<td>1 WTE OT</td>
<td>392</td>
<td>827</td>
<td>Orthopaedics, A &amp; E, medicine</td>
</tr>
<tr>
<td>1 WTE Physio</td>
<td>511</td>
<td>2211</td>
<td>MSK out-patients</td>
</tr>
</tbody>
</table>
Connect the values to patient feedback

What’s it like in our care?

- Listen 1:1 to patients as they tell their stories. What was good and bad? How did it make them feel?
- What would patients like to see ‘more of’ and ‘less of’ from your staff?
- Staff reconnect with passion for care
- Connect values to patient needs. “We do... so you feel”.
Managing Information and Measurement to Achieve Excellence in Service Provision

Fiona Jenkins
Information and measurement in strategic management

- Delivering organisational vision and strategy
- Outcomes framework
- Benchmarking comparison
- Planning
- Assurance
- Organisational performance
- Financial management
- Service improvement
- Innovation
Strategic management
The role requires

- Delivery of organisation's strategy
- Looking at the big picture
- Attention to detail when required
The journey to get there

- Must ensure we focus on the right things
- Quality
- Safety
- Patient experience
- Performance
- Staff - a great place to work
- Education and training
- .. And the money!
National outcomes framework

1. Staying healthy
2. Safe care
3. Effective care
4. Dignified care
5. Timely care
6. Individual care

How many measures?
# Starting big.. How do we compare?

## Country Rankings

<table>
<thead>
<tr>
<th>Overall Ranking (2013)</th>
<th>AUS</th>
<th>CAN</th>
<th>FRA</th>
<th>GER</th>
<th>NETH</th>
<th>NZ</th>
<th>NOR</th>
<th>SWE</th>
<th>SWIZ</th>
<th>UK</th>
<th>US</th>
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</thead>
<tbody>
<tr>
<td>Quality Care</td>
<td>4</td>
<td>10</td>
<td>9</td>
<td>5</td>
<td>5</td>
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<tr>
<td>Effective Care</td>
<td>2</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>5</td>
<td>4</td>
<td>11</td>
<td>10</td>
<td>3</td>
<td>1</td>
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<tr>
<td>Safe Care</td>
<td>4</td>
<td>7</td>
<td>9</td>
<td>6</td>
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<td>11</td>
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<td>8</td>
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<td>3</td>
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<tr>
<td>Coordinated Care</td>
<td>3</td>
<td>10</td>
<td>2</td>
<td>6</td>
<td>7</td>
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<td>4</td>
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<td>7</td>
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<tr>
<td>Patient-Centered Care</td>
<td>5</td>
<td>8</td>
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<td>10</td>
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<td>2</td>
<td>7</td>
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<td>6</td>
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<td>Access</td>
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<td>9</td>
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<td>4</td>
<td>7</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>9</td>
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<tr>
<td>Cost-Related Problem</td>
<td>9</td>
<td>5</td>
<td>10</td>
<td>4</td>
<td>8</td>
<td>6</td>
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<tr>
<td>Timeliness of Care</td>
<td>6</td>
<td>11</td>
<td>10</td>
<td>4</td>
<td>2</td>
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<td>8</td>
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<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Efficiency</td>
<td>4</td>
<td>10</td>
<td>8</td>
<td>9</td>
<td>7</td>
<td>3</td>
<td>4</td>
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<td>6</td>
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<td>Equity</td>
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<td>9</td>
<td>7</td>
<td>4</td>
<td>8</td>
<td>10</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Healthy Lives</td>
<td>4</td>
<td>8</td>
<td>1</td>
<td>7</td>
<td>5</td>
<td>9</td>
<td>6</td>
<td>2</td>
<td>3</td>
<td>10</td>
<td>11</td>
</tr>
</tbody>
</table>

**Health Expenditures/Capita, 2011**

- AUS: $3,800
- CAN: $4,522
- FRA: $4,118
- GER: $4,495
- NETH: $5,099
- NZ: $3,182
- NOR: $5,669
- SWE: $3,925
- SWIZ: $5,643
- UK: $3,405
- US: $8,508

*Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010. Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund National Scorecard 2011; World Health Organization; and Organization for Economic Cooperation and Development. *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).
Figure 8. Emergency admission rates for all respiratory diseases. Age standardised per 100,000 population.
Service level: Weekend working

Physiotherapy Specialties Covered at Weekends

- Orthopaedics
- Respiratory
- A&E/Medical Assessment Units
- Elderly medicine
- Stroke/neurology
- Spinal injuries
- General surgery
- General medicine
- Other

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The essentials

- Have information architecture that extracts data to give you information
- Have agreed data definitions
- Collect data, use information
- Have data informed conversations
- Make data informed decisions
## Planning data

To help commission/plan services at population level

<table>
<thead>
<tr>
<th>Outcome Indicator</th>
<th>LA and cluster distribution (LAs ranked; right = better outcomes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a Potential years of life lost (PYLL) from causes considered amenable to healthcare</td>
<td></td>
</tr>
<tr>
<td>1bi Life expectancy at age 75 (Males)</td>
<td></td>
</tr>
<tr>
<td>1bii Life expectancy at age 75 (Females)</td>
<td></td>
</tr>
<tr>
<td>2 Health-related quality of life for people with long term conditions</td>
<td></td>
</tr>
<tr>
<td>3a Emergency admissions for acute conditions that should not usually require hospital admission</td>
<td></td>
</tr>
<tr>
<td>3b Emergency readmissions within 30 days of discharge from hospital</td>
<td></td>
</tr>
<tr>
<td>4ai Patient experience of GP services</td>
<td></td>
</tr>
<tr>
<td>4aii Patient experience of GP out-of-hours services</td>
<td></td>
</tr>
<tr>
<td>4a(iii) Patient experience of dental services</td>
<td></td>
</tr>
<tr>
<td>0.1i Healthy life expectancy at birth - males</td>
<td></td>
</tr>
<tr>
<td>0.1i Healthy life expectancy at birth - females</td>
<td></td>
</tr>
<tr>
<td>0.1ii Life expectancy at birth - males</td>
<td></td>
</tr>
<tr>
<td>0.1ii Life expectancy at birth - females</td>
<td></td>
</tr>
<tr>
<td>0.2i Slope Index of Inequality in life expectancy at birth - males</td>
<td></td>
</tr>
<tr>
<td>0.2ii Slope Index of Inequality in life expectancy at birth - females</td>
<td></td>
</tr>
<tr>
<td>1A Social care-related quality of life</td>
<td></td>
</tr>
<tr>
<td>2A(1) Permanent admissions to residential and nursing</td>
<td></td>
</tr>
</tbody>
</table>
Planning data: Age band of population

Produced by Public Health Wales Observatory, using Census 2011 (ONS)

- Cardiff males
- Cardiff females
- Wales males
- Wales females

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Proportion (%) of population</th>
</tr>
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<tr>
<td>85+</td>
<td>10</td>
</tr>
<tr>
<td>80-84</td>
<td>8</td>
</tr>
<tr>
<td>75-79</td>
<td>6</td>
</tr>
<tr>
<td>70-74</td>
<td>4</td>
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<td>65-69</td>
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<tr>
<td>60-64</td>
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<td>55-59</td>
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<td>05-09</td>
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<td>00-04</td>
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</table>

Proportion (%) of population

<table>
<thead>
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<th>Age Group</th>
<th>Proportion (%) of population</th>
</tr>
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<tbody>
<tr>
<td>85+</td>
<td>10</td>
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<td>80-84</td>
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<td>75-79</td>
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<td>70-74</td>
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<td>10-14</td>
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<td>05-09</td>
<td>1</td>
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<tr>
<td>00-04</td>
<td>1</td>
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</table>
### Estimated prevalence and incidence of Multiple sclerosis in the population

<table>
<thead>
<tr>
<th>Health Board</th>
<th>Estimated number in population (Hirst)*</th>
<th>Estimated new cases per year in population (Hirst)**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Betsi Cadwaladr</td>
<td>1,100</td>
<td>70</td>
</tr>
<tr>
<td>Powys</td>
<td>200</td>
<td>10</td>
</tr>
<tr>
<td>Hywel Dda</td>
<td>600</td>
<td>40</td>
</tr>
<tr>
<td>Abertawe Bro Morgannwg</td>
<td>800</td>
<td>50</td>
</tr>
<tr>
<td>Cardiff and Vale</td>
<td>700</td>
<td>50</td>
</tr>
<tr>
<td>Cwm Taf</td>
<td>500</td>
<td>30</td>
</tr>
<tr>
<td>Aneurin Bevan</td>
<td>900</td>
<td>50</td>
</tr>
<tr>
<td>Wales</td>
<td>4,800</td>
<td>290</td>
</tr>
</tbody>
</table>

Produced by Public Health Wales, using data from Hirst et al (2009) & MYE (ONS)

*Estimated prevalence rounded to the nearest 100

**Estimated new cases rounded to the nearest 10
Data for assurance

- The Board requires assurance
- The Executive team are accountable
- Patient safety and quality is paramount
  - Is performance as we had planned?
  - How’s the money?
  - Are we delivering to plan?
  - How do our patients rate us?
  - What issues are we facing?
Assurance: Mortality

Mortality from respiratory disease, all ages, males, European age-standardised rate (EASR) per 100,000, Cardiff and Vale UHB and Wales, 2001-09

Produced by Public Health Wales Observatory, using ADDE/MYE (ONS), WIMD 2008 (WG)

- Most deprived within Cardiff and Vale (95% CI)
- Least deprived within Cardiff and Vale
- Wales EASR
- Cardiff and Vale overall

Rate Ratio - most deprived divided by least deprived

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate Ratio</th>
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<tbody>
<tr>
<td>2001-03</td>
<td>2.8</td>
</tr>
<tr>
<td>2002-04</td>
<td>2.8</td>
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<tr>
<td>2003-05</td>
<td>2.6</td>
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<tr>
<td>2004-06</td>
<td>2.6</td>
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<tr>
<td>2005-07</td>
<td>2.3</td>
</tr>
<tr>
<td>2006-08</td>
<td>2.4</td>
</tr>
<tr>
<td>2007-09</td>
<td>2.5</td>
</tr>
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</table>
# National Audit data

<table>
<thead>
<tr>
<th>Routinely Admitting Teams</th>
<th>Number of patients</th>
<th>Overall Performance</th>
<th>Team Centred Data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Admit</td>
<td>Disch</td>
<td>SSNAP Level</td>
</tr>
<tr>
<td><strong>Trust</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>London - London SCN</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calderdale and Huddersfield NHS Foundation Trust</td>
<td>Calderdale Royal Hospital</td>
<td>131</td>
<td>129</td>
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<tr>
<td>Chesterfield Royal Hospital NHS Foundation Trust</td>
<td>Chesterfield Royal</td>
<td>113</td>
<td>115</td>
</tr>
<tr>
<td>Doncaster and Bassetlaw Hospitals NHS Foundation Trust</td>
<td>Doncaster Royal Infirmary</td>
<td>143</td>
<td>145</td>
</tr>
<tr>
<td>Harrogate and District NHS Foundation Trust</td>
<td>Harrogate District Hospital</td>
<td>84</td>
<td>92</td>
</tr>
<tr>
<td>Hull and East Yorkshire Hospitals NHS Trust</td>
<td>Hull Royal Infirmary</td>
<td>200</td>
<td>210</td>
</tr>
<tr>
<td>Leeds Teaching Hospitals NHS Trust</td>
<td>Leeds General Infirmary</td>
<td>263</td>
<td>223</td>
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<tr>
<td>Mid Yorkshire Hospitals NHS Trust</td>
<td>Pinderfields Hospital</td>
<td>211</td>
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<tr>
<td>Northern Lincolnshire and East Yorkshire Hospitals NHS Foundation Trust</td>
<td>Scunthorpe General Hospital</td>
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<td>York Hospital</td>
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<td><strong>South England - South East Coast SCN</strong></td>
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<td>Ashford and St Peter's Hospitals NHS Foundation Trust</td>
<td>Ashford and St Peter's Hospital</td>
<td>95</td>
<td>103</td>
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<tr>
<td>Brighton and Sussex University Hospitals NHS Trust</td>
<td>Brighton and Sussex University Hospitals</td>
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<td>51</td>
</tr>
<tr>
<td></td>
<td>Royal Sussex County Hospital</td>
<td>95</td>
<td>93</td>
</tr>
</tbody>
</table>

**Note:** The table includes various performance metrics and the number of patients admitted and discharged for each trust.
Performance management

- Enables organisations to articulate their business strategy, align their business to that strategy
- Identify their key performance indicators (KPIs) and track progress, delivering the information to decision-makers
- Clear link between the strategic objectives and every work group within your organisation
Performance: Therapy waiting times

- Paediatric OT
- Physiotherapy
- Paediatric SALT
Workforce key performance indicators

- Vacancy rate (WTE)
- Turnover rate (WTE)
- Sickness absence rate
- PADR rate (appraisal rate)
- Statutory and mandatory training rate
- Pay bill over/underspend
- Variable pay rate
Service Improvement/ Innovation

- Providing care as locally as possible
- Ensuring the right care, at the right time, in the right place with the right professional
- Improving and modernising facilities
- Promoting a healthier lifestyle and encouraging people to take better care of themselves
- Ensuring resources are used to their best effect.
Monitoring: Conversion rate to surgery

Conversion rates Apr 08- Mar 09

UCL = 0.41059

CEN = 0.25698

LCL = 0.10337
Falls reduction

<table>
<thead>
<tr>
<th>Metric</th>
<th>Metric Type Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in all patient falls</td>
<td>Reduction in the number of Patient Falls across the UHB. The data is obtained from Datix monthly.</td>
</tr>
</tbody>
</table>
And what does it cost?
Information for strategic management

Collect it

Sort it

Arrange it

Use it to improve!
So You've got the data, now Sell your story

To Whom?

Could it work?

Where's the money?

Is it what we want?

Will it work?

Is it safe? Better?

OUTCOMES Toolkit
A bright idea …

A 12 week community-based physiotherapy exercise program in a local gymnasium for osteoarthritis patients that will improve health outcomes and reduce/delay the need for joint arthroplasty.
Understand the Competitive Advantage of your Proposal

- Unique selling points
- Know your competition
- Key stakeholders (internal and external)
- Stakeholder interest and influence
Stakeholder Mapping and Prioritisation Matrix

- Who are they?
- Interest/power?
- How to manage?
## Options Analysis

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Description</th>
<th>Long List Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale, Scope &amp; Location</td>
<td>What levels of coverage are possible? e.g. by levels of functionality, geographic coverage, population/user base, organisation</td>
<td>• Do Nothing&lt;br&gt;• Do minimum - short term remediation only&lt;br&gt;• Do maximum - short term fixes and long term full remediation of all affected buildings</td>
</tr>
<tr>
<td>Service Solution</td>
<td>How can services be provided? e.g. potential solutions &amp; answers, use of technologies</td>
<td>• Partial Off-site/onsite&lt;br&gt;• Off-site&lt;br&gt;• Full service solution on-site</td>
</tr>
<tr>
<td>Implementation</td>
<td>When can services be delivered? e.g. timing and staging, big bang, phased, modular</td>
<td>• Phased Implementation&lt;br&gt;• Full Implementation</td>
</tr>
<tr>
<td>Service Delivery</td>
<td>Who can deliver the services? e.g. in-house or outsourced or alternative procurement strategies</td>
<td>• Organisation provides services on own site(s)&lt;br&gt;• Other public departments&lt;br&gt;• Private sector</td>
</tr>
<tr>
<td>Funding</td>
<td>How can the investment be funded for both capital and operational costs?</td>
<td>• Organisation provides cash&lt;br&gt;• Crown debt/equity&lt;br&gt;• Private sector debt&lt;br&gt;• Public Private Partnership&lt;br&gt;• User charging</td>
</tr>
</tbody>
</table>

Adapted from: Auckland District Health Board Business Case Template
Benefit Cost Analysis

1. Brainstorm costs and benefits
2. Assign a monetary value to the costs
3. Assign a monetary value to the benefits
   ▪ Tangible/intangible
4. Compare the value of costs to benefits
   ▪ Total cost / total revenue (or benefits) = length of time (payback period)
Identifying and Managing Stakeholder Expectations

Putting yourself in their shoes …
## Community OA Exercise Programme

A structured, evidence-based 12 week physiotherapy exercise program in a local gymnasium for osteoarthritis patients that will improve health outcomes and reduce/delay the need for joint arthroplasty

<table>
<thead>
<tr>
<th>Service Commissioners</th>
<th>Executive Board of the Organisation</th>
<th>Orthopaedic Surgeons &amp; General Practitioners</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the cost/benefit of this proposal?</strong></td>
<td>Does this fit with our strategic direction?</td>
<td>Do our patients need this service? What’s the evidence base?</td>
<td>Will this really help me? (Get fitter, lose weight, reduce my pain …)</td>
</tr>
<tr>
<td><strong>What evidence supports this proposal?</strong></td>
<td>Does it have the support of the Orthopaedic Surgeons and our GPs?</td>
<td>How will this be paid for?</td>
<td>Can I avoid surgery?</td>
</tr>
<tr>
<td><strong>Will we get value for money?</strong></td>
<td><strong>What is the cost/benefit of this proposal?</strong></td>
<td>What impact might this have on my surgical waiting list?</td>
<td>How will I get there?</td>
</tr>
<tr>
<td><strong>Can a public/private physiotherapy partnership work?</strong></td>
<td>Does our local population need this service?</td>
<td>“Not another …. Pilot !!!”</td>
<td>Do I need to pay?</td>
</tr>
</tbody>
</table>
## Community OA Exercise Programme

<table>
<thead>
<tr>
<th>Service Commissioners</th>
<th>Executive Boards of the Organisation</th>
<th>Orthopaedic Surgeons &amp; General Practitioners</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number FTE required</td>
<td>Patient Satisfaction</td>
<td>Reduced BMI</td>
<td>Community Engagement</td>
</tr>
<tr>
<td>Full cost of FTE, incl. overheads</td>
<td></td>
<td>Improved exercise tolerance</td>
<td></td>
</tr>
<tr>
<td>Number of referrals</td>
<td>Sustained health outcomes</td>
<td>Reduced risk of falls</td>
<td>Accessibility of the programme</td>
</tr>
<tr>
<td>Benefit/Cost Sustainability</td>
<td>Benefit/Cost Sustainability</td>
<td>More appropriate surgical candidates</td>
<td>Programme Sustainability</td>
</tr>
<tr>
<td>Rates of complaints/compliments</td>
<td>Reduced LOS following joint arthroplasty</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Remember the measurement question?
The Elevator Pitch
What is it?

- A brief, persuasive speech that you use to spark interest in what your organisation does.

- It should last no longer than a short elevator ride of 20 to 30 seconds, hence the name.

- Elevator pitches should be interesting, memorable, and succinct. It needs to explain what makes your proposal unique.
“This proposal is to ..... by ..... This will give/provide/enable/ensure ..... by allowing/enabling ...., ..., and ....”
“This proposal seeks funding to provide a community-based rehabilitation programme for osteoarthritis patients. As a team of public and private physiotherapists, we will deliver a structured, evidence-based 12 week exercise program in a local gymnasium. *Patients will have improved health outcomes across a range of indicators, with lower conversion to surgery rates. This will enable scarce orthopaedic surgical resource to be optimised, and increased patient satisfaction.*”
HOW EXCITING!! PLEASE TELL ME MORE!!
Stakeholder Feedback

☐ I would like it to be mandatory for ALL patients with arthritis to go through the programme before being seen in secondary services – Orthopaedic Surgeon

☐ I like this project. It works – GP

☐ I’ve forgotten I have arthritis. I just get on with life – Participant

☐ Arthritis doesn’t control my life now; I control it – Participant

☐ I’ve never had exercises so tailored to my needs nor so much support – Participant

☐ I can always tell which patients have been through the programme, they do fantastically well post operatively – Orthopaedic Surgeon

Adapted from: South Canterbury Collaboration to Treat Arthritis in the Community September 2014. Presented to PNZ Conference, Auckland New Zealand
MEASUREMENT ........
An essential element of excellence in service provision

Dr Ina Diener

MANAGING INFORMATION AND MEASUREMENT TO ACHIEVE EXCELLENCE IN SERVICE PROVISION
We need evidence to claim excellence..............
We need evidence to claim excellence................

- **We need results**
  - Robust, accurate, timely

- **We need applicable results**
  - Clinical excellence/ Patient satisfaction
  - Cost effectiveness / Business growth

- **We need reliable and validated results**
  - Evidence-based - strong psychometric properties
  - Specific population and aim
For high quality service provision, need alignment between .......

- vision
- strategy
- performance
- resources
- desired outcomes

Management of quality service
Performance indicators
Management of quality involves the selection & use of performance measures or indicators

- Validated and applicable OMs
  - Clinical outcomes
  - Patient/client satisfaction/experience
  - Cost effectiveness
  - Performance of employees
  - Business/organisation growth
An essential link between management of quality and provision of ‘best´ quality physiotherapy services

- Improvement of quality in physiotherapy services

- Branding of Physiotherapy service from this department/clinic  
  [Wennberg & Thomson, BMJ 2011]

- Change in health policy affecting the clinic / department /profession  
  [Cookson 2005]
Which implementation strategies can be tailored to facilitate the processes of

- measuring clinical outcome?

- measuring practice performance?

- measuring business/organisational effectiveness?
- Physiotherapy services

- Practice/Department organisation

- Professional association
To develop and evaluate a plan for systematic implementation of measurement instruments

1. Problem analysis
2. Literature search
3. Identify barriers and facilitators
4. Develop of strategies by using a planning model for the process of change
BARRIERS / FACILITATORS

1. Therapists’ attitude
2. Therapists’ competence
3. Organisation [policy]
4. Different patient expectations
5. Feasibility of measurement instruments
Which barriers and facilitators contribute to the use of valid outcome measures?

It depends how employees see it....
Feasibility: A local base of valid outcome measures and managing the process

Standardised outcome measurement - to meta-analyse

- Development of local user-friendly and reliable outcome measures
- Careful and precise measurement
- Standardised recording of data & outcomes

[Yeomans & Liebenson 1997]
Feasibility: Which measures make sense for quality of service

- Patient experience/satisfaction
  - Patient-centred Care  *Salisbury et al 2010*

- Clinical effectiveness
  - Impairment VS Function VS Participation  *Jette & Haley 2005*

- Cost-effectiveness
  - Value for money
  - Escalating healthcare costs
Feasibility: Which measures make sense for quality of service

- Strategic effectiveness
  - Intervention/professional service of choice
  - Resource management
  - Keeping employees/members together
  - Impact on the management and provision of physiotherapy services, business cases, performance measurement, staffing levels, staff deployment
Conclusion:

Start education with self-analysis

Use an established model for the process of change

[Groll et al 2005]

Start with small simple projects

[Geboers et al 2001]
Recommendations for your practice/organisation:

- Orientation phase
- Educational facilities
- Readily available instruments
Management of Measurement of Outcomes: Is everyone in the team 'pulling' in the same direction?
Management of Measurement of Outcomes: *Do staff have the motivation to provide value and bring about improvement?*

- Organisational support
- A system to facilitate & check
- Analysis of data
- Reporting

[Salbach et al 2007]
Management of Measurement of Outcomes: *Does the direction benefit all the parties?*

- **Patient**
  - Appropriate, Affordable and Accessible service

- **Practitioner**
  - Work satisfaction & fulfilment

- **Practice/organisation**
  - Contribute to growth
  - Contribute to change in health authorities’ policies [Cookson 2005]
Managing Information and Measurement to Achieve Excellence in Service Provision

Carolyn Oddo, PT, MS, FACHE

WCPT Congress 2015
Objectives

• To provide an overview of new and innovative models of care provision.
• To discuss the implications for physical therapy practice.
• To identify a core set of standardized measures to evaluate Patient Centered Medical Homes (PCMH’s).
• To discuss outcome measures in the areas of cost/utilization/clinical quality.
New and Innovative Models of Care

• Affordable Care Act (ACA) signed into law by President Obama on 3/23/2010.

• Considered the most significant regulatory overhaul of the United States health care system since the passage of Medicare and Medicaid in 1965.

• “Triple Aim”
  • Better care for individuals
  • Better health for populations
  • Reducing per-capita costs
International Appeal

Slowing growth in health care cost, achieving effective utilization of resources and improving patient outcomes are common themes world-wide.
Support for New Models of Care

• The 2010 Affordable Care Act contains various provisions that support implementation of the medical home model including new payment policies, Medicaid demonstrations, and the creation of Accountable Care Organizations (ACO’s) – which are similar to medical homes, on a larger scale.
Medical Home Model of Care

- Designed around patient needs and aims to improve access to care (e.g. through extended office hours and increased communication between providers and patients via email and telephone), increase care coordination and enhance overall quality, while simultaneously reducing costs.
Medical Home Concepts

• Each patient has an ongoing relationship with a personal physician.

• Physician leads a patient care team.

• Innovative approach to delivering comprehensive patient-centered preventative and primary care.

• Attention to the whole-person and integration of all aspects of health care offer potential to improve physical health, behavioral health, access to community-based social services and management of chronic conditions.

• Care is coordinated and/or integrated across all elements of the complex health care system.
Medical Home’s Five Years Later

• 2009
  • 26 Medical Homes
  • 5 million enrollees

• 2015
  • 119 Medical Homes
  • 26 million enrollees
Medical Home Growth

• Health and Human Service Secretary Sylvia M. Burwell announced $35.7 million in ACA funding to 147 health centers in 44 states, the District of Columbia, and Puerto Rico to support patient-centered medical homes through new construction and facility renovations.
Accountable Care Organization Model of Care

• Accountable Care Organizations (ACO’s) are groups of physicians, hospitals and other health care providers who will form one entity to voluntarily provide coordinated care to Medicare patients.

• Goal: Coordination of care to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.
Accountable Care Organization Concepts

Accountable Care Organization’s that meet or exceed goals of Triple Aim will share in the savings it achieves for the Medicare program.
Accountable Care Organization’s 5 Years Later

• 2009
  • 9 Accountable Care Organizations
    • Established financial and quality metrics

• 2015
  • 340 Accountable Care Organizations
  • Quality reporting versus meeting targets
Implications for Physical Therapy Practice

• APTA Vision Statement
  • “Transforming Society by Optimizing Movement to Improve the Human Experience”
APTA Principles and Objectives for the US Health Care System and Delivery of PT Services

• The APTA supports a health care system that provides all individuals within the United States access to and provision of quality health care that meets the needs of individuals, patient populations, and communities.

• The system must include provision of coordinated, collaborative, comprehensive, effective (cost, quality, and value) care, including physical therapist services.

• Physical Therapists are integral to health care and health care teams and make unique contributions that are essential for comprehensive health care regardless of the model of health care delivery.

• Retrieved from http://www.apta.org/uploadedFiles/APTAorg/About_us
APTAT Innovation 2.0: Early PT Adopters

• “Facilitating Access Improving Care-Physical Therapists are Integral ACO members”
  • Thomas Flynn, PT, PhD, OCS, FAAOMPT

• “Adding Value to Postacute Care Settings Through Evidence-Based Physical Therapy Services”
  • Robin Marcus, PT, PhD, OCS

• “Patient-Centered Medical Home: An Innovative Model for Childhood Obesity Prevention With the Physical Therapist as a Key Player to Improve Quality of Care and Reduce Costs”
  • Brian Wrotniak, PT, PhD

• Retrieved from http://www.apta.org/Innovation2
Standardized Outcome Measures

• The Healthcare Effectiveness Data and Information Set (HEDIS)
• Medicare Health Outcomes Survey (HOS)
• Meaningful Use
• Physician Quality Reporting System (PQRS)
PT Related Measures of Care

• **Overuse and Appropriateness Category**
  - Use of Imaging Studies for Low Back Pain (LBP)

• **Screening, Prevention and Wellness Category**
  - Adult BMI Assessment

• **Chronic Condition Management Category**
  - Controlling High Blood Pressure
  - Comprehensive Diabetes Care

• **Measures Targeted Toward Older Adults Category**
  - Physical Activity in Older Adults
Use of Imaging Studies for Low Back Pain

2014 State of Health Care Quality

Health Plan Overview

- Calendar year 2013 Results
- Statistical significance = 95%
- Data Source:
  - 814 HMO’s
  - 353 PPO’s
  - 171 million people
  - 54% of the US population
Use of Imaging Studies for Low Back Pain

Quality Measure Definition

- The percentage of adults 18-50 years of age with a primary diagnosis of low back pain, who did not have an imaging study (plain x-ray, MRI or CT scan) within 28 days of the diagnosis

Overuse and Appropriateness Category
Use of Imaging Studies for Low Back Pain

**Area of Cost**

- Total direct costs of chronic back pain-related health care in a study of 39,425 patients was estimated to be $96 million during one year (Mehra, Hill, Nicholl, & Schadrack, 2012)

**Report Findings**

- Avoiding imaging among patients for whom there is no clinical necessity can prevent unnecessary harm, reduce unnecessary surgeries to patients and reduce costs
Use of Imaging Studies for Low Back Pain

**Area of Utilization**

- 25-50% American adults affected yearly and it is one of the most common reasons for seeking health care (Haldeman & Dagenais, 2008)
- Evidence shows that many patients diagnosed with LBP receive excessive imaging

**Report Findings**

- Rates for imaging studies for LBP have been slightly lightly lower for 5 years among commercial and Medicaid HMO’s
- Commercial PPO rate has had slow but statistically significant improvement
- Have had statistically significant gains over the last 3 – 5 years
Use of Imaging Studies for Low Back Pain

Area of Clinical Quality
• LBP imaging before 28 days and without any red flags will not improve clinical outcomes or benefit the patient (Chou, Fu, Carrino, & Deyo, 2009)

Report Findings
• For the great majority of individuals who experience severe LBP, pain improves within the first two weeks of onset (ICSI, 2012)
• Conservative treatment and avoiding expensive imaging are key to effective, efficient treatment of uncomplicated LBP
• Exposure to radiation is reduced
Physical Therapy Research

• Newly consulted primary care referred patients with low back pain referred for advanced imaging as a first management was associated with higher health care utilization and charges than physical therapy (Fritz, Brennan, & Hunter, 2015)

• Patients managed by physical therapists were associated with reduced costs due to a reduction of imaging services (Daker-White et al., 1999)

• Late referral to physical therapy for patients with low back pain may increase the risk for additional health care consumption and costs (Fritz, Childs, Wainner, & Flynn, 2012)

• Older adults with low back pain who receive imaging within six weeks of their doctors visit do not have better outcomes than similar older adults who do not receive early imaging. (Jarvik et al., 2015)
Physical Therapy Opportunities

- Physical therapists need a “seat at the table” with entities to influence selection of quality measures and to contribute towards meeting/exceeding targets
- Use data to demonstrate the value of physical therapy services
Physical Therapy Opportunities

- Adoption of innovative models of care for low back pain and musculoskeletal conditions that include:
  - Physical therapy as first management strategy
  - Physical therapists as entry point providers
  - Granting of imaging privileges for physical therapists
Thanks ya’ll!
References


References


• National Committee for Quality Assurance. 2014 State of Health Care Report