The Value Agenda for the Netherlands

A Call for Action to accelerate Value-Based Health Care implementation in the Netherlands
The authors would like to thank Harvard University Prof Michael Porter, PhD and his team for their valuable input. Responsibility for the document rests with Prof Dr Fred van Eenennaam (The Decision Group) and his team. This report is intended to generate, discuss and take action on bringing Value-Based Health Care to the next level in the Netherlands.

If you have additions or remarks on this report, please share these with us by sending an email to: v.wiersma@thedecisiongroup.nl

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There is a commitment to move towards VBHC among health care providers in the Netherlands. A number of excellent initiatives promoting VBHC have already been developed. The next challenge is to implement these practices on a large scale.

To accelerate large-scale VBHC implementation in the Netherlands, The Decision Group, Amgen and Medtronic organized a ‘Call for Action’ working session with Professor Porter. The key hurdles of VBHC implementation were identified by twenty-five decision makers in health care. The inspiring working session with Professor Porter resulted in a Value Agenda with six key calls for action to accelerate VBHC implementation in the Netherlands.

**Call for action I: Build VBHC leadership to change the culture towards appreciation of value**

Health care professionals are often reluctant to adjust their working practices. An important driver for change should be the acknowledgement that working in an integrated care setting is more rewarding. Many physicians are worried that reporting outcomes makes them look bad. However, the opposite effect is expected. To stimulate outcome measurement, Professor Porter stresses that a lack of reporting should be penalized, not bad outcomes.

**Call for action II: Continue building IPUs across institutions with medical leaders as the dominant driving force and managers as enablers**

The new center of leadership should revolve around IPU teams, instead of siloed departments. To achieve this, clinicians should be made enthusiastic about how they can achieve superior value by IPUs for patients with breast cancer, diabetes, et cetera. In this process, it is necessary to break down the barriers between primary, secondary, and post-acute care and to get the patient involved.

**Call for action III: Let the Dutch government enforce the use of outcome measures like ICHOM’s minimum international set, since no stakeholder coalition seems to be able to take the lead**

Almost every country faces the problem that there is no owner for standardization of benchmarking outcome data. Health care institutions can decide to adopt these standards on their own. However, the path of least resistance would be if the Dutch government were to adopt the ICHOM-standards as a minimum required set, since no stakeholder coalition seems to be able to take the lead.
Call for action IV: Move quickly to bundled payments for all care, away from the current mix of Fee For Service/DOT and capitation based payments, to break wrong incentives
Shifting from fee-for-service reimbursement to bundled payment creates a strong incentive for departments to start working together in IPUs. In bundled payment contracts, risk sharing, shared savings, reasonable profit margins, relevant data sharing, and value-based involvement of patients and other parties should all be addressed.

Call for action V: Engage patients to choose care providers based on quality
Patients are not used to choosing a health care provider based on outcomes. They should be encouraged and supported in their choice for medical teams and treatment plans. A clear statement of what IPUs are good at is needed, as well as initiatives enforcing the need to consult with the right team of physicians and a strong focus on joint medical decision making. Professor Porter points out that an IPU might be more convenient for patients, even at a greater distance. After all, in an IPU the care path is shaped as one seamless process, while in a situation with specialty departments patients have to go back multiple times for diagnostic tests and treatment.

Call for action VI: Build IPUs to better cater for patients with multi-morbidity
The IPU-model approaches a medical condition and the care delivered in its entirety. Specialists for common co-occurrences will be on the team. Other specialists may be called in when necessary; per specialty, this should always be the same physician as this allows him to build up experience with this particular co-morbidity. When a patient needs treatment at two IPUs, the two health care teams’ specialists overseeing this patient need to interact and coordinate. However, this situation is to be preferred over the current practice, in which maybe a dozen unconnected clinician are involved almost randomly.
Value-Based Health Care is on the Rise

“The Netherlands could become a leader in the field of Value-Based Health Care”, states Harvard Professor Michael Porter.

We have come a long way since the introduction of the Value-Based Health Care (VBHC) concept in 2006. During the last ten years, VBHC has provided fundamental insights into creating excellent patient value. Patient value is becoming a major topic in healthcare. This is reflected in the many initiatives which have begun focusing their care around patients and their medical conditions.

Now, a decade after the introduction of VBHC, the Netherlands could be a leader in this field. And even though we are making good progress in improving patient value, we need to step up now. The question is: how can we scale-up VBHC implementation, and why is now the time to do this?

2006: Redefining health care

In 2006, Harvard’s Professor Michael Porter and Professor Elizabeth Teisberg first introduced the concept of Value-Based Health Care (VBHC) in their book Redefining Healthcare. In VBHC, the focus is on patient value. Patient value is defined by the equation whereby health outcomes achieved are the numerator, and costs per patient in delivering those outcomes are the denominator. Since the book was published, many organizations have adopted (components of) the VBHC concept.

One of the earliest and most inspiring examples of improving measurable health outcomes is the Martini Klinik in Germany. Since the founding of the clinic in 2005, the Martini Klinik has focused on improving long-term health outcomes for patients with prostate cancer. The Martini Klinik massively improved their health outcomes of patients by measuring patient relevant outcomes. The superior outcomes in turn led to growth in volume, and the Martini Klinik became the world’s largest prostate cancer care clinic by 2013. It later received the VBHC European Inspiration Award 2016.

2010: Value in health care

In 2010, Professor Porter described VBHC in his well-known article in the New England Journal of Medicine (Porter, M.E. 2010). Since then, the concept has and is being developed internationally. The ideas have proven their worth in renowned centers worldwide, including the Cleveland Clinic, UCLA Medical Center, MD Anderson Cancer Center, Children’s Hospital of Philadelphia and the Schön Klinik.
Value-Based Health Care Prize

In 2014, the Value-Based Health Care Prize was handed out at the VBHC Prize Event for the first time. Throughout four editions of the VBHC Prize, several trends in VBHC have emerged, which are illustrated in figure 1 (see appendix 2 for all the VBHC Prize nominees 2017).

![Figure 1: Trends in VBHC seen through four editions of the VBHC Prize](image)

**2014: Measuring outcomes**

Patient relevant outcome measures are key in defining patient value. Therefore, the transparent reporting of patient relevant outcome measures for specific medical conditions is essential in implementing VBHC.

*Meetbaar Beter is an example of an initiative that is strong on transparent reporting of outcomes. Meetbaar Beter reports and uses patient relevant outcome measures to improve quality and transparency of care for Dutch patients with heart diseases. The project started as the initiative of two hospitals, and by now fourteen renowned heart centers are involved, including academic medical centers. Meetbaar Beter is the winner of the VBHC Prize 2014. According to the jury, Meetbaar Beter has greatly implemented outcome measurement in a standardized format, with an outstanding collaboration between multiple hospitals.*

**2015: Network approach**

To integrate all current medical, paramedical and other specialties around the patient, Integrated Practice Unit are essential and need to be build.

*ParkinsonNet is an example of a networked IPU. In ParkinsonNet, over 2,700 medical and allied health professionals collaborate. The IPU includes neurologists, nurses, physiotherapists, occupational therapists, patients and hospital leaders.*
Value-Based Health Care is on the Rise

2016: Value-based contracts and bundled payments

With a growing number of VBHC initiatives, there is also a growing need for innovative forms of value-based contracts. In the Netherlands, the services provided are being paid, which actually means that volume is rewarded instead of quality or efficiency. The transition from reimbursement based on volume to value in health care is challenging but widespread.

*The Catharina Hospital in Eindhoven and the healthcare insurance company CZ managed to establish an innovative way of contracting. They developed the first model for value-based healthcare purchasing based solely on patient relevant outcomes.*

2017: Institutional transformation

Institutional transformation towards an organization in line with the VBHC model is happening increasingly often. Essential to this transformation are IPUs: creating better interconnections between specialties and medical team to encourage collaboration and transformation on institutional level.

*Diabeter is a clinic network that specializes in care for patients with type-1 diabetes. In contrast to hospital delivered diabetes care, Diabeter is organized as an IPU. A multidisciplinary, interdependent team focusing solely on diabetes care and taking joint responsibility for the full cycle of care. Diabeter was the winner of the VBHC Prize 2017 for their thorough VBHC implementation approach that is easily scalable.*

2018: The next phase of VBHC implementation

A growing number of excellent initiatives have started focusing on patient value and adopting the VBHC methodology. As we move to the next phase in VBHC implementation, we must consider the challenges ahead. One of the biggest challenges is the large-scale implementation of VBHC in the Netherlands.

Given these developments, the need and the possibility to scale up now, The Decision Group, Amgen and Medtronic organized a working session with Professor Porter to accelerate large-scale VBHC implementation in the Netherlands.
During a Working Session held in Nijkerk on May 11, 2017, Professor Porter and 25 key decision makers in health care discussed the key challenges for large-scale implementation of VBHC in the Netherlands.

The working session was organized as a call for action and had one primary goal: to accelerate VBHC implementation in the Netherlands. The result of this working session is a Value Agenda with six key actions to collaboratively accelerate VBHC implementation in the Netherlands and to improve value for patients.

The Value Agenda

Prior to the ‘call for action’ working session, attendees and other health care leaders identified sixty-one challenges encountered by physicians, hospital management, health insurance companies, and government officials when it comes to large-scale VBHC implementation in the Netherlands (see appendix 1 for the list of all sixty-one challenges for VBHC implementation).

These sixty-one challenges were categorized based on the six components of Professor Porter’s Value Agenda. A seventh component, considered vital to VBHC implementation in the Netherlands, was added to the Value Agenda based on the input of the attendants: Change culture and stimulate leadership (see figure 3).

During a round table session, the listed challenges were discussed in groups that contained a balanced mix of stakeholders. A number of key questions were extracted and discussed in an open and challenging working session with Professor Porter.

Professor Porter discerns a pragmatic, pioneering spirit in the Netherlands and a commitment to move towards Value-Based Health Care, both among health care providers and at a ministerial level. In his opinion, the Netherlands and Australia could become world leaders in the field of VBHC, as a number of excellent initiatives have already been developed in these countries.

Right now, the challenge is to implement those practices on a larger scale. The same problems that health care workers, boards of directors and government officials in this country encounter implementing VBHC-practices are also faced by stakeholders around the world.

At the same time, the field is developing rapidly. During the working session with Professor Porter, possible solutions were discussed to accelerate large-scale VBHC implementation in the Netherlands; this resulted in six calls for action.
Components of the Value Agenda that contain the biggest challenges for the Netherlands to accelerate VBHC implementation

Additional components for the Netherlands:

1. Organize into integrated practice units (IPUs)
2. Measure outcomes and costs for every patient
3. Move to bundled payments for care cycles
4. Integrate care delivery across separate facilities
5. Expand excellent services across geography
6. Build an enabling information technology platform

Change culture and stimulate leadership

Figure 3: Components of the Value Agenda that contain the biggest challenges for the Netherlands to accelerate VBHC implementation, according to input of the attendees and other health care leaders.

Free to the Value Agenda of Prof Porter (The strategy that will fix health care, 2013).
Call for action I: Leadership & Culture

Build VBHC leadership to help change the culture towards appreciation of value

For implementation of VBHC a cultural change is required, both among health care professionals and patients. A major disadvantage in this respect is that the current health care structure has been in place for a long time. Patients are used to going to the nearest hospital instead of choosing an institution based on its quality of care.

‘In order to overcome fear of transparency, the lack of reporting and unwillingness to do better should be penalized, instead of bad outcomes.’

Never before have health care providers been asked to share their results with the greater public. One way to change this, is by making reporting outcomes mandatory. Concerns among health care workers that reporting outcomes makes them look bad and lose patients are unfounded. In Professor Porter’s experience, patients value transparency more than the actual result. He stresses that, in order to overcome fear of transparency, the lack of reporting and unwillingness to do better should be penalized instead of bad outcomes. Leaders implementing VBHC should set a good example by submitting themselves to the same standards they set for others. Learn as much as you can from the data and focus on improvement. The next generation of VBHC leaders must be exposed to this way of working early on, and see that resources are directed towards the VBHC way of working.

An important driver for change among health care professionals should be the acknowledgement that working in a VBHC-setting is more rewarding. Cultural change is, therefore, a short-term issue. In the Cleveland Clinic, the transition to integrated practice units (IPUs) has been made. Now, none of the care providers want to go back to the siloed department structure. In Professor Porter’s experience, no one wants to go back once the transition to IPUs has been made.

‘An important drive for change should be the acknowledgement that working in a VBHC-setting is more rewarding.’

In the Netherlands, excellent examples of integrated care are found at Erasmus MC, Santeon and in networks such as ParkinsonNet, Diabeter and Meetbaar Beter. These parties should share their insights and experience with health care workers and institutions in the process of setting up IPUs and moving towards VBHC.

From a financial perspective, it has become clear that the current system is no longer sustainable and that change is required. It is possible to create both financial and non-financial rewards for physicians who are forerunners in VBHC. Examples include putting them in charge of co-located facilities and providing them with new operating theatres tailored to their patients’ needs.
Call for Action II: Integrated Care

Continue building IPUs across institutions with medical leaders as the dominant driving force and managers as enablers

The new center of leadership should revolve around integrated practice units (IPUs). This vision opposes the traditional definition of medicine by specialist departments. Professor Porter acknowledges that the majority of people involved in patient care want to do a good job and to run processes smoothly. However, the current health care structure is not the optimal setting to get the best results.

To encourage the shift towards integrated care, clinicians should be made enthusiastic about what they can achieve in an IPU for breast cancer patients, diabetics, et cetera. Primary care VBHC should be organized around patient segments (patients with similar medical needs or symptoms), such as those with hypertension or frail elderly with multi-morbidity.

‘The most passionate clinicians should spearhead the concept of VBHC in their particular fields’

In order to make this transition from a fragmented organization to a coherent team, institutions need strong leadership. In Professor Porter’s opinion, the most passionate clinicians should spearhead the concept of VBHC in their particular fields. A great leader can inspire and encourage colleagues to change.

In this process, leaders should focus on people that are willing and supportive, instead of wasting energy on people that oppose change. The task of hospital administrators is to encourage and support efforts to move from a fragmented structure towards coherent IPU-teams and the implementation of VBHC.

One way of facilitating the formation of IPUs is by creating a dialogue between people who, in the current setting, hardly ever meet each other, yet provide care to the same group of patients. For example, an exchange on best-practices among a shoulder surgeon and people in a rehab centre who take care of patients after shoulder surgery could be very valuable.

‘The best results in medicine can only be achieved through team efforts.’

Working in an IPU-setting is a team sport. Many health care workers currently work individually, so this requires a change in mindset. Professor Porter recognizes that specialist physicians are generally very bright people and may well be the best in their field, but he is convinced that the best results in medicine can only be achieved through team efforts.
Call for Action

‘The key to change is through experience: working in an IPU-setting proves to be more rewarding.’

The key to change is through experience: working in an IPU-setting proves to be more rewarding. For people who are incapable of working in a team, there will still be suitable roles in an IPU setting.

In an IPU, the classical separation between in-patient and out-patient is no longer relevant. Those who currently only care for in-hospital patients should be made responsible for out-patients as well. This means breaking down barriers between primary, secondary, and post-acute care. Get the patient involved.

‘In an IPU, the classical separation between in-patient and out-patient is no longer relevant.’

For example, for orthopaedic care the post-acute phase is crucial. In the current situation, patients are often told to convalesce in a rehab centre. But with the right support, many patients can rehabilitate at home. This situation is preferable for several reasons: it is more pleasant for the patient, reduces costs and improves outcomes. Surgeons may initially consider discussing postoperative details with their patients a tedious affair, but after a while most of them find it very rewarding, as they get to see better results.

In the world of academic medical centers, specialist departments are not only involved with patient care, but also with research and teaching. In Professor Porter’s opinion, these last two elements can remain compartmentalized as long as the next generation of physicians are familiarized with integrated care early in their training and administrators make sure that resources are directed towards the VBHC way of working.
Call for Action

Call for action III: Universal Measurement

Let the Dutch government enforce the use of outcome measures like ICHOM’s minimum international set, since no stakeholder coalition seems to be able to take the lead

When it comes to the measurement and output of benchmark outcome data, different stakeholders have opposing views on what data should be recorded and who should be the owner for standardization. Porter affirms that other countries implementing VBHC encounter similar problems.

‘Ideally, standards for outcome measurement should be adopted internationally.’

Currently, no universal tools for outcome measurement exist; such standards need to be created. In some hospitals outcome measurements are currently in place, but these data sets and outcomes are often only relevant to a specific department. The aim is to measure true health outcomes that matter to patients over the full cycle of care as outcomes for diabetes, for example, go far beyond endocrinology.

Ideally, standards for outcome measurement should be adopted internationally. However, no international authority currently exists that can enforce worldwide adoption of such standards; most governing bodies in health care are national.

In the United States, the International Consortium for Health Outcomes Measurement (ICHOM) has been established to create minimum standard sets of health outcomes per medical condition.

Adoption of these sets by other countries would enable international comparison of outcomes. National bodies and hospitals would have the liberty to add data to these sets, as long as they adopt the minimum standard set.

‘The biggest driver behind implementation of universal outcome measurement would be the adoption of ICHOM standards by the governments.’

To harmonize outcome measurement, health care institutions may decide to adopt the ICHOM standards of their own accord, or insurance companies could ask care providers to provide these data. The biggest driver behind implementation of universal outcome measurement would be the adoption of ICHOM standards by governments. Professor Porter believes that there is a fair chance that the Dutch government will demand implementation of the ICHOM sets as the minimum requirement in the near future.

One thing to consider before implementation of the ICHOM standards is how to collect the data and how to translate these into outcomes. Where information technology platforms are not yet in place, they should be built to enable outcome measurement.
Call for action IV: Bundled Payment

Move quickly to bundled payments for all care, moving away from the current mix of Fee For Service/DOT and capitation based payments, to break wrong incentives

In Professor Porters experience, replacing Fee-For-Service reimbursement with bundled payments is a powerful tool for breaking down barriers between departments. It starts a cultural change, as bundled payment creates an incentive to work together, improve care pathways, and ultimately share the benefits of improvements. The United States has seen an explosion of bundled payment contracts in recent years.

‘Long-term bundled payment contracts need to be set up, which allows VBHC leaders to initiate value-based programs.’

In the Netherlands, regulations need to be changed in order to allow for negotiations on price (P) and quantity (Q) between health insurance firms and health care providers who want to move towards VBHC. Long-term bundled payment contracts (preferably three years minimum) need to be set up, which allow VBHC leaders to initiate value-based programs aimed at improving patients’ health outcomes and reducing costs over a full cycle of care. Risk sharing, shared savings, reasonable profit margins, relevant data sharing and the involvement of patients and other parties must all be arranged in bundled payment.

One key hindrance for the implementation of bundled payments is that moving away from Fee-For-Service or capitation-based reimbursement needs to be supported by all stakeholders.

‘One key hindrance for the implementation of bundled payments is that it needs to be supported by all stakeholders.’

In the United States, members of the board of directors often do not see a need for change. These boards are generally comprised of business people lacking sufficient insight in health care to drive innovation. The Cleveland Clinic is an exception because they are physician-lead, setting an excellent example of multidisciplinary care in the United States. Training boards of directors and/or supervisory boards on VBHC is needed to help these bodies orchestrate VBHC change inside and outside of their institutions. Prof Porter and Prof Dr Van Eenennaam are embarking on this journey.

In the Netherlands, the situation is more favourable as quite a number of board members have a background in medicine. Indeed, these board members often initiate the transformation from a fragmented, siloed, organizational structure towards a more integrated approach in order to deliver care for patients.
Call for action V: Patients’ Choice

Engage patients to choose care providers based on quality

Among patients, change is needed as they are not used to choosing a health care provider based on the outcomes that they want to pursue. Without the opportunity and support in choosing, patients will (most likely) just go to their local provider. Patients and families must be encouraged and assisted in seeking the best possible care that fits their medical needs, and interested in making their choice for medical teams and treatment plans.

To help patients with their choice, there should be a clear statement by care providers/teams on the health outcomes achieved (quality of care) and what their focus is. It must become clear that differences in quality exist on the medical condition level (and eventually more specific sub-populations), not the level of hospitals or doctors. Key are initiatives enforcing the need to consult (or get a good second opinion) with the right team of physicians. Patients and families can make much better decisions concerning health care when a strong focus is placed on joint medical decision making. There are plenty examples of initiatives in which value for the patient and their family is greatly improved while the starting point really is the patient, not a reduction of costs.

‘Help patients with their choice for care by providing them the quality of care achieved.’

An excellent example of an initiative that improves value for patients through the early identification of patients’ wishes and needs is ‘Desired Care in the Last Phase of Life’. This care-initiative implements a transmural multidisciplinary palliative care pathway, collaborating with many institutions. The focus is on improving the quality of dying, rather than quality of life, through early detection of the last phase of life by measuring outcomes and other factors. The initiative received the VBHC Patient Outcomes Award 2017.

‘Visiting a proven specialized IPU: better outcomes, lower costs and higher satisfaction.’

Professor Porter points out that visiting a proven and specialised IPU may not only result in better outcomes and lower cost, but also be more satisfactory. After all, in an IPU the care path is shaped as one patient-based seamless process, while in a setting with specialty departments patients have to go back multiple times for diagnostic tests and treatment. Successful networked approaches like the Children’s Hospital of Philadelphia provide inspirational lessons on the patient outcomes, cost and location challenges from a patient/family perspective, not a supply perspective.
Only if IPUs have enough volume, can the reduction in costs per patient be used to allow for tailored approaches at different medical/behavioural patient segments. Especially with chronic diseases, one-size-fits-all protocols and reimbursement-based activities can not only be needlessly costly, but also an unnecessary burden for patients, families and their employers. For instance, quarterly diabetes II tests for all patients annually is a policy, ignoring meaningful variation.

The virtual platform ‘Luchtbrug’ facilitates outcome measurements through which physicians as well as patients and their families can monitor their condition.

Another great example of e-health is telemedicine ‘myIBDcoach’, which enables continuous monitoring of relevant PROMs and PREMs. Patients with inflammatory bowel disease using myIBDcoach have a 36% reduction in outpatient visits, a 31% reduction in telephone consultations and a 50% reduction in hospitalization.

We need to radically rethink the use of diagnostics in Value-Based Diagnostics. For example, ‘FAMOUS’ is a pre-hospital triaging system for chest pain patients. In this initiative, paramedics, general practitioners, cardiologists and clinical chemists work together for risk stratifications of chest pain patients, reducing stress of patients (fear of hospitalization/having a heart attack), potentially preventing overcrowding of the emergency department and reducing costs through earlier and more effective diagnosing.

Patients and families are a crucial part of the generation of patient value. The medical decision making, the doctor as decision coach and predictive results of treatment paths are available. Reorganizing the information flow from and to patients as well as carefully designing the patient touch points needs to be a priority in the next phase of Value-Based Health Care. Health plans may also be able to help enforce preventive health behaviours to an extent.

The patient and family must be the master of their own medical data, in which the rapid rise of e-health, internet and big data initiatives provide a way forward. A great example of e-health and VBHC Cost-Effectiveness Award winner 2017 is the ‘Virtual Asthma Clinic for Children’, that decreased how often children need to visit the hospital.

‘We need to radically rethink the use of diagnostics in Value-Based Diagnostics.’
In the current system, patients with multi-morbidity visit a large number of unconnected physicians. In Professor Porter’s opinion, this is very inefficient and a sign that the system is flawed.

The IPU model does not only consider a patient’s narrow condition, but looks at the broader picture. Setting up an IPU for patients with a certain medical condition, common co-occurrences and complications should be identified, and physicians specialized in those health issues need to be on the team. For example, patients with diabetes often develop renal, ocular and vascular problems. As such, the IPU should not only include an endocrinologist, but also a nephrologist, ophthalmologist, and vascular specialist.

‘When patients develop two conditions that require specialist care, they should visit two IPUs.’

If only a small number of patients need to see a certain specialist, he or she can be called in on a consultation basis. Professor Porter’s advice is to always bring in the same specialist, as this allows him or her to build up experience with a disease unrelated to their specialty. This optimizes treatment of the (secondary) co-condition.

When patients develop two conditions that require specialist care, they should visit two IPUs. For example, when a patient with diabetes gets cancer he or she should be treated by a diabetes IPU and a specific oncology IPU. In a well designed IPU, the care path of each patient will be managed by one health care specialist. So when two IPUs are involved, only these two coordinators have to interact with each other and synchronize care paths. It is evident that this situation is preferred over the current system, in which often a dozen or more clinicians are involved.

‘Keep an IPU focused on the full cycle of care and handle the exceptions as exceptions.’

It is essential to manage the interfaces with other care providers strictly and control for its quality. Most errors, risks and faults occur during handovers, especially outside an IPU. Keep an IPU focused on the full cycle of care and handle the exceptions as exceptions.

In the initiative ‘G-Watch’, elderly patients with heart disease are connected to cardiac and geriatric experts in a tele-rehabilitation program 24/7. Elderly patients are thus able to stay in their own homes with a potentially higher quality of life.
Aside from the identified Calls for Action, there are of course additional hurdles to tackle in the future for VBHC implementation. The three main hurdles the Netherlands can expect to have to deal with are:

I. **Improve the IT/data approach**

To make VBHC delivery successful, some major data and information points need to be addressed.

a. Make sure that the doctor and the team have all of the required information, medical and logistics path ways available, instead of asking the patient for previous test results;

b. Provide the doctors and the system the opportunity to override the protocol, reward those that do so and learn from the reasons why they chose to override the protocol;

c. Make sure that the bundled payments contracts can be supported easily by the data and data portability;

d. Report on IPUs and patient journeys in addition to cost centers/unit bases;

e. Since data and information have become a source of power for different stakeholders in the system, new security issues will arise, as well as the need to analyse big data. New frameworks need to be developed.

II. **Fairly distribute the benefits**

The single most important threat to any health care system is the fact that perverse incentives exist, meaning that sometimes those that improve the value for patients and reduce the cost per patient do not share in the benefit and end up being get penalized. Choices for health insurance systems, NHS type systems, ‘semi’ free market systems or underserved populations all require accurate measurement of outcomes, costs and IPUs competing through improved results to gain the community’s trust.

III. **Expand excellent services across geography**

The Netherlands has the advantage of being a small, condensed country. However, this is also accompanied by low volume and/or scale, creating a new challenge to ensure sufficient support for IPUs. Cross border care delivery within and outside the European Union is an issue to address. We see many international collaborations that we would like to test in the higher patient value equation in the future.
Follow up Working Session

Working Session part II
In 2018, this unique working session will be continued. On April 25 (date tentative), we will again extract the relevant challenges to further stimulate VBHC implementation in the Netherlands. Together with a varied group of decision makers in health care, we will set the Value Agenda for the Netherlands for 2018/2019. Until then, we will actively support the implementation of the actions illustrated in this report.

More information?
For more information about the next working session, please contact Vincent Wiersma at v.wiersma@thedecisiongroup.nl.
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Website Value-Based Health Care Center Europe: [www.vbhc.eu](http://www.vbhc.eu).

Website Value-Based Health Care Prize: [www.vbhcprize.com](http://www.vbhcprize.com).

Value-Based Health Care education

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Strategy for VBHC delivery
Texas Executive Education | Austin, USA

Online Master of Health Administration (MHA)
George Washington University | Washington, USA

Value Based Healthcare Programme
University of Oxford | Oxford, United Kingdom

Erasmus Summer Programme (ESP)
Erasmus MC | Rotterdam, the Netherlands

Master of Public Health Program
The Dartmouth Institute | Lebanon, USA

The Decision Group has an international network of over 120 universities worldwide. If you are thinking about following VBHC education, please do not hesitate to contact us for advice.
Components of the Value Agenda that contain the biggest challenges for the Netherlands to accelerate VBHC implementation

- Organize into integrated practice units (IPUs) - 10%
- Expand excellent services across geography - 8%
- Measure outcomes and costs for every patient - 32%
- Integrate care delivery across separate facilities - 12%
- Move to bundled payments for care cycles - 22%
- Build an enabling information technology platform - 16%

Additional components for the Netherlands:
- Change culture and stimulate leadership
Appendix 1: VBHC Working Session with Prof. Porter – Input by attendees

VBHC Working Session with Prof. Michael Porter
‘The Value Agenda for the Netherlands’

1. Organize into integrated practice units (IPUs)

**Identified key hurdles to accelerate VBHC implementation in the Netherlands:**

1. How to take and show ownership for clinical and costs outcome across care pathways?
2. How to organize pathways as an integrated process?
3. How to deal with care that not integrated at the moment and highly fragmented?
4. How to integrate other professionals and other stakeholders in the integration of care delivery?
5. How to incentivize all disciplines in the full cycle of care to be collectively responsible for delivering patient value?
6. How to increase patient centeredness within care delivery, not the organization?
7. How to increase efforts on other patient segments than interdisciplinary for older patients of multiformor comorbidity patients?
8. How to move towards network-based IPU’s?
9. How can we shift the mindset in healthcare towards innovation?
10. How can we establish that medical doctors (partly) give up autonomy?
11. How can we increase trust to collaborate and include non-medical stakeholders?
12. How to change culture/behavior of medical teams that deliver care for patients?
13. How to increase leadership by doctors and the care providers to drive putting value-based health care at the center of their policy?
14. How can we implement closed outcome-based learning cycles systematically?
Appendix 1: VBHC Working Session with Prof. Porter – Input by attendees

VBHC Working Session with Prof. Michael Porter
‘The Value Agenda for the Netherlands’

2. Measure outcomes and costs for every patient

Identified key hurdles to accelerate VBHC implementation in the Netherlands:

15. How do we stimulate working from current best-practices, not ‘negotiating’ and ‘implementing’ a total blue-print first?
16. How can we make quality data transparent and routinely accessible to everybody, free?
17. How to reduce administrative expenses to make a real-world implementation feasible?
18. How to provide value for the complete functioning of people, not only for patient outcomes?
19. How should we establish the involvement of patients and value their input the same way as the input of professionals?
20. How to make sure that we do not only measure outcomes, but really improve outcomes?
21. Can we collect cost and outcome data for all patients across care providers in a systematical way?
22. What are key aspects when making agreements on outcome indicators?
23. Can we make comparison of outcomes along the same standards obligatory?
24. How to shift the focus on patient outcome measures to measure value instead of focus on volume of care?
25. How can we accelerate transparency on outcome and cost?
26. How to enable and deal with patients to choose a provider that provides superior value?
3. Move to bundled payments for care cycles

**Identified key hurdles to accelerate VBHC implementation in the Netherlands:**

27. How to collaborate towards healthcare reimbursement?
28. How to introduce / start pilots with bundled payments?
29. What should we do to get the systems for value-based payments in place?
30. How to deal with providers focusing on optimizing efficiency of their part of the care cycle and sub optimizing the total system?
31. How should we shift the current funding mechanism for hospitals?
32. Is accurate cost data mandatory to estimate the effect (and risk) of a bundled payment?
33. How to facilitate support for the transmural development of care (or even within the organization)?
34. How to include other stakeholders in bundled payments next to care providers and insurance companies?
35. How can we incentivize moving to bundled payments (doing the right thing, now lowers provider’s income)?
36. What measures can we take to align the interest of stakeholder to fairly share realized benefits and savings?
Appendix 1: VBHC Working Session with Prof Porter – Input by attendees

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4. Integrate care delivery across separate facilities

**Identified key hurdles to accelerate VBHC implementation in the Netherlands:**

37. How to break through the traditional patterns that stabilize the current healthcare system, meaning every hospital delivering all types of specialisms and focusing on their own part of the Care Delivery Value Chain and their financial results each year: Should we force portfolio choices?

38. How to stimulate working across institutions to improve care across the full cycle?

39. How to move from fragmented care to integrated care?

40. How to include, and motivate, other professionals and other stakeholders in the integration of care delivery?

41. How to disseminate best-practices on resource optimization and resource sharing opportunities?

42. Should we focus on making sure all supporting facilities work at full capacity and volume?
5. Expand excellent services across geography

**Identified key hurdles to accelerate VBHC implementation in the Netherlands:**

43. How can we collect cost and outcome data for all patients across care providers more systematically?
44. How can we deal with volume as money driver instead of being transparent on publishing clinical outcomes collaboratively?
45. Should we concentration high volume procedures in max. five centers?
46. How should we simulate working with each other, not against each other?
47. How to reduce administrative expenses to make real-world implementation feasible?
48. How can we put the focus with all stakeholders on patient value and stop the obligatory old school quality control mechanisms?
49. How to move from pilots to (inter)national overall implementation?
50. How to include (or attract) other organizations along the implementation journey?
51. How can we build a network between different stakeholders to enable sharing and collecting data and transparently transport and compare data?
52. How to align organizational strategies to stimulate network approach/strategies?
53. How to deal with stakeholders misusing the term of value-based health care focusing on capitation?
VBHC Working Session with Prof. Michael Porter
‘The Value Agenda for the Netherlands’

6. Build an enabling information technology platform

Identified key hurdles to accelerate VBHC implementation in the Netherlands:

54. How to enable sharing of knowledge in a structured way?
55. How should we build and organize a network between different stakeholders to enable data collection and measurement across healthcare and be transparent on this?
56. How should IT in value-based health care deal with large players such as Google, Apple, IBM etc.?
57. How do we cope with the transition phase as data collection/registration being time consuming (and costly)?
58. How to approach the challenge to move towards a solid IT platform as this is often underestimated (or neglected)?
59. How can we build on trust to increase data sharing and showing best-practices in underlying IT-platforms?
60. How can we cope with data privacy constraints limiting use of e-health solutions and data sharing across care pathway providers?
61. Should we facilitate and stimulate solutions that enable outcomes/cost data being present for medical teams when discussing with patients, insurer or other stakeholders?
### Meet the nominees of the VBHC Prize 2017:

<table>
<thead>
<tr>
<th>Nominees</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Netherlands Heart Network</strong></td>
<td>&quot;The NHN aims to continuously improve outcomes that matter most to cardiac patients. Subsequently, those patient relevant outcomes are delivered at the lowest costs.&quot;</td>
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<tr>
<td><strong>Benchmarking Mental Health Care</strong></td>
<td>&quot;ROM and Benchmarking aims to enhance quality of mental health care by providing transparency about outcomes and costs to all stakeholders: patients, providers, and financiers.&quot;</td>
</tr>
<tr>
<td><strong>G-Watch</strong></td>
<td>The aim of G-Watch is to reduce Emergency Department-patient presentations and hospital admissions and increase Quality of Life for elderly with Heart Disease by enabling them to self-manage via a tele-rehabilitation program that connects them 24/7 to cardiac and elderly experts.</td>
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<tr>
<td><strong>Closing the Loop</strong></td>
<td>Our initiative aims to improve patient empowerment, shared decision making, transparency and continuous learning during healthcare delivery.</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td>We aim to decrease the burden of type 1 diabetes for patients by helping them to achieve outstanding outcomes, providing individualized care and supporting self-care, focusing on digital care and measuring outcomes for every patient.</td>
</tr>
<tr>
<td><strong>Desired care during the last phase of life</strong></td>
<td>Our pathway improves the quality of dying, prevents health care misuse and overuse, and prevents informal caregivers from becoming overburdened.</td>
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<tr>
<td><strong>The Dutch Surgical Colorectal Audit</strong></td>
<td>The nationwide DSCA was initiated by the Association of Surgeons of the Netherlands to monitor, evaluate and improve care for colorectal cancer patients.</td>
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<tr>
<td><strong>MyIBDcoach</strong></td>
<td>The aim of this project was to validate the effects of the telemedicine tool myIBDcoach compared to standard care on healthcare utilization and patient-reported quality of care (PRoC) in a pragmatic randomised trial.</td>
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<tr>
<td><strong>Value-Based HIV Care</strong></td>
<td>To increase value of HIV care, OLVG has developed a selected set of HIV care indicators, made data to these indicators easily accessible to multidisciplinary teams which are supported towards ongoing improvement of care. Patients and insurers are included in this doctor-led initiative.</td>
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<tr>
<td><strong>EAMOUS</strong></td>
<td>Famous triage aims to achieve a worldwide accessible, efficient and safe triage method in chest pain patients to improve patient service and reduce emergency crowding with considerable less cost.</td>
</tr>
<tr>
<td><strong>VBHC@Santeon</strong></td>
<td>We aim to continuously improve value to our patients by improving outcome and cost over the full cycle of care for 20-25 conditions in 2020. Transparency on outcomes and costs, including patients, health insurers and professionals from all relevant disciplines, are key parts of the initiative.</td>
</tr>
<tr>
<td><strong>Value-based healthcare in pulmonary sarcoidosis</strong></td>
<td>Participating hospitals collect, exchange and discuss their outcomes with the aim to identify best practices in order to improve value for pulmonary sarcoidosis patients.</td>
</tr>
<tr>
<td><strong>A virtual asthma clinic for children</strong></td>
<td>A virtual asthma clinic for children: improving asthma control in children while reducing visits to the outpatient clinic by 59%.</td>
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This exclusive working session with Prof. Porter is organized by three content-based partners in VBHC who are eager to move VBHC forward collaboratively:

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