Working session with
dr Richard Bohmer
and
prof. Matthew Cripps

April 26, 2018

Full report

Juli 2018

VALUE AGENDA NL
ValueBasedHealthCare

The Value Agenda for the Netherlands 2018-2019

The 15 actions needed to move the needle on VBHC implementation

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Content

Executive summary

Over the past ten years, The Netherlands has become one of the leading countries in the world for VBHC implementation. However, a full-scale implementation of Value-Based Health Care in the Netherlands healthcare system is not yet fully realized. In 2017, the Value Agenda for the Netherlands was composed by 25 key decision makers together with Prof. Porter, which contained six Calls for Action to help accelerate large scale Value-Based Health Care (VBHC) implementation in the Netherlands.

In order to respond to the Calls for Action of the Value Agenda NL and to stay ahead of the curve, a follow-up Working Session was organized in 2018 with 30 key decision makers in Dutch health care and two prominent VBHC experts: Dr. Bohmer and Prof. Cripps. The aim of this session was to build on the Value Agenda 2017 and the six Calls for Action and to identify practical actions and solutions for each stakeholder group in order to accelerate VBHC implementation in the Netherlands.

According to the attendees and key decision makers in Dutch Health Care, the Call for Action "Leadership and Culture" is the most important action at this stage and has the highest future potential (31%).

The Working Session 2018 resulted in five actions to promote and stimulate VBHC Leadership and Culture. Healthcare stakeholder groups can respond and contribute to one or more key action(s).

A focus solely on the Call for Action Leadership and Culture will not be enough. Therefore, in addition to the five key actions on Leadership and Culture, ten additional actions were formulated for the other five Calls for Action on the Value Agenda NL, resulting in the 15 actions on the Value Agenda for the Netherlands.

The 15 actions together provide a guide for the onward journey towards large scale VBHC implementation in the Netherlands. We encourage all stakeholders in health care to support the actions and move the VBHC needle together.

Building VBHC Leadership and Culture: the primary focus to move the VBHC needle

Call for Action I: Leadership and Culture	
Action	**Who**
1. Dare to experiment and dare to fail	
2. Be part of the team	
3. Develop policies that advance change	
4. Really work together in an integrated way with primary focus on the patient	
5. Use the power of small financial incentives	

Progress needed on the other Value Agenda NL - Calls for Action: highest priority actions

Call for action 2: Integrated Care	
6. Navigate leadership in the direction of teamwork	
7. Create shared responsibility and accountability across various departments	
Call for Action 3: Universal Measurement	
8. Start making outcome measurements mandatory	
9. Teach medical teams to work with outcome sets	
Call for Action 4: Bundled Payments	
10. Focus less on shared savings and more on improved outcomes to stimulate outcome based payments and innovation	
11. Start by defining a longer-term contract with learning potential	
Call for Action 5: Patients' Choice	
12. Make outcome information available and empower the patient by providing the relevant information to make an informed decision	
13. Include outcome measures, preferably PROMs, in the consultation room to discuss best treatment with patients	
Call for Action 6: Complex care	
14. Rigorously manage the interfaces between the several care providers and IPUs strictly	
15. Create IPUs that focus on managing high risk/complex patients	

Medical industry
Care providers board/management
Health insurers
Care/patients associations
Care providers - (para) medical team
Stimulators/Enablers (Government + IT)

Introduction

Taking Value-Based Health Care to the next level

"The Netherlands could become a leader in the field of Value-Based Health Care" according to Harvard Professor Michael Porter.

Value-Based Health Care (VBHC) is the key to making responsible choices in the way we organize our healthcare system. Over the past ten years, VBHC has shown to have changed the face of health care as we know it. As a result, many if not most people now see VBHC as the most effective way to improve Dutch health care. VBHC is all about creating excellent patient value, which over the years has become a major issue in health care. Focusing on VBHC gives everyone involved a clear-cut definition of patient value so that the right choices can be made. The shared focus on patient health outcomes and the cost of delivering these outcomes will create a unified language to enable all stakeholders to learn, collaborate and integrate care so as to improve patient value. This patient value equation will change the way we look at and deliver health-care, which could help in structurally restrain the ever-increasing health care budget.

However, a full-scale implementation of VBHC in the Dutch healthcare system is not yet fully realized. To move forward on VBHC and stay in the lead as a country, ways to accelerate the implementation of this powerful concept should be discussed openly and made actionable with all stakeholders involved.

The Value Agenda NL

To generate and discuss actions on taking VBHC to the next level, in 2017 The Decision Group, Amgen and Medtronic organized a Working Session with Harvard Professor and founding father of VBHC Prof. Michael Porter and 25 key decision makers in Dutch health care. As a result of this Working Session, the Value Agenda for the Netherlands was set out. This agenda consists of six Calls for Action to accelerate the implementation of VBHC in the Netherlands.

The Value Agenda NL 2017 – a Call for Action

Call for Action 1: Develop VBHC leadership to change the culture towards appreciation of value.

Call for Action 2: Continue building Integrated Practice Units (IPU's) across institutions with medical leaders as the dominant driving force and managers as enablers.

Call for Action 3: Let the Dutch government enforce the use of outcome measurements like ICHOM's minimum international set, since no stakeholder coalition seems to be able to take the lead.

Call for Action 4: Move quickly to bundled payments for all care, away from the current mix of free for service/DOT and capitation based payments, to break wrong incentives.

Call for Action 5: Engage patients to choose care providers based on quality.

Call for Action 6: Build IPU's to better cater for patients with multi-morbidity.

VBHC Working Session 2018 - discussion with Dr. Bohmer and Prof. Cripps

At the 2018 Working Session, held on April 26, thirty key decision makers representing various stakeholders – policy makers, board members, hospital managers, care providers, health insurers, patient organizations and the medical industry – were present to discuss the 2018-2019 Value Agenda.

The Working Session had two main goals:

1 to build on the Value Agenda NL 2017 and the corresponding six Calls for Action and,
2 to define the key actions for each stakeholder group to accelerate VBHC implementation over the coming year.

Prior to the Working Session, participating key decision and policy makers in health care identified the main hurdles and challenges to overcome or actions to take, in order to respond to the six Calls for Action as stated in the Value Agenda NL 2017. Furthermore, they selected the Call for Action which could generate most impact and the Call for Action on which they had observed most progress last year.

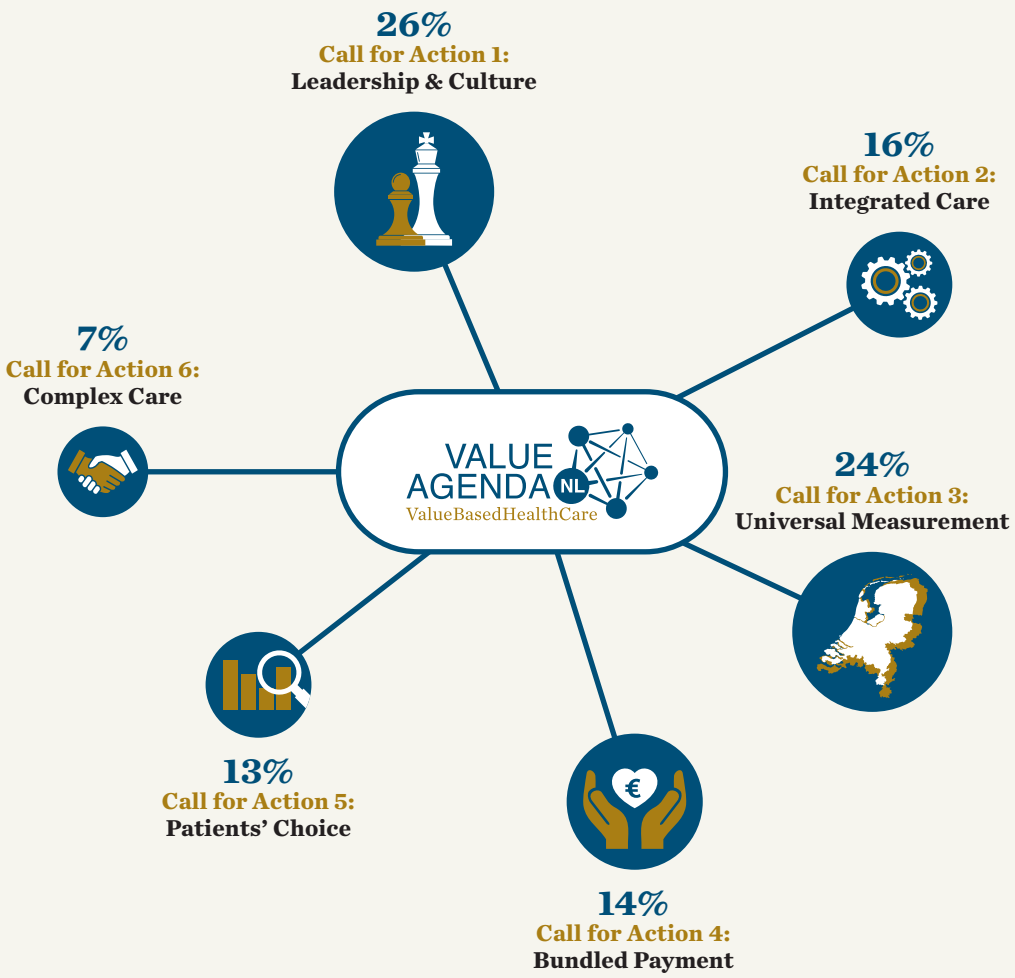
During the Working Session, the Call for Action which could generate most impact coming year was collectively chosen: Leadership and Culture. Thereafter, the focus was on the identification of practical actions and solutions to respond to this Call for Action with the help of VBHC experts Dr. Richard Bohmer (creator of world leading Harvard programs on Health Care Delivery and author of bestselling book "Designing Care") and Prof. Matthew Cripps (leader of the Value programme for NHS England and director of NHS RightCare).

As a result, the key actions for the 2018-2019 Value Agenda were set. The Value Agenda is a work in progress. This report details the progress already made since the first Working Session in 2017, how this progress gave focus to the agenda set in the 2018 Working Session and the 15 actions to jointly take the next step in large scale VBHC implementation.

Progress made in 2017 - 2018

One year after the Calls for Action were formulated, much progress has been made and a great deal has undeniably been achieved. It was the general consensus of key decision makers in Dutch health care that two Calls for Action stood out as having made the most progress: Leadership and Culture (26%) and Universal Measurement (24%).

Observed progress on the six Calls for Action 2017



Major steps taken in 2017-2018

Call for Action 1: Leadership and Culture

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

We saw a growing number of VBHC initiatives getting off the ground and enduring. In 2017-2018 significantly more VBHC initiatives were instigated and developed than ever before. This was amongst others, demonstrated by the greater number of nominees for the fifth annual VBHC Prize in 2018, where applications almost doubled compared to 2017 with more than 120 institutions involved worldwide.

Call for Action 2: Integrated Care

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

In 2017 there was a major focus on developments aimed multidisciplinary ways of working across the current silos of the healthcare system. These developments indicate that health care is slowly moving towards an IPU centred system. In 2018 it was announced that prostate cancer care in western and eastern parts of the Netherlands are (or will be) centralized to treat patients in IPUs instead of separate hospitals. An example of a prostate cancer IPU is Prostate Cancer Center, a collaboration between three hospitals in the east of the Netherlands and one of the VBHC Prize 2018 nominees (visit the website www.vbhcprize.com for further inspiration and initiatives).

Call for Action 3: 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

The Ministry of Health, Welfare and Sports has added the ambition that, by 2021, outcomes for fifty percent of the disease burden must be transparently recorded. Furthermore, the Ministry of Health, Welfare and Sports has tasked the National Health Care Institute of the Netherlands with identifying whether the implementation of ICHOM sets is a valuable tool in outcome measurement and whether ICHOM sets can accelerate shared-decision making between physicians and patients: a clear indicator that the Ministry recognises the importance of measuring outcomes transparently. To ensure transparency on outcomes, it is highly important to look at learn from existing sets of outcome measures at global initiatives f.i. like ICHOM & NHS, as well as national initiatives like Meetbaar Beter & Santeon.

Call for Action 4: Bundled Payments

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

Many institutions are now awarding multi-annual contracts with a value component that is increasingly moving towards true health outcomes. An example is the bundled payment contract held by Menzis with ten Dutch hospitals for angioplasty and bypass operations based on outcomes selected by the NHR (Netherlands Heart Registry, VBHC Prize 2018 nominee). The contract is a so called "shared savings contract". The heart care is procured on expected health outcomes. Hospitals receive a pre-arranged amount of money for treatments: when hospitals perform better they are allowed to keep the residual money (or share this with the insurer) and may receive a bonus; when hospitals perform below expectations based on NHR outcomes they have to repay a part of the fee received.

Call for Action 5: Patient Choice

Engage patients to choose care providers based on quality

We see increasing attention being given to shared decision-making in the consulting room. The Ministry of Health, Welfare and Sports indicated that shared decision-making must be facilitated and incentivised in Dutch health care. This issue was also addressed in the coalition agreement in November 2017 and the Ministry wants to encourage shared decision-making in this way. Based on these statements, health institutions are also increasingly focusing on shared decision-making, mainly in relation to conversations with the patient in the consulting room. The ambition of the Ministry of Health, Welfare and Sports to ensure transparency on outcomes for 50% of the disease burden will allow for transparency on outcomes which in turn facilitates shared decision making.

Call for Action 6: Complex Care

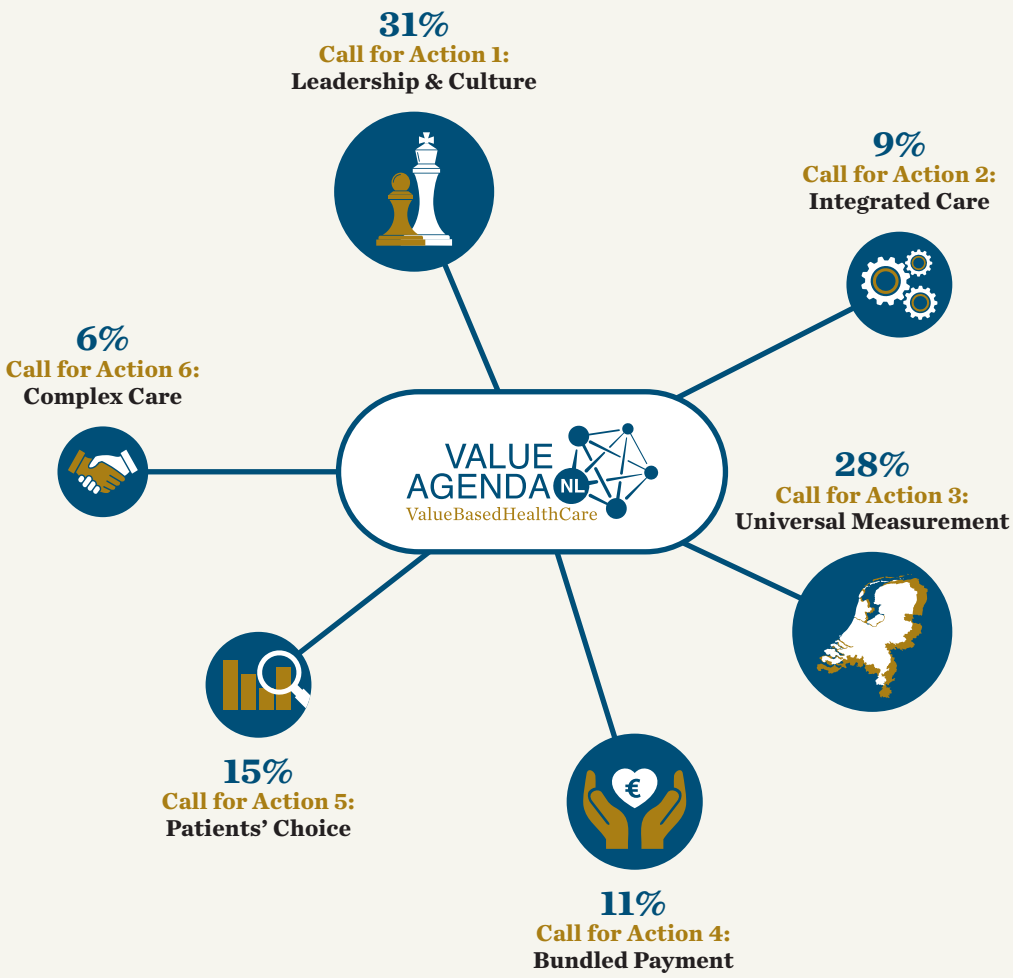
Build IPUs to better cater for patients with multi-morbidity

Patients with multi-morbidity (more than one condition) have to be treated in two separate IPUs. By redefining care for each medical condition, only the coordinators of the IPU have to discuss the patient's health and not several physicians from several departments. One example where IPUs are already working together to manage complex care is at the Erasmus MC (VBHC Prize 2018 nominee). This hospital already has 30 IPUs running where administration for patients can be handled in multiple IPUs when they have multiple conditions.

Establishing priorities for 2018-2019 and beyond

Notwithstanding the significant progress described in the previous section, there is still much more to do. Key decision-makers in health care and those attending the Working Session indicated that the Calls for Action with the highest future potential were again Leadership and Culture (31%) and Universal Measurement (28%). This demonstrates that, even though much has been achieved in 2017-2018, there still is a great deal more that could be achieved in relation to these Calls for Action.

Calls for Action with the highest future potential 2018



Key actions VBHC Leadership & Culture

The key decision makers present at the Working Session affirmed the importance of VBHC Leadership and Culture to accelerate VBHC implementation. Five key actions were defined. The key actions stated below are not solely aimed at the stakeholder (group) mentioned. All stakeholders should try to find the means to assist in putting the actions into effect or adapting the action to suit their own perspective. Stumbling blocks that arise because each stakeholder is operating from their own perspective can be tackled if stakeholders are prepared to work together towards the goal of advancing VBHC.

In other words: if the stakeholders give the development of VBHC leadership free reign to enable the culture to change.

The key actions will act as a guideline for all stakeholder groups in health care on how to change leadership and culture as they work towards a VBHC approach. This will take time and will not happen overnight. In the words of Prof. Matthew Cripps: **"Have patience, it all starts with patient choice, it's a journey. And it will only happen if leadership and culture change. It takes time."**

Building VBHC Leadership and Culture: the primary focus to move the VBHC needle

Call for Action I: Leadership and Culture

Action	Who
1. Dare to experiment and dare to fail	
2. Be part of the team	
3. Develop policies that advance change	
4. Really work together in an integrated way with primary focus on the patient	
5. Use the power of small financial incentives	

- Medical industry
- Care/patients associations
- Care providers board/management
- Care providers - (para) medical team
- Health insurers
- Stimulators/Enablers (Government + IT)

Key action 1: Dare to experiment and dare to fail
by medical industry and care providers – (para) medical team

The medical industry increasingly acknowledges the focus on value for patients and understands they are a part of the integrated care and value/outcomes delivered. As they (in)directly influence the outcomes achieved for the medical industry, it is important to further drive the implementation of VBHC through payment based on outcomes. However, this is still hard to achieve as in the current healthcare system it is usual to pay for volume instead of outcomes and value. Consequently, the medical industry needs to experiment with paying for value. Five years ago being paid for outcome was not even considered an option; now it is an innovative option, however innovation leads to variation. During the process of awarding contracts based on outcomes, some industries will be forced to conclude that the(ir) impact on outcomes is less than expected or highly differs per patient segment and impact on outcomes of other organizations is superior. The key is not to stop experimenting and to dare to fail. As the medical industry increases its focus on health outcomes, new ways to innovate (from a patient perspective) will arise. This will lead to additional/ancillary tools, services and solutions from the perspective of patient health outcomes, rather than a product focus (potentially with decreasing lead time to allow earlier access for patients).

Medical multidisciplinary teams, on the other hand, are very well-placed to experiment to optimize care delivery in their own way. This applies to non-medical care delivery and to medical care (including medical decision-making). An increased focus is needed on collaborative learning from clinical relevance to allow for better management of meaningful variation between patients, while keeping the aim of moving towards evidence-based practice.

"A lot has been achieved over the past five years. Before that being paid for outcome was not even considered an option. It is now, but can it really be achieved? Maybe it can, it goes in fits and starts." Dr. Richard Bohmer

Key action 2: Be part of the team
by care/patient associations and stimulators/enablers

Care and patient associations should help with VBHC leadership by making patients part of the team. The first step is a local plan to identify needs and wishes among the local population. If cardio-vascular diseases are the biggest problems in your region, then address that problem first. Also, patient organizations need to enter into partnerships with local charities. Stimulators/enablers could help by teaching healthcare professionals how to work together with patients to show the professionals that every decision that they make has consequences for patients.

Key action 3: Develop policies that advance change
by care providers board/management

The board and management of healthcare institutions should develop policies that advance change. Dare to drive change and identify what is holding back its establishment. In Dr. Bohmer's opinion change comes from the clinical and management teams. The ultimate question should be: what policy changes make it easier for managers to make change successful? Leaders in VBHC should set a good example by applying the same standards to themselves that they set for others (creating a new organizational context). And, the next generation of VBHC leaders needs to be exposed to this way of working early on and to see that resources are directed towards the VBHC way of working. An important driver for change among healthcare professionals should be the recognition that working in a VBHC setting is far more rewarding than not doing so.

Key action 4: Really work together in an integrated way with primary focus on the patients
by care providers-(para)medical team and care/patient associations

Medical teams should work together more to get away from the siloed structure doctors work in at the moment. They need to think out of their own reference framework and gain awareness of the effects of decisions they make further down the line, in other words what it means for patients. Start by identifying the entire multidisciplinary team that cares for a medical condition and arrange a quarterly or six-monthly retreat to focus as a team on ways to improve care delivery and value for patients. By taking a multidisciplinary approach, medicals will be identified who can be in the driver seat of transforming the current healthcare structure into a VBHC structure. In any team, the focus must remain on the patients' needs and value, and therefore patients or patient representatives should be included as frequently as possible. At the end of the day, patients are the most valuable source of information because they have been through the entire care cycle.

Key action 5: Use the power of small financial incentives
by health insurers

Financial incentives are always tricky, money can always lead to unintended consequences. The real incentive should be based in meeting the needs of the population. However, people like to be rewarded and money is a way to reward them. The use of small financial incentives based on outcomes could be valuable to incentivise VBHC implementation in Leadership and Culture.

The Value Agenda NL: What else should we be doing?

More action is needed to implement VBHC on a large scale. Therefore, in addition to the five key actions on Leadership and Culture, ten additional actions were formulated for Calls for Action 2 to 6 in response to input questions from the participants of the 2018 Working Session (visit **www.thedecisiongroup.nl/value-agenda-nl** for the full input document). This resulted in a total of 15 actions needed to continue the journey towards large-scale VBHC implementation and to move the VBHC needle together (see page 4).

Progress needed on the other Value Agenda NL - Calls for Action: highest priority actions

Call for action 2: Integrated Care	
6. Navigate leadership in the direction of teamwork	
7. Create shared responsibility and accountability across various departments	
Call for Action 3: Universal Measurement	
8. Start making outcome measurements mandatory	
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Call for Action 5: Patients' Choice	
12. Make outcome information available and empower the patient by providing the relevant information to make an informed decision	
13. Include outcome measures, preferably PROMs, in the consultation room to discuss best treatment with patients	
Call for Action 6: Complex care	
14. Rigorously manage the interfaces between the several care providers and IPUs strictly	
15. Create IPUs that focus on managing high risk/complex patients	

Medical industry
Care providers board/management
Health insurers
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Stimulators/Enablers (Government + IT)

Call for action 2. Integrated Care

Key action 6: Navigate leadership towards teamwork by care providers board/management and care providers – (para) medical team

Leadership should be navigated towards teamwork and the entire team. In order to make the transition to coherent teams, institutions need strong VBHC leadership with a focus on the team. Passionate leaders should lead the way and encourage colleagues to change and work together rather than individually. The entire team needs to be involved, because they have to make the change together. To accomplish this, not only clinicians, but people responsible for the organisational aspects also need to be involved.

Key action 7: Create shared responsibility and accountability across different departments by care providers board/management and care providers – (para) medical team

Shared responsibility and accountability should be created across different departments, on the basis of the patient and medical condition. This will automatically lead to different ways of organizing care delivery. Accountability needs to be embedded in the culture and organizational context, instead of being enforced top-down. Lastly, the value of integrated care needs to be communicated to other medical specialists, nurses, etc. Managers and the board of directors should motivate others to work in this way.

Call for action 3. Universal Measurement

Key action 8: Start making outcome measurements mandatory by stimulators/enablers, care providers board/management and health insurers

Government needs to specify outcome measurements and make them mandatory, In addition, private funders need to choose to go down this path. Outcomes need to be made part of every patient's care. Standard sets of true outcomes measures are rapidly becoming available for most major conditions (nationally and globally); which form a good starting point. Medical teams need to be taught to implement and work with standard available outcome sets to manage, act and report on outcomes.

Key action 9: Teach medical teams to work with outcome sets by stimulators/enablers, care providers board/management, care providers – (para) medical team and care/patient associations

Working with outcome sets may seem obvious and easy, but in practice this is far from the case. Medical teams are not used to working with outcomes, instead they mainly work with only the (limited number of) clinical outcomes and with process measures that focus on a part of the integrated care. So, serious attention is required here. The implementation of any outcome set to ensure measurement and careful recording is only step one. The real 'value' is in the way the outcome set is used to continuously learn and improve on outcomes. The key to working with an outcome set is that it is all about people. Medical teams need to learn how to manage, act and report on outcomes. While patients need to be informed about the collection, sharing, use and feedback of outcomes throughout the entire care cycle.

Call for action 4. Bundled payments

Key action 10: Focus less on shared savings and more on improved outcomes to stimulate outcome-based payments and innovation by stimulators/enablers and health insurers

An increased focus on shared saving structures with regards to long-term contracts can currently be observed. Although this is a great way to share benefits resulting from improved and more efficient care delivery, the focus/incentive of long-term agreements should initially be set on the improvement of outcomes and innovation. In this way, the conversation is shifted from 'how to share the pie we create' to 'how can we create a bigger pie that patients (and others) can enjoy'. What we need is less focus on shared savings and more focus on improved outcomes and innovation.

Key action 11: Start by defining a longer-term contract with learning potential by health insurers and medical industry

Let's start by defining a longer-term contract with learning potential. Make agreements over multiple years, based on current arrangements, with a quality/outcome incentive. Reward better outcomes and find ways to link any financial/cost benefits to improve outcomes or innovation as well.

Call for action 5. Patient Choice

Key action 12: Make outcome information available and empower the patient by providing the relevant information to make an informed decision by stimulators/enablers, care/patient associations and care providers – (para) medical team

Outcome information needs to be made available to patients. There are two perspectives to this:

1 Outcomes for all patients with the same medical condition at a hospital level to inform them (and all referring specialists in primary and secondary care) so they can make an informed decision to choose/not choose a care provider;
2 Outcomes for all patients with, and patient segments within, a medical condition to set learning cycles/meetings to improve outcomes with the entire multidisciplinary team.

For both perspectives, a core outcome set should be aligned between various healthcare providing organizations (additional outcome measures can be used to differentiate); the acceptance, adoption and implementation of already existing sets (ICHOM/NHS and local sets) by medical teams should be accelerated to bear the fruits of patient choice on a large scale.

Key action 13: Include outcome measures in the consulting room to discuss best treatment with patients by care providers – (para) medical team and care/patient associations

Include outcome measures, preferably PROMs, in the consulting room to make a weighted and medically informed decision together with the doctor on a preferred treatment plan. Outcomes need to be made part of every patient's care. Standard/standardised sets of outcome measures are available for many major medical conditions; these form a good starting point. Medical teams need to be taught to work with the standard outcomes sets to manage on outcomes, act on outcomes and report on outcomes.

Call for action 6. Complex Care

Key action 14: Rigorously manage the interfaces between the several care providers and IPUs

by stimulators/enablers, care providers board/management and care providers – (para) medical team

This Call for Action can only be accomplished if there is rigorous management of the interfaces between the various care providers and IPUs. As VBHC progresses and care is increasingly integrated into IPUs, two main IPU types will arise: Primary Care IPUs organized around a defined patient segment (with similar medical needs) and Specialism IPUs organized around a defined medical condition. To allow for efficient and effective care delivery and to minimise instances of patients 'ping ponging' between the two, it is highly important to put a strong emphasis on creating/making the connections between primary and specialism care IPUs or multiple specialism care IPUs.

Key action 15: Create IPUs that focus on managing high risk and/or complex patients

by care providers board/management and care providers – (para) medical team

IPUs should be created around patients' medical needs and also IPUs that focus on managing high risk and/or complex patients. Specialised IPUs should be created that only manage patient risk in order to identify the primary medical condition quickly (increasing first time right) and refer on to the specialised IPU for that primary medical condition. In addition to IPUs that are able to quickly assess patients and assign them to the right specialised IPU, IPUs will emerge with a focus on better management of high risk patients by a focus on prevention, care and earlier intervention (moving from cure to care to preventive care).

Next steps

The six Calls for Action described above leave the next steps that need to be taken in no doubt. The focus is clear; Leadership and Culture and Universal Measurement are the most important priorities. However, actions are described for every Call for Action, and stakeholders could contribute at every implementation level described.

On April 18, 2019 (under reservation) we will again assess progress and identify the relevant challenges to further incentivize the implementation of VBHC in the Netherlands together with key decision makers in health care and a prominent international VBHC expert. For further information about the next Working Session, please contact Vincent Wiersma at **v.wiersma@thedecisiongroup.nl** or stay up to date via the website: **https://www.thedecisiongroup.nl/value-agenda-nl**

Until then, we will actively support the implementation of the actions illustrated in this report and we hope you will do as well.

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Website The Value Agenda: www.thedecisiongroup.nl/value-agenda-nl

Website Value-Based Health Care Center Europe: www.vbhc.eu.

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