

Value in Healthcare (ViHC) Ontario Type 2 Diabetes Pilot

Kick-off Meeting Pre-read

16 February 2018

Objectives for kick-off



Agree on foundations for value-based health systems



Share global best practice examples of value-based healthcare (VBHC)



Agree how to leverage positive work already underway in Canada



Begin discussions about Ontario's health system for Type 2 diabetes patients

Agenda

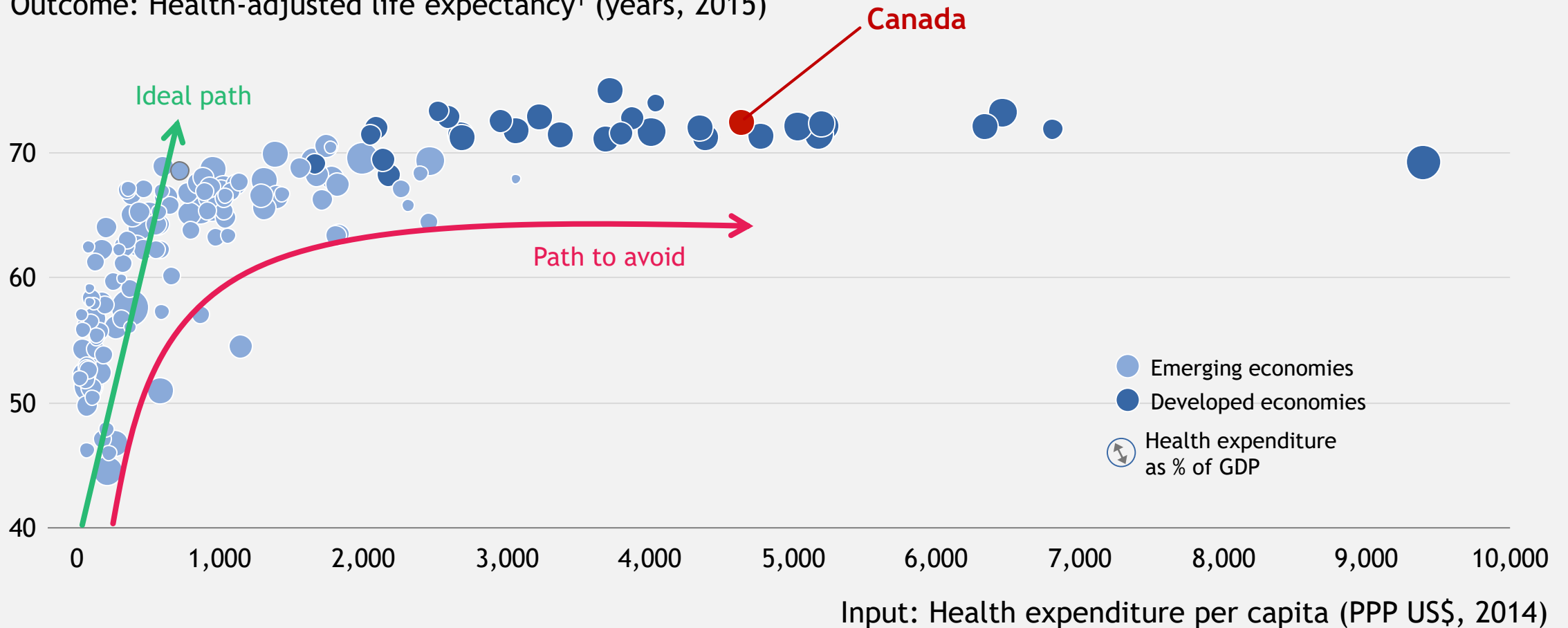
Topic	Presenter	Time
Welcome address	Joshua Tepper, President and CEO, Health Quality Ontario	9.00 - 9.10am
The patient's perspective	Charlene Lavergne	9.10 - 9.20am
Introduction to the World Economic Forum	Vanessa Candeias, Head of Global Health and Healthcare System Initiative	9.20 - 9.30am
Value-based healthcare and pilot approach	Mathieu Lamiaux, Senior Partner and Managing Director, BCG	9.30 - 9.55am
Opportunity for Q & A		9.55 - 10.05am
Building off current successes <ul style="list-style-type: none"> Informatics: Diabetes Action Canada Informatics: ICES Informatics: LMC Registry 	Prof. Catharine Whiteside, Executive Director A/Prof. Baiju Shah, Scientist and Endocrinologist Priya Narula, Endocrine Physician Assistant	10.05 - 10.30am
Break		10.30 - 10.45am
Building off current successes <ul style="list-style-type: none"> Benchmarking: HQO Payments: Ontario MOHLTC Delivery organization: Diabetes Canada 	Dr. Joshua Tepper, President and CEO Fredrika Scarth, Director, HQO Liaison & Program Development Russell Williams, Vice President, Government Relations and Public Policy	10.45 - 11.10am
Value-based healthcare diagnostic		11.10 - 11.55am
Wrap-up	Jonathan Lim, Project Leader, BCG	11.55 - 12.00pm

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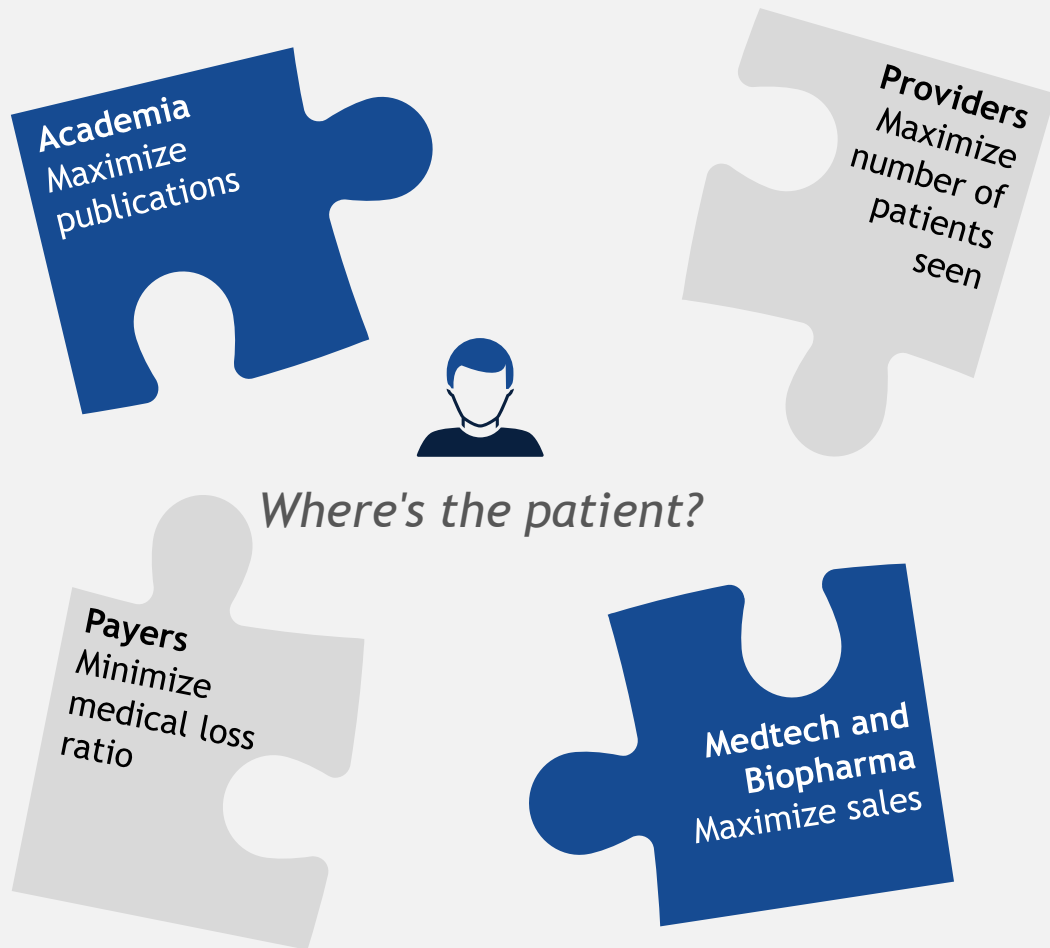
Healthcare delivery is a global challenge

Outcome: Health-adjusted life expectancy¹ (years, 2015)



1. Health-adjusted life expectancy: Estimates the number of years in full health an individual is expected to live at birth by subtracting the years of ill health (weighted according to severity) from overall life expectancy. Sources: WHO, BCG analysis

Misaligned incentives are at core of system inefficiency



Value in Healthcare







The paradigm shift to align stakeholders on the outcomes that matter most to patients and ensure health system sustainability...

Value-based healthcare: People-centered health systems



Source: BCG analysis

The enabler transformation roadmap

	Phase 1 Internal performance improvement	Phase 2 System learning and performance improvement	Phase 3 Transparency and value competition	Phase 4 A continuously improving VBHC system
 Informatics	Data collection by individual stakeholders	➤ Standardized measurement of value	➤ Interoperable IT systems with risk-adjusted outcomes	➤ Increased patient data collection and ownership
 Benchmarking, research & tools	Comparisons within organizations only	➤ Anonymized benchmarking among organizations	➤ Competition based on public reporting; data available for research	➤ Decision support tools and new clinical guidelines
 Payments	Experimentation with new models	➤ Shift away from fee-for-service	➤ Quality improvement efforts with bundled payments & capitation	➤ Value-based payments, optimized by patient group
 Delivery organization	Increasing clinician engagement and ownership of value	➤ Coordinated care across care chain	➤ Quality improvement programs	➤ Reorganization around population segments

Note: VBHC= value-based healthcare
Source: BCG analysis

US: Cystic Fibrosis registry improved patient outcomes



Standardized reporting enabled better patient/provider dialogue



Tailored registry tools for QI efforts/research to speed up drug launch

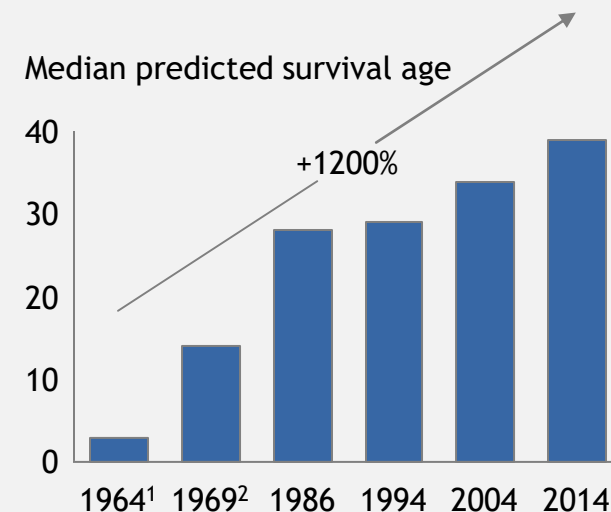


Remuneration based on complete & accurate data reporting



Large QI program helps parties to share best practices in network

Increase in patient survival and ability to lead full, healthy lives



Note: QI = quality improvement
1. Bell Curve, Gawande 2. Journal of pediatrics 1993, Changing Epidemiology of Cystic Fibrosis, FitzSimmons
Source: Cystic Fibrosis annual report 2014

Sweden: Rapidly moving to a value-based health system

Model design



Gov't invested €165B to improve coverage & use of >100 registries



Annual national comparison of hospitals on outcomes and costs



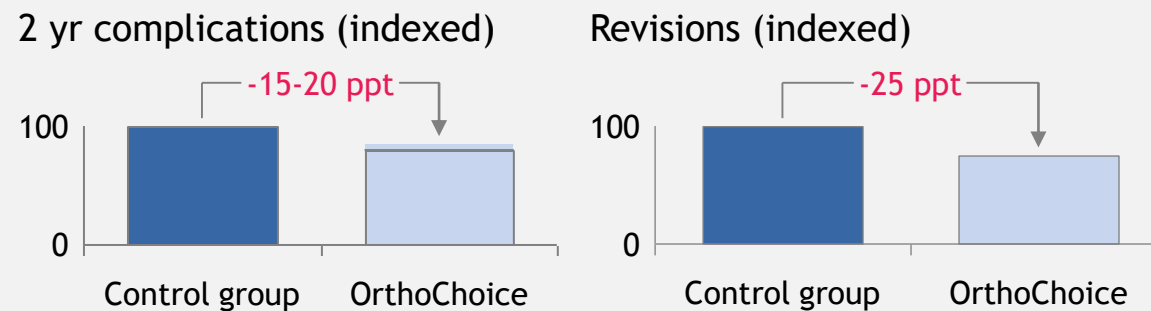
Value-based pricing of drugs since 2002; rollout of bundled payments



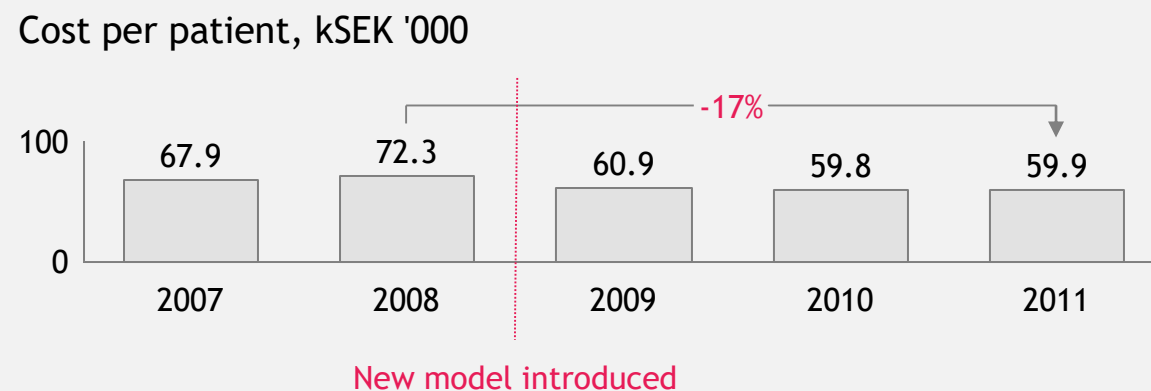
Surgeries shifted toward specialty hospitals

Improved outcomes and lower costs for hip and knee surgeries

Outcomes



Cost



Note: Unpublished data

1. Control group: Patients enrolled in SLL standard payment scheme. All groups matched and controlled for age, multiple socio-economic factors and co-morbidity. All data statistically significant. Source: SLL, BCG analysis

Netherlands: Santeon is a cooperative of 7 hospitals



Combined >13% of national hospital care



EUR 2.6B in revenues



26,600 employees



1,580 physicians

Two key elements to Santeon's value-based approach

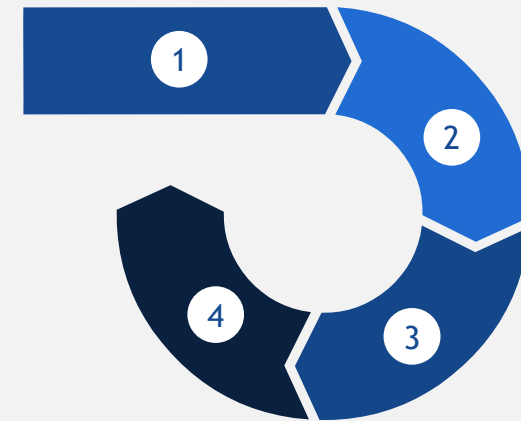
Care for outcomes

Developed condition-specific outcome indicators, starting with lung and prostate cancer

Analytics teams worked with doctors to survey six years of data. Key observations included:

- More expensive tests not always better
- Concentrated care delivery delivered better outcomes
- Predictive tools improved clinician outcomes and patient choice

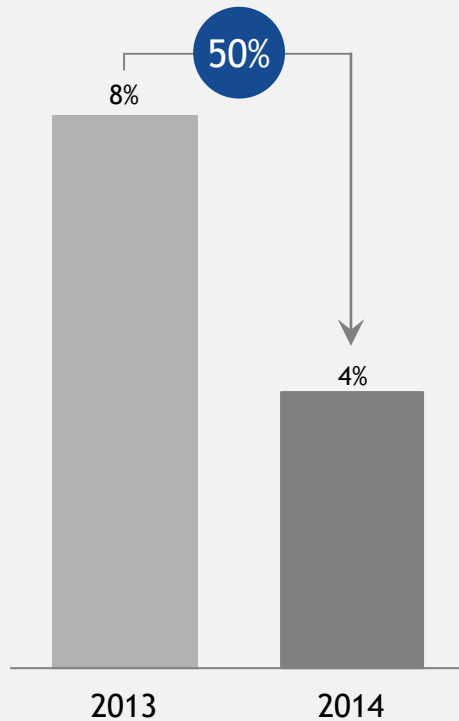
Care for improvement: Continuous improvement cycles



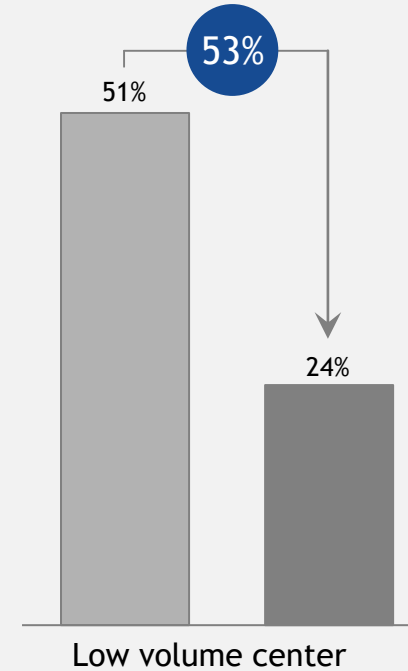
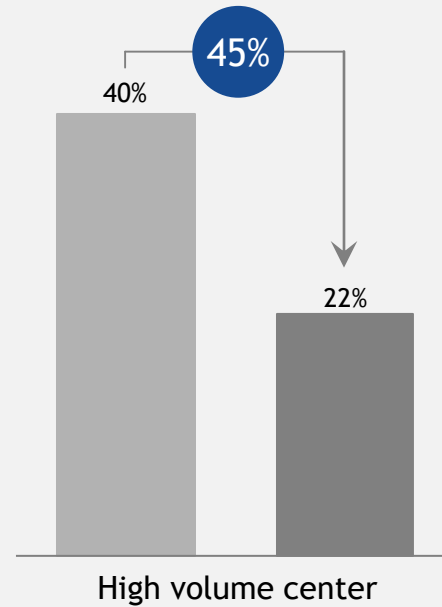
- ① Develop scorecard
- ② Conduct data collection and analysis
- ③ Identify improvement opportunities
- ④ Implement improvement plan

Significant improvements in individual doctor results

Decrease in prostatectomy complications



Decrease in positive surgical margin rate



\$1500 saving per procedure

“One hospital cannot improve quality alone. A single hospital can set up improvement programs but will need to compare its performance with others to understand where it can improve and which procedures deliver the best outcomes...”

Leonique Niessen, Former Santeon Director

Value-based healthcare is a global movement: ICHOM is a global non-profit that defines outcomes standards

Founded in 2012 by Harvard Business School Professor Michael Porter, the Boston Consulting Group, and Karolinka Institutet



International focus with involvement of multiple countries around the world



Open source and peer reviewed standard sets



23 Sets covering 53% of the global disease burden



Endorsed by the OECD to map key disease areas



Independent, non-profit

ICHOM has widespread support of health community

STRATEGIC PARTNERS



PLATINUM



GOLD



SILVER



BRONZE



COFOUNDERS



SUPPORTERS



ICHOM's standard sets developed by global clinical experts and patients

Principles of standard sets

- 1 Outcomes are defined around the medical condition, not the specialty or the procedure
- 2 Patients are directly involved in defining sets
- 3 The standard set is a “minimum set” focused on outcomes that matter most to patients
- 4 A “minimum set” of initial conditions/risk factors is included to facilitate meaningful comparison
- 5 PROMs include functional status, symptom burden and health-related quality of life
- 6 Time points and sources of data collection are clearly defined to ensure comparability of results

Rigorous development process

Diverse teams collaborate in working groups

- Internationally-recognized clinical and registry leaders from top institutions
- Patients with “real-world” experience

Working groups identify a comprehensive set of potential outcomes that matter to patients

- Proposed outcomes are prioritized to minimize capture requirements

Each set developed over ~12 months

Example: Diabetes standard set

2017

April 2018

Outcome domains
& definitions



PROMs



Case-mix domains
& definitions



Standard set
publication and
launch



Literature review of
outcomes, definitions
and risk factors



Patient input to
working groups

Diabetes standard set being developed by global experts

26

Working Group
members led
by 2 co-chairs

19

Countries
represented

5

Patients across
4 continents

>10

Expert profiles
e.g. primary
care, public
health,
biostatistics



International representation in diabetes working group



Massimo Massi-Benedetti

Co-chair

- President and Scientific Director of Hub for International Health research
- Co-director of the WHO Collaborating Centre for Improvement of Diabetes Care
- Former IDF Vice-president



Fabrizio Carinci

Co-chair

- International Expert on Health Information for Policy
- Principal Epidemiologist, National Observatory of Patient Safety
- Adjunct Professor, University of Bologna

Maria Santana—O'Brien Institute for Public Health
 Katherine Barnard—Bournemouth University, University of Southampton, BHR
 Andrew Pumerantz—Western Diabetes Institute, Western University of Health Sciences
 William Polonsky—Behavioral Diabetes Institute, University of California
 Mark Peyrot—Loyola University Maryland
 Anne Peters—USC Clinical Diabetes Program
 Andreas Schmitt—Diabetes Center Mergentheim
 Joao Raposo—APDP, Nova Medical School Lisbon
 Sergio Hernandez-Jimenez—Instituto Nacional de Ciencia Medicas y Nutricion
 Cristina Garcia Ulloa—Instituto Nacional de Ciencia Medicas y Nutricion
 Jean Claude Mbanya—University of Yaounde

Daniel Barthelmes—University of Zurich, University of Sydney
 Jelka Zaletel—National Institute of Public Health Slovenia, University Medical Centre
 Jana Klavs—University Medical Centre Ljubljana
 Massimo Massi-Benedetti—Hub for International Health Research
 Fabrizio Carinci—University of Bologna, AGENAS
 Ronit Calderon-Margalit—The Hebrew University of Jerusalem
 Anil Bhansali—Postgraduate Institute of Medical Education and Research
 Wee Hwee Lin—National University of Singapore
 Naomi Levitt—University of Cape Town
 Soren Eik Skovlund—Aalborg University and Aalborg University Hospital
 Jihan Dennaoui—National Health Insurance Company Daman
 Saf Naqvi—Imperial College London Diabetes Centre, Abu Dhabi

Standard set for T2DM will cover variety of outcomes

Illustrative



Health status

Glycemic control

Micro/macro vascular complications

Patient reported outcome measures (PROMs) assessing psychosocial health

Co-morbidities that influence outcomes e.g. obesity, cardiovascular disease



Short term treatment complications

Hypoglycemia

Hyperosmolar hyperglycemic states



Sustainability of health

Functional level after complications development

Ability to self-manage

Value in Healthcare project takes systemic approach to value-based healthcare (VBHC)

Year 1: Defining the foundation for VBHC systems



Year 2: Mobilizing cooperation for system transformation



Launches today

Year 3: Scaling & accelerating system transformation

Support new and ongoing pilots:

- Atlanta
- Ontario
- Singapore +/- China

Establish value-based health systems network

Convene stakeholders on informatics standardization

Atlanta heart failure pilot: Stakeholders across city improving life for heart failure patients

Atlanta can be a pioneer of health system transformation with a bold vision



To create a continuously improving value-based healthcare system that positions Atlanta as a national leader in heart failure patient survival rate by 2022 while significantly improving quality of life and reducing the average cost per patient



Atlanta pilot has convened ~40 organizations

Providers



Payers



Government



Patient groups



Pharma







Medtech/digital



Academic/foundations



To be the national leader in heart failure survival requires transformative solutions

 Informatics	Implement a standard set of heart failure outcomes measures including selected PROMs
 Benchmarking, research & tools	The Georgia Health Information Network (GaHIN) will benchmark heart failure outcomes
 Payments	Shift reimbursement towards bundles or capitation tied to outcomes
 Delivery organization	Atlanta Regional Commission will establish a catalog of evidence-based interventions
Core intervention example	Evaluate Coleman Care Transition Intervention ¹ for care in-home after discharge

Note: PROMs = patient-reported outcomes measures

1. Coleman Care Transition Intervention involves home visit from a Coach within 3 days of discharge focused on: a) Medication reconciliation/review b) Symptom management/red flags c) Scheduling follow-up visit with primary care physical d) use of personal health record to document medications and issues to discuss with physician, phone follow-up over next 30 days

In Canada, diabetes is a large burden for health systems

Outcomes



Canada is in **bottom 1/3 of OECD countries** for age-adjusted diabetes prevalence



3.5 million people estimated to have diabetes in Canada, with prevalence expected to increase ~40% by 2025



Canadians with Type 2 diabetes (T2DM) are **~3x more likely to be hospitalized for CVD¹**, and **face a reduced life expectancy of 5 to 15 years**



>2-fold variation exists in compliance to guidelines for T2DM across Canada (e.g. % of people receiving all 4 recommended screening tests)

Costs



~\$3 billion direct healthcare costs for diabetes each year

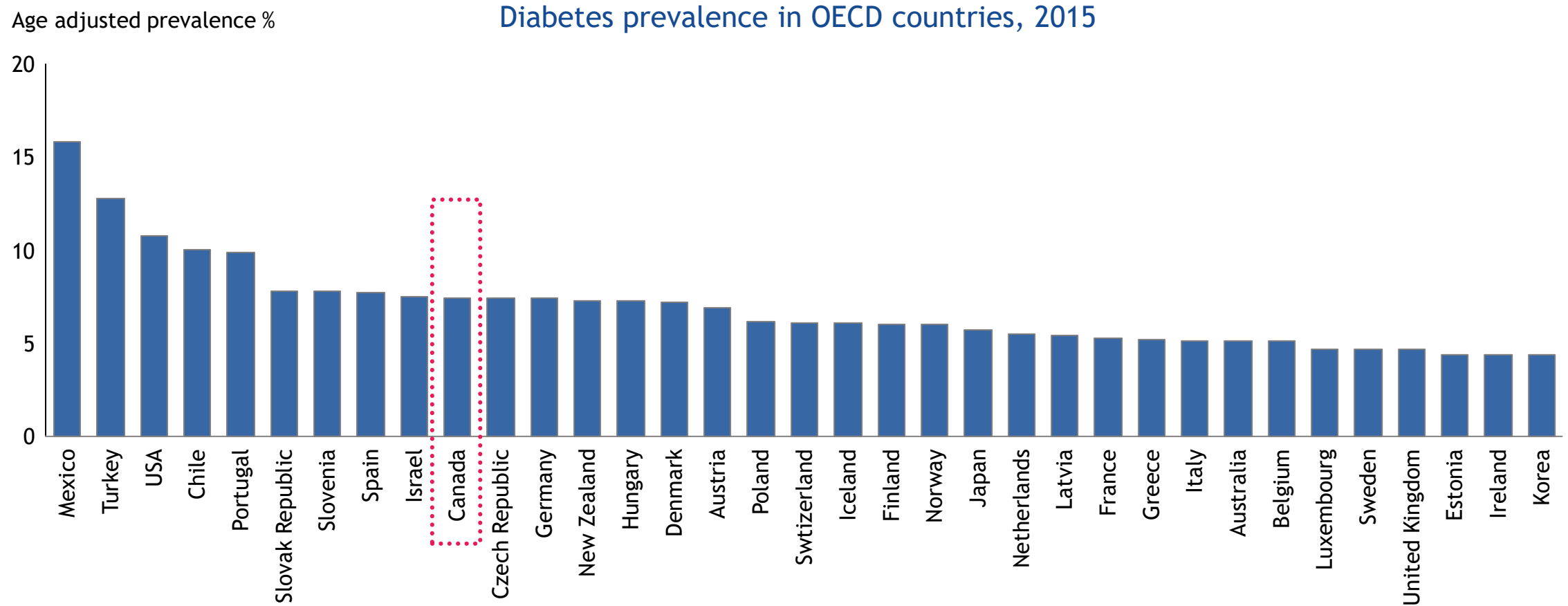


~\$9.2 billion indirect costs² from lost productivity and early mortality

1. CVD: cardiovascular disease; 2. Both the methodologies for measuring indirect costs and reported results themselves vary greatly between publications. Figures in this presentation are from the Canadian Diabetes Cost Model due to its widespread usage and the variable evidence quality in other studies.

Source: Canadian Diabetes Association - Report on Diabetes (2015); OECD (2017) Update on Diabetes; Canadian Diabetes Association - Diabetes: Canada at the Tipping Point (2011)

Canada is in the bottom 1/3 of the OECD for diabetes prevalence



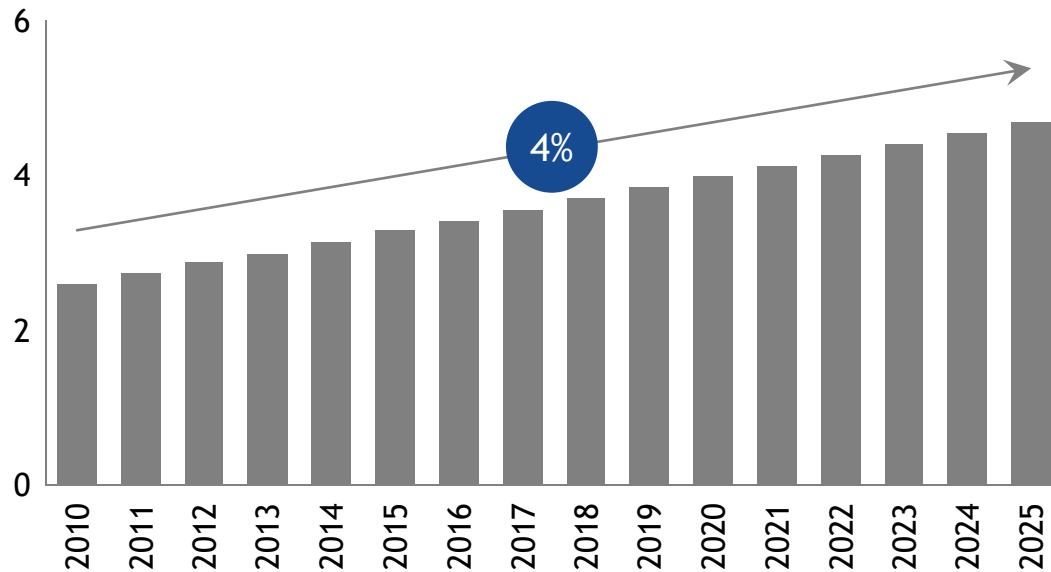
Note: age-adjusted comparative estimates are generated to compare countries with different population age structures. These are calculated by applying the country's age-specific diabetes prevalence estimates to each age-group and standardizing the country's population age structure to the average global age structure.

Source: Diabetes Atlas: Seventh Edition, International Diabetes Federation (2015), Brussels, www.idf.org/diabetesatlas/previouseditions.

Diabetes prevalence and healthcare expenditure will continue to rise

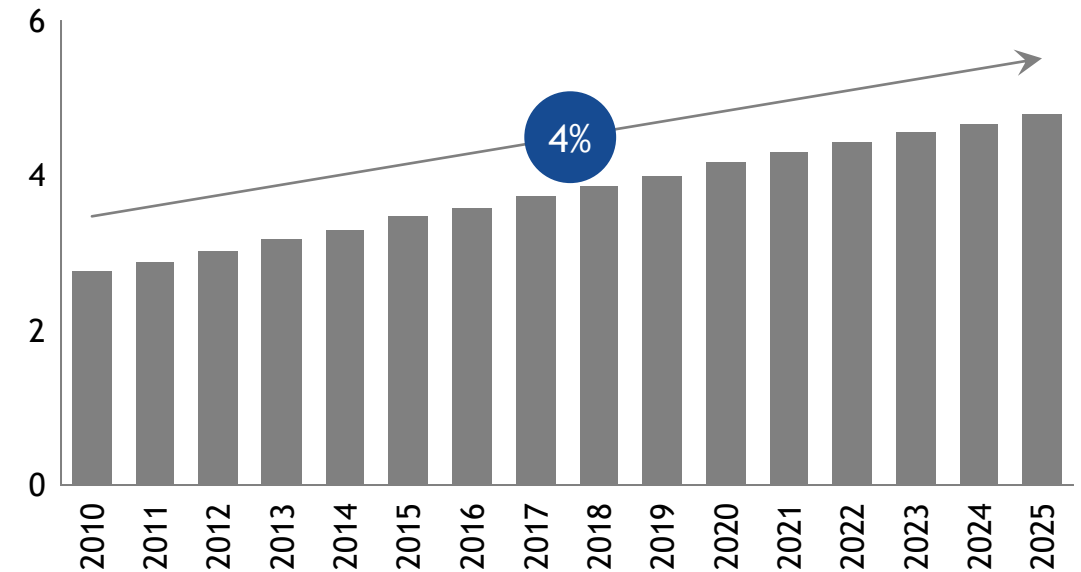
Diabetes prevalence in Canada 2010-2025

Number of prevalent cases (M)



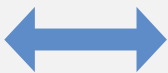




Direct health costs of diabetes in Canada 2010-2025

Direct health costs (\$B)



In Ontario, diabetes is also a significant challenge

Outcomes		1 in 10 adult deaths in Ontario related to T2DM complications
		4.6 million people or 30% of population classified diabetic or pre-diabetic in Ontario in 2016, expected to increase to 5.9 million by 2026
		Only 34% of Ontarian T2DM patients received all four recommended screening tests, lower than the national average
Costs		\$1.5 billion in direct health costs
		\$3.8 billion in indirect costs ¹ from lost productivity and early mortality

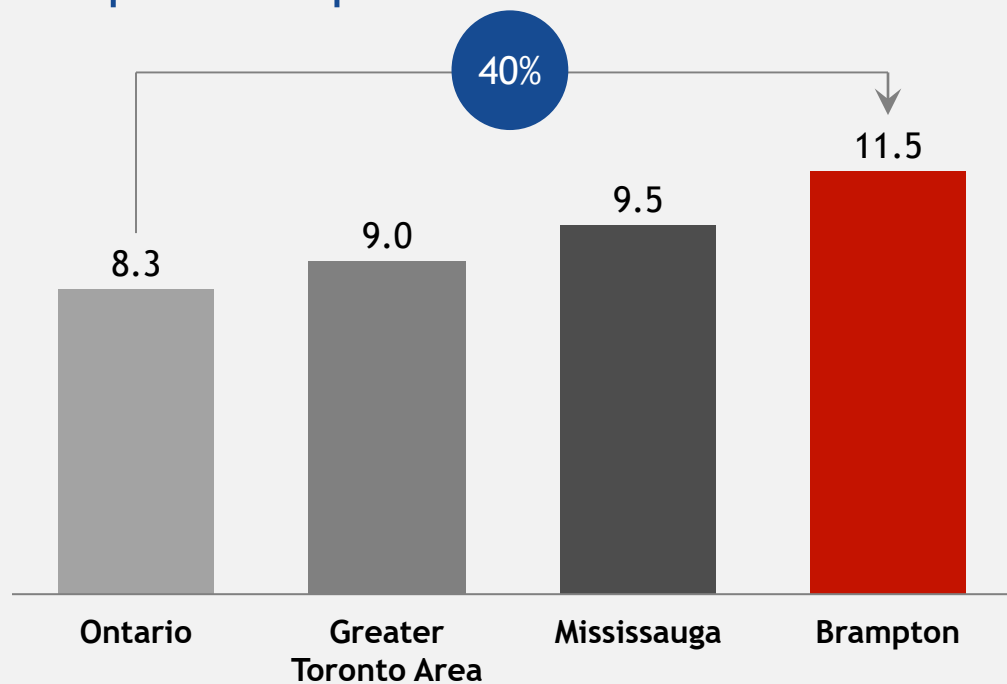
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Source: Canadian Diabetes Association - 2015 Report on Diabetes; The Cost of Diabetes in Ontario, Canadian Diabetes Association; Public Health Agency of Canada. (2011).

Diabetes in Canada: Facts and figures from a public health perspective; Canadian Institute for Health Information. (2013). Compromised wounds in Canada; Ontario Ministry of Finance: Ontario Fact Sheet 2017.

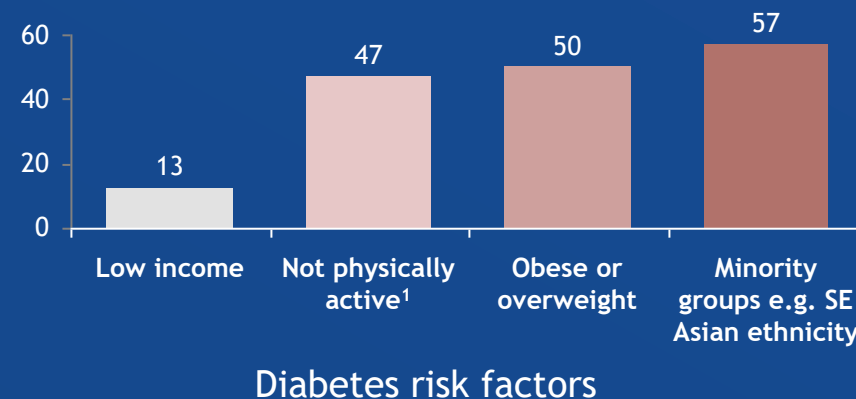
Within Ontario, diabetes prevalence varies

In 2013, ~40% higher diabetes prevalence in Brampton compared to rest of Ontario



Brampton population has significant diabetes risk factors

Percentage of Brampton residents



1. Compared to Ontario benchmarks for adult activity

Source: Peel Public Health - Diabetes Atlas for the Region of Peel 2013; Peel Data Centre - Income Earnings & Housing Bulletin 2011; Canadian Diabetes Association - 2016 Report on Diabetes in Ontario

T2DM complications compound its disease burden



Retinopathy risk

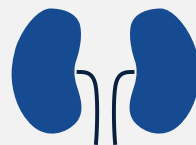
Diabetic retinopathy leading cause of blindness in Canada

500,000 Canadians affected



Cardiovascular disease

11,000 diabetes-related heart attack admissions to Ontario hospitals every year



Nephropathy

T2DM is primary cause of end-stage renal disease in Canada

~9000 new cases in Ontario yearly



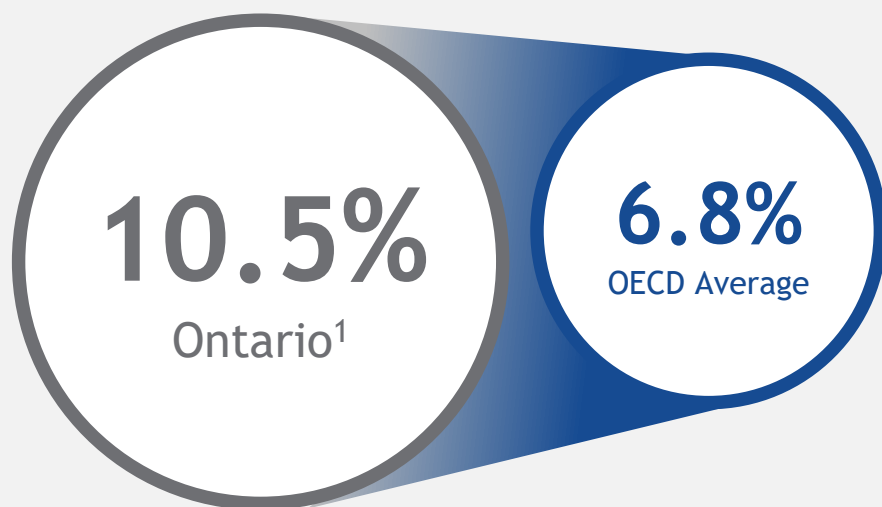
Lower limb injury

>33% of lower limb amputations in Canada due to diabetic foot wounds and chronic ulcers

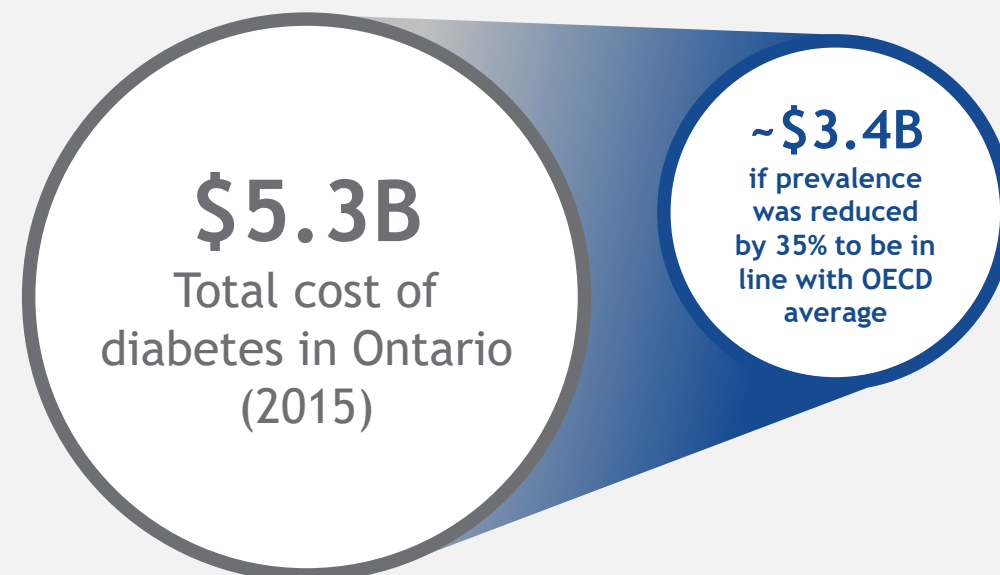
~2000 diabetic amputations in Canada every year

Significant positive societal impact possible

If Ontario at OECD average, diabetes prevalence would reduce 550K...



...resulting in ~\$1.9B in direct and indirect cost savings per year



1. Ontario prevalence is not adjusted for age. Last known age adjusted prevalence was 8.8% in 2005, published in the Lancet. See 'Trends in diabetes prevalence, incidence, and mortality in Ontario, Canada 1995-2005: a population-based study'.
Source: The Cost of Diabetes in Ontario, Canadian Institute for Health Information (2013); Diabetes Atlas: Seventh Edition, International Diabetes Federation (2015), Brussels, www.idf.org/diabetesatlas/previouseditions.

Enablers key to improve outcomes, reduce costs

From the status quo...



Siloed patient data locked in EMRs



Hospital benchmarking based mostly on process metrics; disconnected pilots and proof of concept studies



Predominant fee-for-service model with some experimentation with bundled payments



Stakeholders optimizing their role in the value chain

Note: EMR= electronic medical record

Sources: World Economic Forum Report: Value in Healthcare: Laying the Foundation for Health System Transformation, expert interviews, BCG analysis

To a bold vision...

Integrated person-centered health informatics, while still protecting integrity of patient data

Continuous improvement based on outcomes benchmarking: updated clinical guidelines and decision-support tools reflecting best practices

Payments models that incentivize transparent and improved outcomes, optimized by patient group

Integrated care that incentivizes cooperation between clinical care providers

Ontario Pilot Vision Statement

"To create a continuously improving value-based healthcare system that reduces the prevalence and rate of complications of Type 2 diabetes by 2021 while significantly improving quality of life and reducing average cost per patient"

Focus on four Local Health Integration Networks

- Toronto Central
- Mississauga Halton
- Central West
- North West

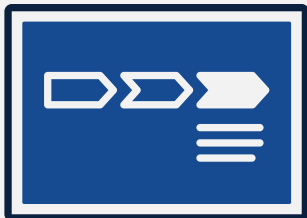


Pilot will comprise two phases

Design and Roadmap Phase

Build consensus on priorities and develop customized roadmap towards a value-based health system for T2DM patients

Requires approximately 6 months



Implementation Phase

Implement short and long term initiatives in order to improve health outcomes and lower costs

3-year time horizon



Diverse roles and responsibilities



Steering Committee

Central decision making body

Review and refine working group recommendations

Champion VBHC

4 in-person workshops



Working Group

Provide local subject matter expertise

Drive content development

Ensure roadmaps are pragmatic and tailored to each stakeholder

1-2 hours per week



THE BOSTON CONSULTING GROUP

WEF/BCG core team

Manage overall process

Provide thought leadership and research support

Share best practices across pilot initiatives

Full-time support

Multi-sectoral approach is key

Government



Toronto Central
Mississauga Halton
Central West
North West

Providers



St. Michael's



Meno Ya Win
HEALTH CENTRE

Patient advocacy groups



Academia / research



Private sector

Medtronic



omada



SANOFI



MEDELLA HEALTH

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For discussion: What is the VBHC system maturity for T2DM patients?

Small group discussion



30 min

Break into 4 groups based on each of the enablers of the ViHC framework

- Groups have been assigned
- Discuss key questions & align on the current state of play in Ontario



Group readout



15min

We will then discuss each enabler as a group

- One person per group will share findings with focus on 3-4 key messages

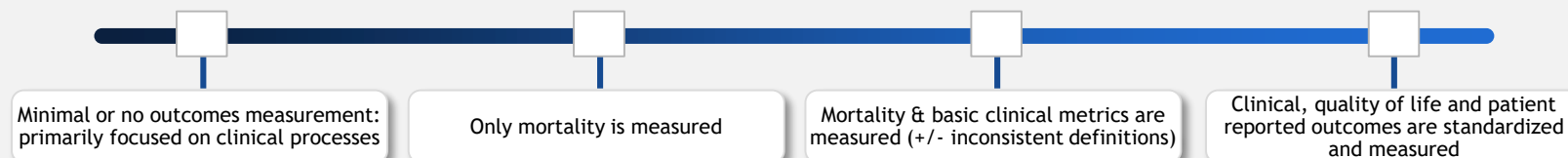


At this time you can break into your sub-groups

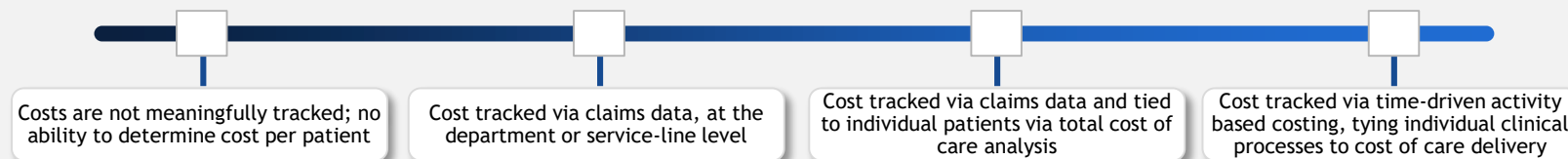
Informatics	Benchmarking, research, and tools	Payments	Delivery organization
Jonathan Lim Project Leader, BCG	Mathieu Lamiaux Senior Partner and Managing Director, BCG	Vanessa Candeias Head, Global Health & Healthcare, WEF	Andrew Smith Consultant, BCG
Baiju Shah Researcher, Sunnybrook Research Institute	Bruce Perkins Director of Research, Sinai Centre for Diabetes	Alexis Wise Health Advisor, MaRS Discovery District	Anne-Sophie Viard Federal Affairs Manager, Novo Nordisk
Brian Hilberdink President, Novo Nordisk Canada	Eva Baginksa Associate Director, Becton Dickinson	Asger Jacobson Head, Market Access & Public Affairs, Novo Nordisk	Bryna Rabishaw Vice President, Sinai Health Systems
Catharine Whiteside Executive Director, Diabetes Action Canada	Michael Glogauer Researcher, University of Toronto	Cynthia Castro Sweet Director Medical Affairs, Omada Health	Jason Vanderheyden Director, Market Access & Gvt Affairs, Medtronic
Dean Osmond Sioux Lookout Meno Ya Win Health Centre	Jocelyn Charles Physician Advisor, Toronto Central LHIN	Gabriel Seidman Consultant, BCG	Jonathon Cini Community Lead, N. America, WEF
Fredrika Scarth Director and HQO Liaison, MOHLTC	Joshua Tepper President & CEO, Health Quality Ontario	Geneviève Lavertu Senior Director, Medtronic	Jonathan Fetros Director, Diabetes Care Program, St Michael's
Gillian Booth Endocrinologist, St Michael's	Laura Kokocinski CEO, NW Ontario LHIN	Gerard Meuchner VP, Henry Schein	Kevin Davidson Health System Specialist, Central West LHIN
Harry Ghandi Founder & CEO, Medella Health	Liane Fernandes VP Regional Programs, Miss. Halton LHIN	Jane Yao University of Toronto School of Public Health	Lori Sutton Diabetes Outreach Facilitator, Toronto Central LHIN
Lillian Mortensen VP, Becton Dickinson	Lucia Vanta University of Toronto School of Public Health	Megan Skinner Clinical Education Specialist, Becton Dickinson	Martin Bohl Economic Development Manager, Brampton
Matthew Morgan VP Clinical, Toronto Central LHIN	Malcolm Moffat Executive VP Programs, Sunnybrook Hospital	Nicole Nitti Primary Care, Toronto Central LHIN	Martine Carbonneau Associate Director, NovoNordisk
Melissa Farrell Assistant Deputy Minister, MOHLTC	Neil Fraser President, Medtronic Canada	Nida Shahid University of Toronto School of Public Health	Priya Narula Physician Assistant, LMC
Naheed Jivraj University of Toronto School of Public Health	Robyn Tamblyn Scientific Director, CIHR	Susan Swartzack Director, Clinical Program, Miss. Halton LHIN	Rhonda Cockerill University of Toronto School of Public Health
Thiv Paramsothy University of Toronto School of Public Health	Ronald Heslegrave Chief of Research, William Osler Health	Ruth Pichora Director of VBHC and Reimbursement, Medtronic	Seema Negpal Senior Leader Public Policy, Diabetes Canada
Zayna Khayat Future Strategist, St Elizabeth	Russell Williams VP Gvt Relations & Public Policy, Diabetes Canada	William Charnetski Chief Health Innovation Strategist, Gvt of Ontario	Tony Jin University of Toronto School of Public Health

For T2DM patients in Ontario, what is the current maturity of health informatics?

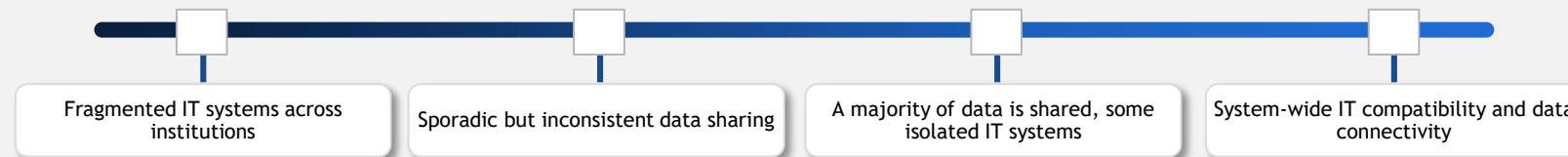
To what extent are outcomes measured in Ontario across the full patient cycle of care?



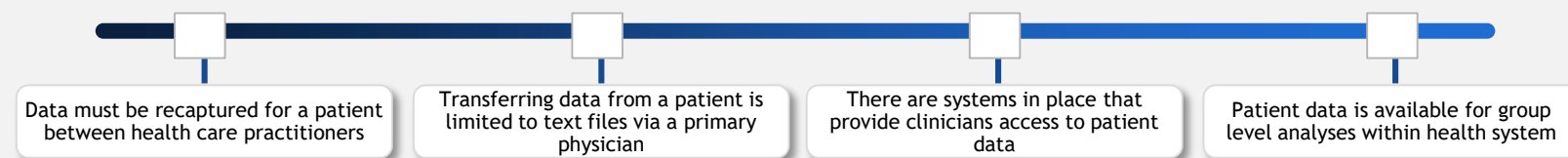
How extensively are costs per patient measured?



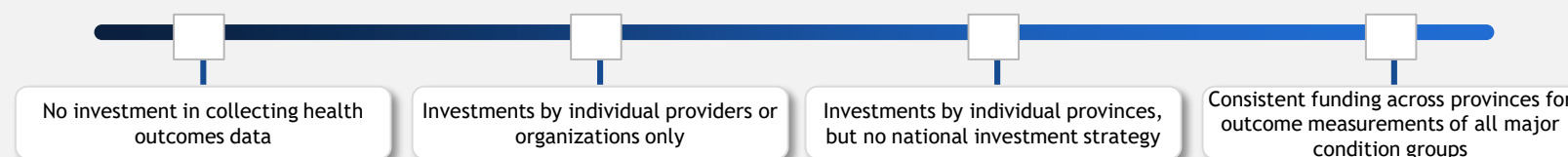
To what extent does interoperability / data sharing exist between IT systems?



What privacy policies are in place that ensure data security while enabling interoperability?



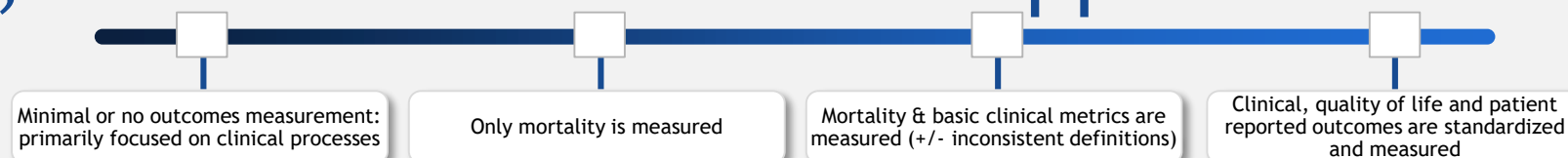
Do the provincial/national governments invest adequately in collecting and using health outcomes data?



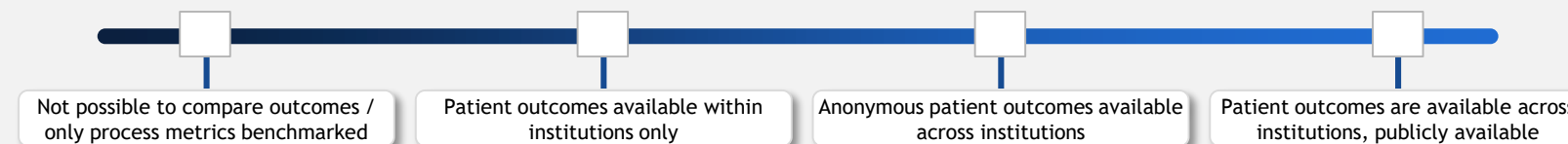


For T2DM patients in Ontario, what is current maturity of benchmarking, research and decision support?

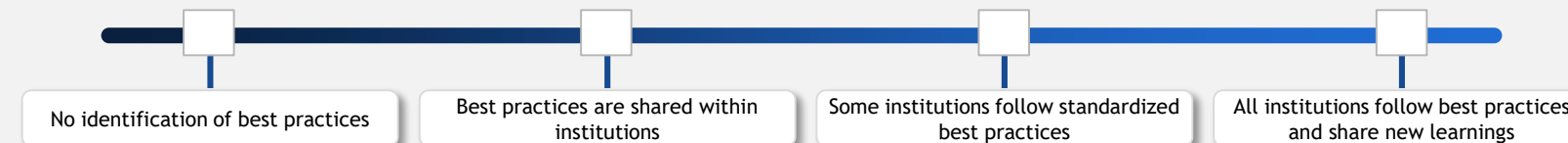
To what extent are outcomes measured in Ontario across the full patient cycle of care?



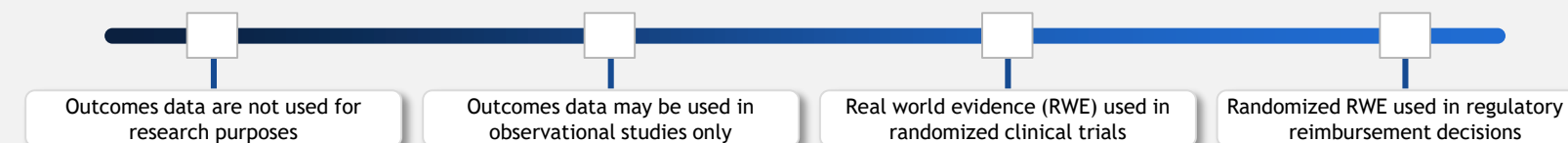
To what extent is outcomes benchmarking established amongst stakeholders?



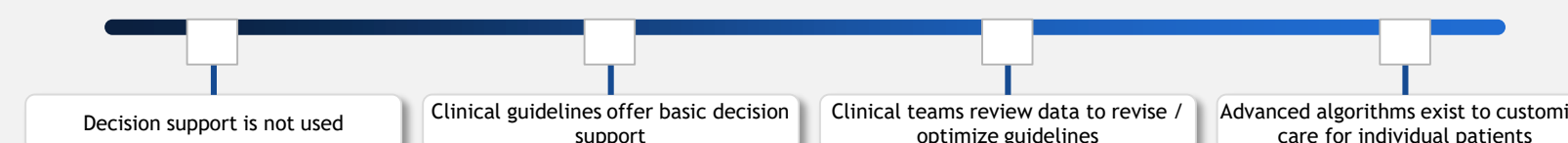
Are best practices identified and shared?



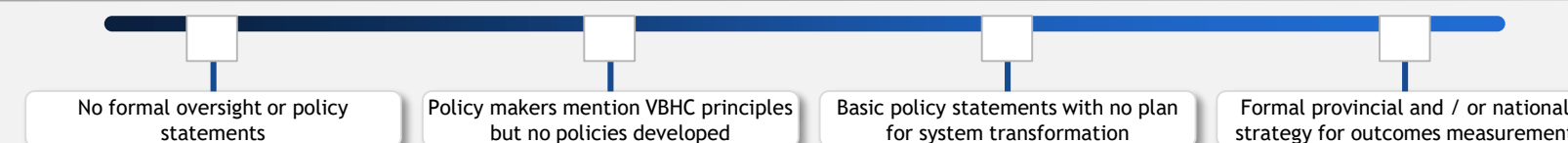
How are outcomes data used to inform research?



How often are decision support tools used in clinical practice?

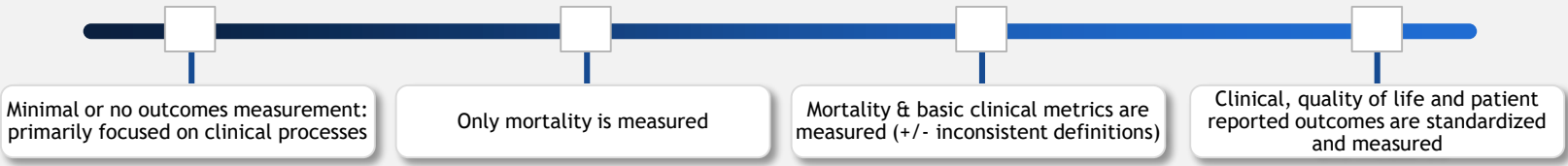


Are there specific policies in place to support outcome measurement and transparency?

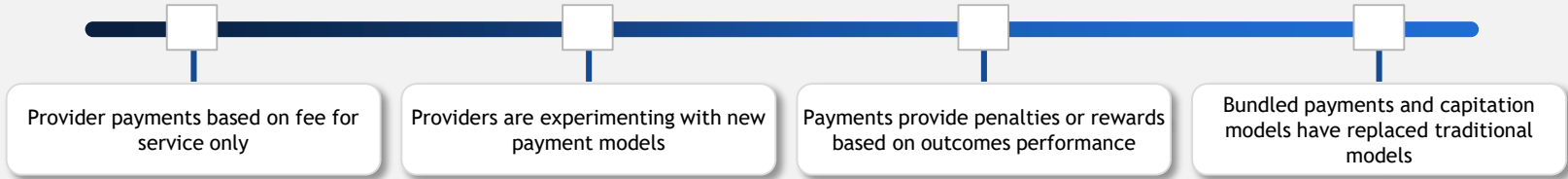


For T2DM patients in Ontario, are payment models linked to value?

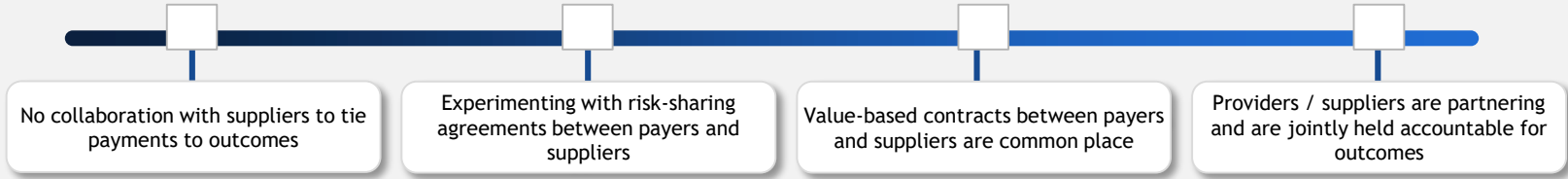
To what extent are outcomes measured in Ontario across the full patient cycle of care?



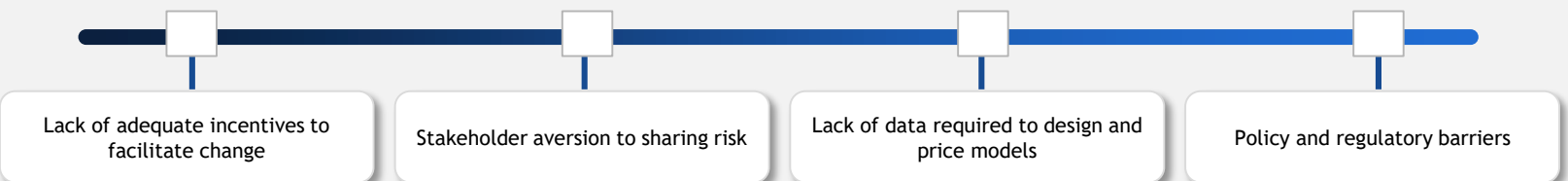
Are provider payments based on outcomes?



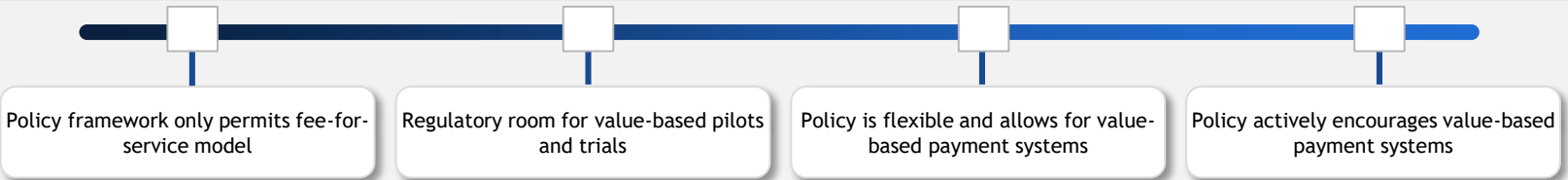
Are supplier (e.g. pharma, medtech) payments based on outcomes?



What are the barriers to moving towards value based payments in Ontario?

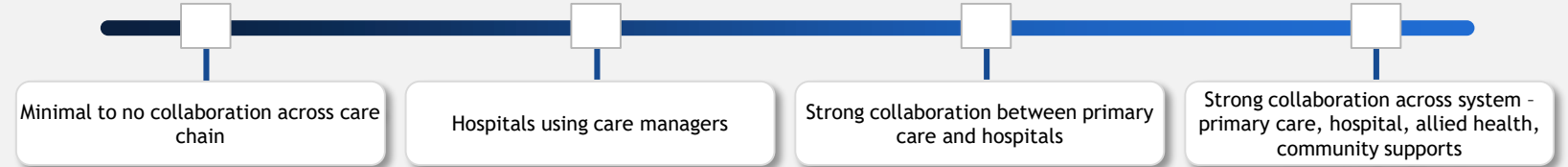


Does public policy enable value-based payment models?

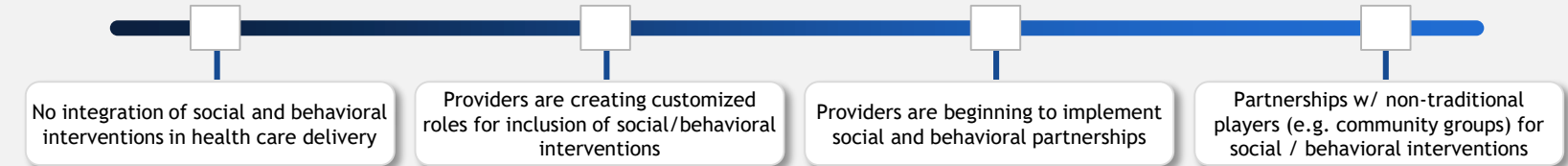


For T2DM patients in Ontario, how do delivery organizations optimize outcomes?

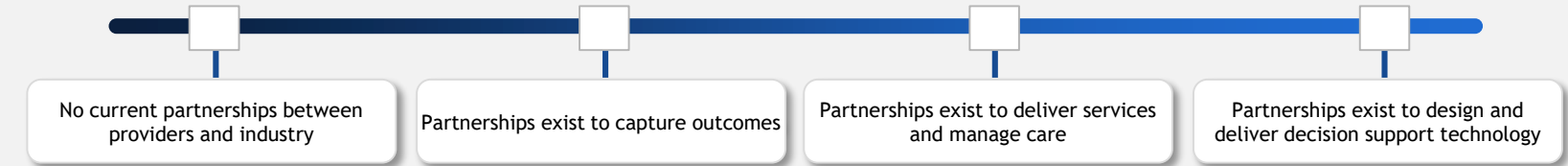
How much provider collaboration exists across the care chain for diabetes patients?



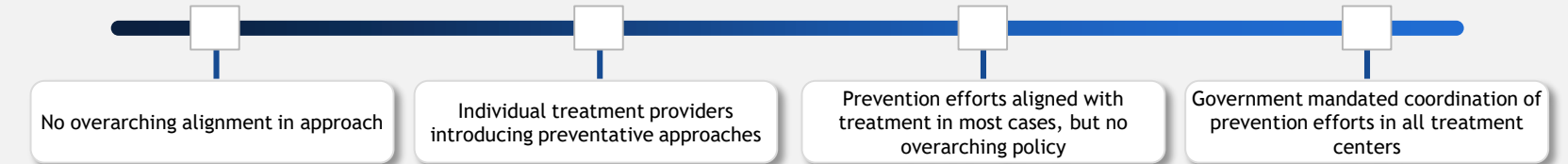
To what extent are social and behavioral interventions included in care delivery?



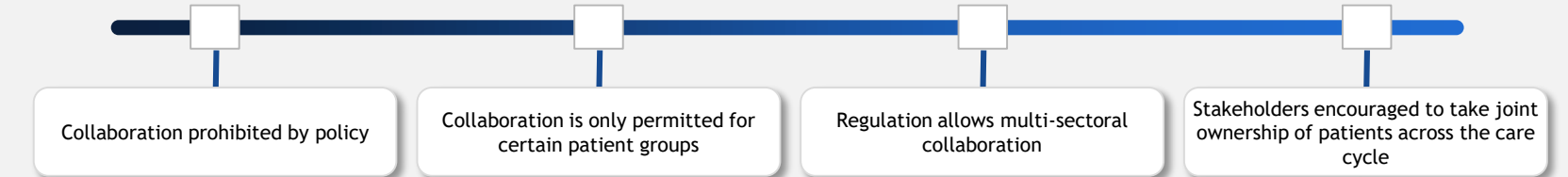
To what extent do partnerships exist with pharma, medtech, and digital health partners to go "beyond the pill or device"?



How is prevention and treatment coordinated in the health system?



Do policies promote multi-sectoral collaboration to advance value?



Agenda

Topic	Presenter	Time
Welcome address	Joshua Tepper, President and CEO, Health Quality Ontario	9.00 - 9.10am
The patient's perspective	Charlene Lavergne	9.10 - 9.20am
Introduction to the World Economic Forum	Vanessa Candeias, Head of Global Health and Healthcare System Initiative	9.20 - 9.30am
Value-based healthcare and pilot approach	Mathieu Lamiaux, Senior Partner and Managing Director, BCG	9.30 - 9.55am
Opportunity for Q & A		9.55 - 10.05am
Building off current successes		
<ul style="list-style-type: none"> Informatics: Diabetes Action Canada Informatics: ICES Informatics: LMC Registry 	Prof. Catharine Whiteside, Executive Director A/Prof. Baiju Shah, Scientist and Endocrinologist Priya Narula, Endocrine Physician Assistant	10.05 - 10.30am
Break		10.30 - 10.45am
Building off current successes		
<ul style="list-style-type: none"> Benchmarking: HQO Payments: Ontario MOHLTC Delivery organization: Diabetes Canada 	Dr. Joshua Tepper, President and CEO Fredrika Scarth, Director, HQO Liaison & Program Development Russell Williams, Vice President, Government Relations and Public Policy	10.45 - 11.10am
Value-based healthcare diagnostic		11.10 - 11.55am
Wrap-up	Jonathan Lim, Project Leader, BCG	11.55 - 12.00pm

The path to "Diagnosis" Steerco...

Working group actions

Next Steerco

Complete formal maturity assessment

Document best practices

Identify barriers

Diagnosis readout

Perform deep dive on maturity assessment for 4 key enablers

Identify areas of strengths and areas for development in Ontario



Find local case studies highlighting best practices on each enabler

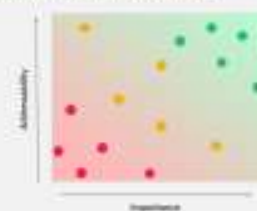
Discover key learnings to apply in pilot



Uncover barriers likely to be faced in implementation

Find gap between norms in Ontario and best In class

Prioritization unearthed key barriers in Ontario based on addressability and importance



Present key areas of strength and development

Share case studies on best practices

Align on key barriers



Introducing day-to-day team members



Emmanuel Akpakwu

Practice Lead, Value in Health Care,
World Economic Forum

M.Eng Computer Science (Artificial
Intelligence), M.Sc Finance,
MBA/M.Phil in Technology Policy

6 years in Healthcare Investment
Banking at J.P. Morgan

Associate Director, Corporate Strategy
at Merck Pharmaceuticals



Dr. Gabriel Seidman

The Boston Consulting Group, NYC

Doctorate of Public Health from
Harvard School of Public Health with
focus on global health systems

Case experience in global health,
international development, and
biopharma

Published multiple articles in peer-
reviewed journals



Dr. Andrew Smith

The Boston Consulting Group, Toronto

PhD in Molecular Genetics, MBA, BSc in
Molecular Genetics and Biology (Hons)

Case experience in biopharma, market
access, R&D

Previously worked as a researcher,
publishing articles in Genome
Research, Nature Chemical Biology,
and Nature Biotechnology

Immediate next steps



Poll to be sent to Working Group to agree times for weekly calls



Weekly offline contributions to be sent out this PM, due Friday 23 Feb. 12 noon



First Working Group call during week of 26 February



Following 3 SteerCo dates to be confirmed within next week

