Value-Based healthcare

from theory to practice

An implementation guide
Many roads lead to value-based healthcare

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1 A guide to value-based healthcare

1.1 Background to the guide

Dear readers! The discussion on value-based healthcare (VBHC) has arrived in Switzerland. When it comes to putting this concept into practice, many providers are still at the beginning of their journey. That is why the fmc Swiss Forum for Integrated Care, in cooperation with All.Can Switzerland, set itself the goal of discussing the implementation of the value-based healthcare concept with recognised experts in a practice-oriented webinar. It took place in September 2021.

This guide has been written based on the webinar and is intended to help providers interested in value-based healthcare on their way to a successful implementation. In the spirit of value-based healthcare, we have chosen a multidisciplinary approach for its development. We incorporated elements from theory, lessons learned from practical experience, examples from existing toolkits from other countries, and elements from project and innovation management.

fmc

As an independent think tank, the fmc Swiss Forum for Integrated Care promotes the exchange of knowledge, insights and experiences for better integration and coordination of health care. Our aim is to always increase the quality, efficiency and safety of treatment and care for patients.

You can find out more about the fmc at
www.fmc.ch

All.Can

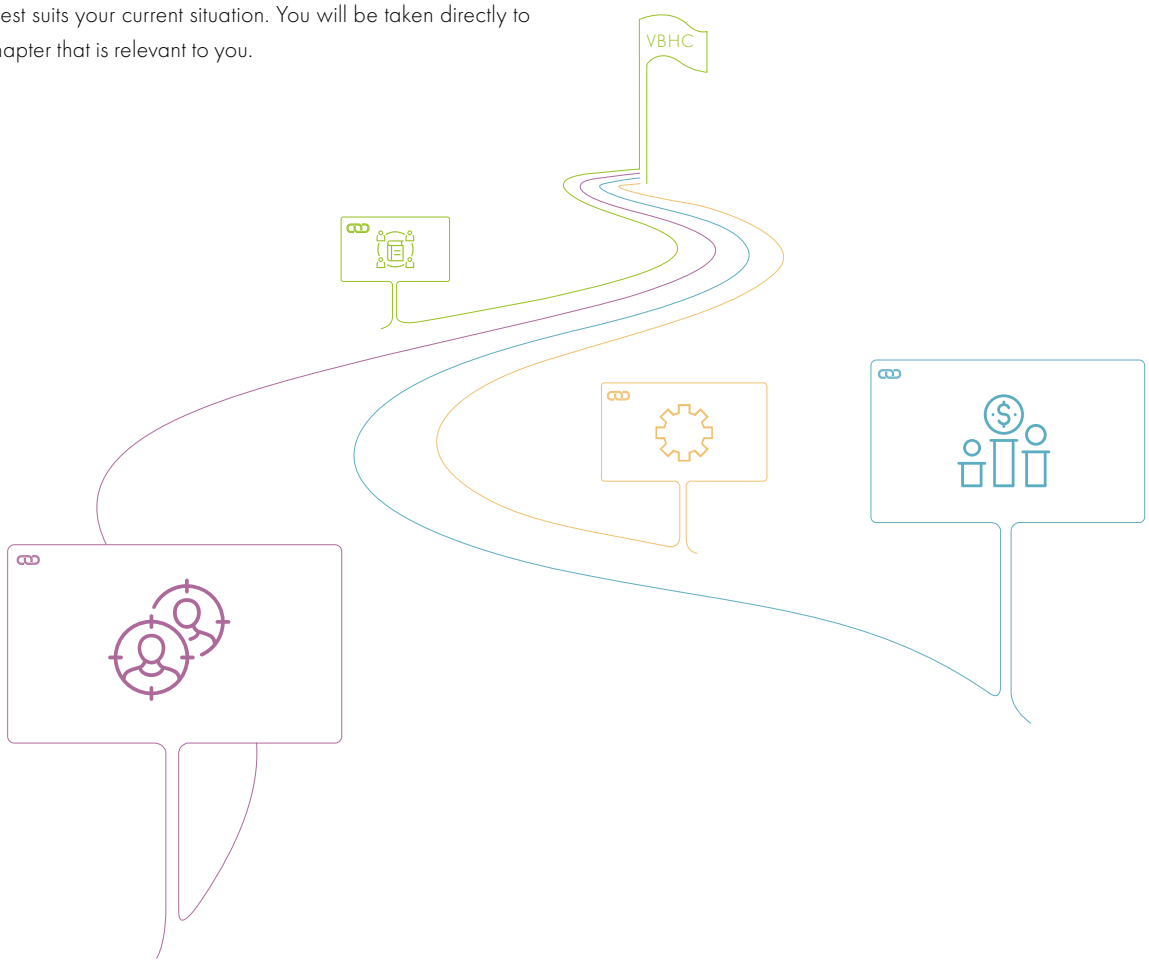
All.Can Switzerland is committed to sustainable and high-quality cancer care. All.Can Switzerland firmly believes that this goal can only be achieved through close cooperation between all parties involved: patients, healthcare professionals, health insurers, the scientific community and the pharmaceutical industry are working hand in hand with great dedication to achieve this. The All.Can initiative now exists in over 20 countries.

You can find out more about All.Can Switzerland at
www.allcan-schweiz.ch

1.2 Structure of the guide

The guide consists of different parts to allow you to begin from where you are.

Read through the following statements and move to the colour that best suits your current situation. You will be taken directly to the chapter that is relevant to you.



You are not or little familiar with VBHC and would like to start by getting an overview of the theory and knowledge about the background of the concept.
Start here

You are familiar with the basic features of VBHC and have ideas for projects. You want to prioritise these ideas and get to the implementation phase/drive implementation forward or put yourself in the customers' (= patients') shoes.
Start here

You are familiar with the VBHC concept and VBHC projects are already running in your organisation. As part of the continuous improvement process, you would like to have a quality check of your initiatives/processes.
Start here

You are familiar with the theory of VBHC and want to learn from external experience. You want to draw comparisons based on case studies or simply be inspired.
Start here

In addition to the VBHC roadmap and its links, the following elements will help you navigate the guide:

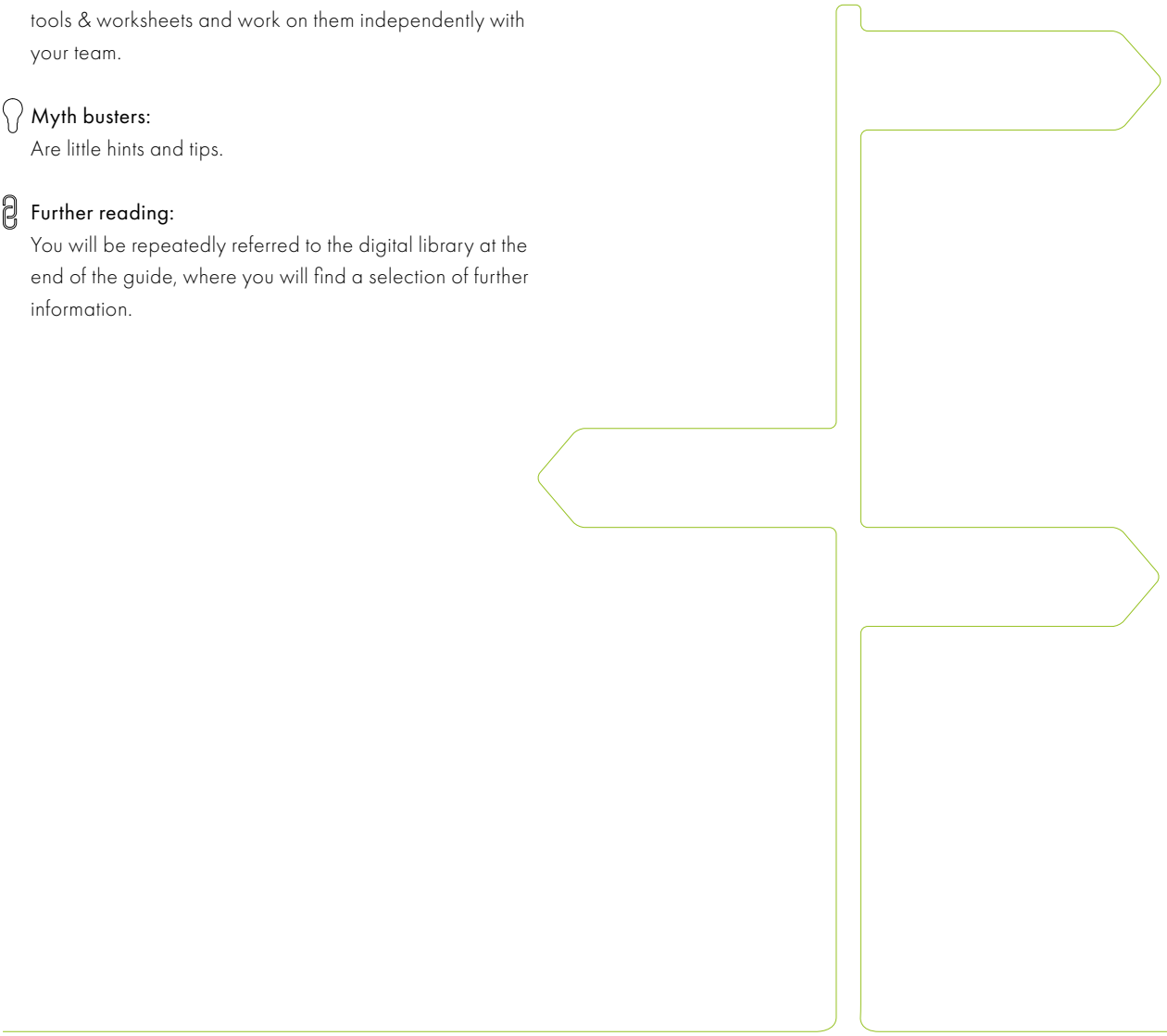
Reflection questions:
Help you to relate what you read to your own context.

Tools & worksheets:
Help you with specific challenges. You can download the tools & worksheets and work on them independently with your team.

Myth busters:
Are little hints and tips.

Further reading:
You will be repeatedly referred to the digital library at the end of the guide, where you will find a selection of further information.

The tools and reflection questions are not intended to give conclusive and/or right/wrong answers. Rather, they are intended to stimulate critical reflection and discussion along VBHC's implementation path, as well as to facilitate initiatives and changes before or during the implementation process.



Definition of terms

Both the concept and the terms used in VBHC were mainly coined in the US-English language area.

Value

There is no general definition of value in value-based healthcare. The definition of value is subjective and what is considered valuable may differ between patients, clinicians, healthcare providers, policy makers and industry advocates. In this document, value is primarily understood as defined by M. Porter, as (added) value for patients.

Value-based healthcare

A concept of healthcare that focuses on value for patients, and where reimbursement for providers is based on outcomes rather than volume. Value can be defined for other aspects, such as: technical, allocative, societal or for the workforce.

Patient-reported indicators

Disease-specific Patient Reported Outcome Measures (PROMs)
These instruments are specifically designed for a disease (e.g. breast cancer) or a procedure (e.g. joint replacement). These PROMs are tailored to the symptoms of a specific condition or to the symptoms that are to be treated with a specific procedure. Their advantage is that they are sensitive and specific.

General health ('generic') Patient Reported Outcome Measures (PROMs/QoL instruments)
These instruments map the broader range of physical and psychosocial domains that are considered important determinants of health-related quality of life. Their advantage is that they can be compared across different disciplines, procedures and interventions.

Patient Reported Experiences (PREMs)
Patient experience is measured using various surveys or questionnaires. The questions can be tailored to a specific area (e.g. primary care, hospital sector, long-term care) or can highlight a particular aspect of care or treatment pathway (e.g. continuity, autonomy, information provision). PREMs have become increasingly sophisticated and go far beyond the more subjective patient satisfaction surveys of the past.

2 Value-based healthcare guide – from theory to practice

2.1 Value-based healthcare – understanding the theoretical approach

2.1.1 Why we need a new approach towards healthcare – a case for change

In Switzerland, we have an excellent health system in many respects. But is it sustainable? Similar to other countries, the costs of healthcare have been rising inexorably and increasingly represent a burden for the national economy and the population. This increase in healthcare costs is partly due to higher life expectancy, but also to rapid technological development and the associated availability of new diagnostic and treatment methods.

The current system of reimbursement also creates incentives for providers to increase the volume of services. This approach can lead to overuse and wasteful spending. Unnecessary treatments can be carried out without complications and therefore remain unnoticed, even though they do not improve the patient's quality of life. This can lead to misuse or overuse of treatments. At the same time, precisely these resources may be lacking elsewhere in the system, and shortage can occur.

Healthcare systems around the world face similar challenges, despite the hard work of well-intentioned and well-trained clinicians, and investments in infrastructure. Over the last two decades, different management and solution approaches have been applied to correct the weaknesses in the system: evidence-based decision-making, improving quality of care, cost reduction programmes, etc. These are all good approaches, but none of them has fully had the desired effect to date.

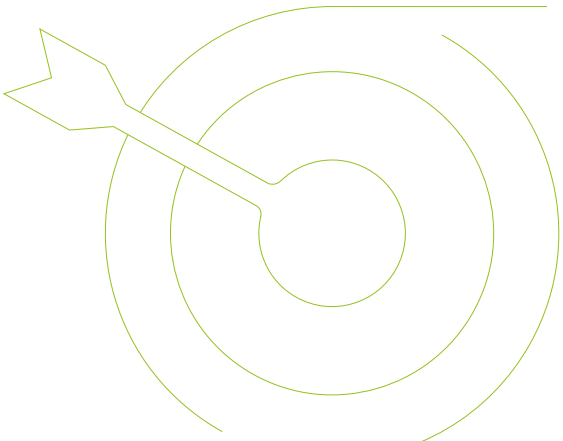
In response, experts and innovators around the world have made it their goal to improve the value (= outcome) of healthcare for (certain) patient groups or population groups. This has given rise to the concept of value-based healthcare (VBHC).

2.1.2 What is value-based healthcare?

M. Porter and E. Teisberg from Harvard Business School are the founders of the VBHC concept. In response to the challenges identified in 2.1.1, they proposed a shift from a supply-oriented healthcare system to a patient-centred system as early as 2006 🔗. Their idea is to shift the focus from activity to results, or in other words: all parties involved in a care system are geared towards offering added value to patients. This sets VBHC apart from a supply-driven health system, driven by the activities of health professionals and remunerated by volume, towards a system that puts the individual at the centre and is organised around the needs of that person. The following equation is used to determine the (added) value:

The aim is to provide the best possible care for each patient within existing resources. The approach promotes the integration of healthcare and therapy across the entire patient pathway, which starts with the first symptoms.

Resources refers not only to financial resources, but to all kinds of resources, including personnel, infrastructure, etc.



This means that health outcomes are no longer measured and ultimately reimbursed solely on the basis of the volume of services provided (e.g. number of surgeries performed, treatment days per patient, etc.), but on the basis of the final outcomes for the health of the patients (= PROs). The measurement of outcomes should not be seen as a replacement for existing indicators, but as a complement. The data set of a VBHC institution includes data on costs (or time per patient, costs per operation, etc.), the process (number of days between outpatient visit and operation, cancelled/postponed operations, etc.) as well as data on outcomes (quality of life, pain, functionality, etc.).

PROs are a part of VBHC. However, collecting PROs does not automatically equate to VBHC.

M. Porter and E. Teisberg have initiated a global, ongoing discussion among health professionals and other stakeholders around the concept of VBHC. The VBHC concept is constantly evolving and being implemented in different ways. However, all VBHC initiatives follow the same basic idea: to use the limited resources available for the right care, at the right time, at the right place, to improve the person's benefit.

2.1.3 Value – but for whom? Goals/aims of value-based healthcare

Achieving the highest possible value for patients is the overarching goal of healthcare. One way to assess the real value of care is to measure outcomes from the patient's perspective. This is exactly what VBHC can offer. According to Porter, value is defined as the health outcomes achieved per resource spent (see equation on p. 3). This approach accelerates innovations that bring real benefits to patients.

Leading researchers in Europe point out that the VBHC concept devised in Harvard falls short in European health systems. Sir Muir Gray (Oxford University) suggests adapting Porter's original VBHC concept. As in most European countries, universal healthcare systems have the explicit and statutory obligation to meet the needs of all residents within a limited budget.

Sir Muir Gray proposes a link between value-based healthcare and population health that considers value across three dimensions (1 – personal, 2 – technical, 3 – allocative value). The European Commission has added a fourth dimension (4 – societal value) to this model. From the fmc perspective, another dimension should be included: 5 – value for healthcare workforce. To summarise: the definition of value should always focus on patients – embedded in the broader dimensions – and in a VBHC system, the creation of value for patients determines the rewards for all other players in the system.

2.1.4 Elements of value-based healthcare

To create a sustainable health system, it is no longer enough to make progress in isolated treatment areas; real progress can only be made by looking at patient pathways holistically, starting with the first symptoms. To do this, we need to break down the silos of traditional organisational divisions that have developed so that the different providers can coordinate and complement each other's care services.

The VBHC concept consists of the following elements:

- Patient centred/patient-oriented:
  Patients and their needs are made the focus as customers of the services provided. Patient-oriented means breaking away from specialties, breaking down structures and silos and building care around patients. There are clear patient pathways for all services and active involvement of patients in their development. Ideally, there is a form of cooperation in which patients are seen as partners (co-designing the process, patient engagement etc.).

- Measuring and using outcomes:
  Based on the criteria considered important by patients, the outcomes to be measured are defined and collected. Different clinical conditions require different outcomes. Quality is more important than quantity when it comes to outcomes. Choosing standardised instruments enables comparison with other clinics and providers and makes it easier to introduce continuous learning as a prerequisite for any quality improvement. Measurement alone is not enough. There is a clear, logical concept of use for the data collected.

- Coordination/integration of care:
  Building upon the patient pathway, the provider assumes their position and role within patient-centred care. Integration can first take place internally (building multidisciplinary teams across department, specialties) and then externally (via joint care plans, mergers, initiatives, fully integrated care pathways). Integration can also extend to completely new care models. This requires time and a good basis for discussion with the involved parties.

- Governance/organisation:
  The vision and strategy are clear to all involved and is steered centrally (service provider or system level). At the same time, the governance allows enough scope to implement the upcoming changes and the staff is empowered to make decisions independently within these structures. This means that staff are given responsibility and can independently implement improvements along the treatment pathway.

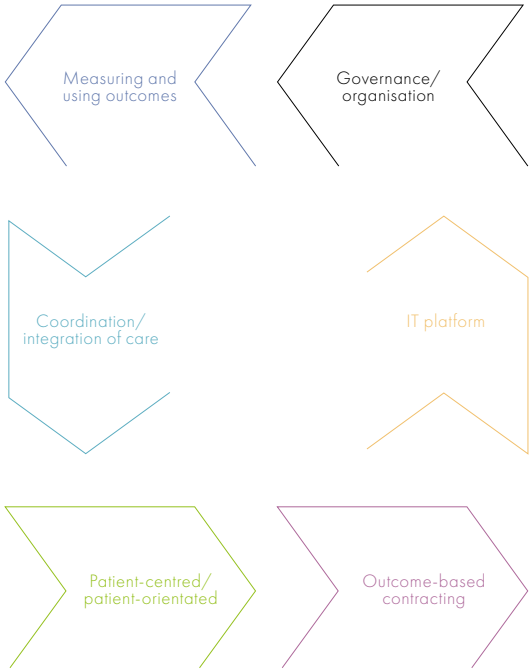


Figure 1 – Original illustration

- Outcome-based contracting:
  New reimbursement contracts can be a catalyst for patient- and outcome-based care. In addition, they help to stabilise this by financially mirroring the adapted care at the pathway level and thus interconnecting these two worlds. It is advisable to start the discussion with the involved stakeholders at an early stage in order to create common ground. A certain flexibility is advisable when negotiating contracts. Outcome-based reimbursement is introduced in stages, for example starting with shadow billing for the baseline, then fee-for-service with quality bonuses, through to flat rates or bundled payment models.

- IT platform:
  You need a platform that allows for easy collection and analysis of the additional indicators. Integrated solutions, where patients can answer their questionnaires directly on their smartphones or tablets, increase the acceptance of patients and care teams. The latter also benefit from immediate availability and meaningful analysis readily available on the care teams' desktop in real time.

If your organisation is thinking of moving towards VBHC, always start with a clear vision of an integrated care pathway, as well as a shared understanding of what value (patient benefit) means in this context.

As these elements are interrelated, it is important that you take coordinated action across all areas. M. Porter goes one step further with his 'Strategic Value Agenda' and proposes a sequence of steps. Starting with the formation of Integrated Practice Units, Porter's final step is the introduction of an IT platform. When talking to experts about the introduction of VBHC, most of them agree that this exact sequence does not necessarily have to be followed. However, they all point out that the formation of multidisciplinary care teams (as opposed to organisation by individual specialties), the collection and measurement of relevant data and an associated IT solution are indispensable for the first steps.

Find more information in the webinar case studies or take inspiration from Porter's Value Agenda.

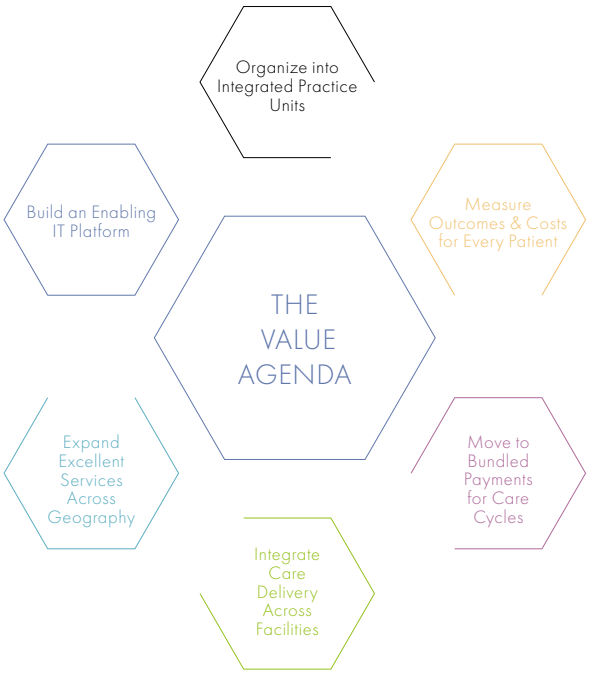


Figure 2 – Porter's strategic Value Agenda (Source: NEJM Catalyst)

2.1.5 Prerequisites for implementation

The concept of VBHC can be approached in diverse ways when it comes to implementation. Therefore, we do not have a ready-made blueprint for implementation. However, there is a toolkit consisting of the elements described above as well as a wealth of experience you can draw on. A strength of VBHC is that you do not have to fit into a given structure designed for other conditions or systems. Rather, you can co-shape and arrange the elements in a way that you can address your challenges and, have a VBHC concept that is aligned with your reality at the same time.

Building on the experience of an ever-growing VBHC community, we have learned that certain factors being clearly focused on patient benefit (= value) supports the implementation of VBHC.

When experts and practitioners are asked for their recommendations to people who would like to embark on the VBHC journey, they mention the following points:

- Medical leads:
  VBHC is more than the next management magic wand. There must be a desire and the possibility for VBHC to be experienced at the grassroots level. Therefore, the care teams should also drive implementation.

- IT solution:
  Of course, it is possible to collect patient-reported indicators with paper and pencil, but experts recommend the swift introduction of an IT solution that allows patients to fill in the form via a smartphone or tablet, provides care teams with easy-to-understand analyses in real time, and allows for benchmarking, etc., at a provider and system level.

- Teamwork:
  VBHC is not a quick fix, but a sustainable change that takes time and requires a highly motivated team with perseverance. This means there needs to be a necessary minimum level of staff resources and/or support from the administrative departments.

Reflection questions for Chapter 1:

Now you are more familiar with the VBHC concept: What benefits could VBHC bring to your clinic/department/organisation? What considerations would need to be made?

To what extent is your practice/clinic geared towards providing as many services as possible (e.g. number of procedures performed, number of diagnostics used, etc.)? Which treatments/examinations would you say yes/no to if the volume aspect did not play a role?

What challenges do you see for the VBHC concept and/or its implementation in the context of your organisation?

If you would like to read more about the experiences of experts and professionals, you can do so here.

2.2.1 Changing perspective and prioritising

Taking the patient's perspective

The use of customer insights is standard in other industries when it comes to developing or improving a product/service. Therefore, a team often takes the perspective of the customer – in our case patients.

The Voice of the Patient (VoP):
This simple tool helps you and your team to listen to your patients more consciously and provides various ideas on how this could be done.

Patient satisfaction/wishes:
The Kano Model helps to capture what is necessary, important or a 'nice-to-have' from the patient's point of view.

Prioritising

Innovation and project implementation is as much about deciding what not to do as it is about deciding what to do ('We can do anything, but we can't do everything').

Collect ideas with Crazy Eight:
A simple exercise to collect everyone's ideas and select the most promising ones.

Effort/impact matrix:
A simple tool with a big impact. Locate your ideas in the matrix and get a clear view of the relationship between effort and impact.

Matrix as solution finder:
A simple tool that weighs ideas according to jointly defined criteria and enables an informed, consensus-based decision for the next step.

2.2 From theory to practice – tools and worksheets

Here you will find a number of tools and worksheets that you can work on together with your team.

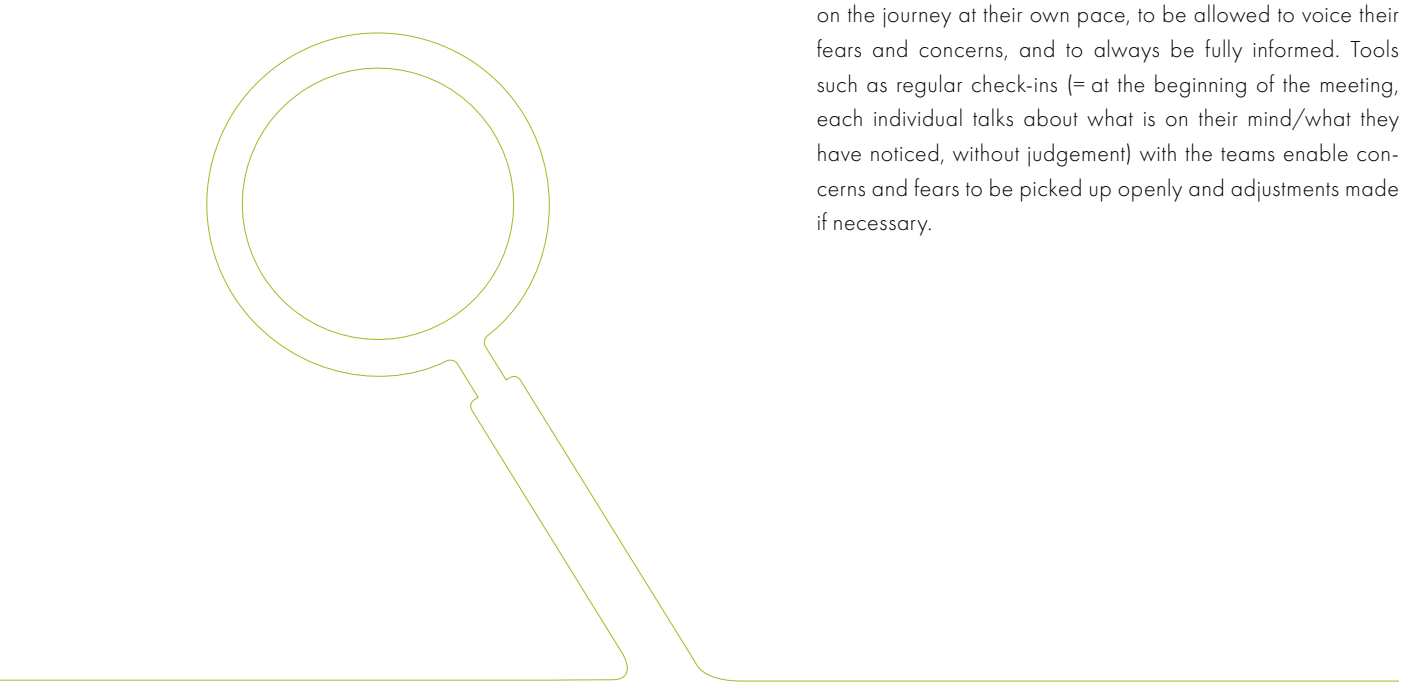
2.2.2 Improvement

A fundamental principle of VBHC is the pursuit of continuous improvement. Each process can be subjected to critical review and improvements can be introduced.

Team reflection:
Often, there is very little time available in the daily routine of a clinic for joint reflection on its quality improvement efforts. This simple tool gives you a framework for that conversation.

Improvement cycles (plan-do-study-act):
An improvement cycle is a helpful tool to set, plan and measure quantifiable goals and to document, test and refine changes or adjustments.

You can find more examples of tools and inspiration here.



2.2.3 A few words on project management

Hardly any other industry is as complex and has as many different stakeholders, dependencies, objectives, interests, etc. as the health sector. This often leads to innovative projects facing strong headwinds. Do not let this discourage you.

You can influence whether you and your team end up toasting successful implementation or whether your efforts come to nothing. Studies on project management in healthcare institutions show that 'lack of resources at the project start' and 'unclear definition of goals and requirements' are the most common reasons for project termination. This can be avoided by investing enough time in properly planning a project and getting more resources if you have little time.

Another time-consuming aspect, which we often underestimate, is summarised under the term 'change management' (= how we manage the changes that a project can entail). Think of an example in your life where someone presented you with a process change or a finished product without involving, informing or consulting you. How did that make you feel?

New concepts like VBHC demand a lot from our organisations and teams. For example, it is not enough to introduce an IT platform for the collection of PRO data. For a project to succeed, all participants should have the chance to come along on the journey at their own pace, to be allowed to voice their fears and concerns, and to always be fully informed. Tools such as regular check-ins (= at the beginning of the meeting, each individual talks about what is on their mind/what they have noticed, without judgement) with the teams enable concerns and fears to be picked up openly and adjustments made if necessary.

2.3 Case studies – inspiration

Countries, regions and care providers around the world have started to put VBHC or elements of VBHC into practice. In doing so, the stakeholders are applying different approaches. Some of the initiatives originated directly at the grassroots level (bottom-up), others at the operational strategy or health policy/regulatory level (top-down) and some were initiated by the industry. Other initiatives arose from the further development of previous management concepts, such as cost containment or quality improvement. Up to now, projects that were driven in a purely top-down manner have been less successful. Ideally, there is an interplay between top-down and bottom-up approaches that complement each other. As you can see, there is no right or wrong. The beauty of the VBHC concept is that you can adapt it to your individual needs.

2.3.1 Case studies in the fmc webinar

In the fmc webinar of 29 September 2021, two case studies were presented and discussed in detail. Both case studies can be viewed online at the following link (Martini Clinic Hamburg starting from minute 34:32 and University Hospital Basel from minute 1:08:36). The case studies are summarised in terms of the six VBHC elements below.

Martini Clinic (Germany), specialising in the diagnosis and treatment of prostate cancer

- Patient centred/patient-oriented:
  The Martini Clinic (MC) processes are fully patient-oriented. The core of the process design here lies in the question 'How would you like things to be as a patient?' This starts with the initial contact with the patient and continues throughout the outpatient and inpatient care. The Martini Clinic also sees itself as a partner for patients after they have been discharged from hospital. The parallel measurement of outcomes creates a win-win situation thanks to ongoing information collection for the clinic and optimal care for the patient according to the latest scientific findings.

- Measuring outcomes:
  In Hamburg, the following outcomes are included in measurements in addition to the traditional clinical indicators: PROMs (quality of life, continence, erectile function, oncological follow-up therapies) and CROMs (Clinician-Reported Outcome Measures). The MC has developed its own database and a team supports it in data collection and processing (consisting of two database technicians, three documentation assistants, a statistician and a medical doctor).

- Coordination/integration of care:
  Within MC, a multidisciplinary team works at eye level on the caring for the patients. In addition to the University Medical Centre Hamburg-Eppendorf, the partners also include various medical institutions and health insurance companies in Germany and abroad.

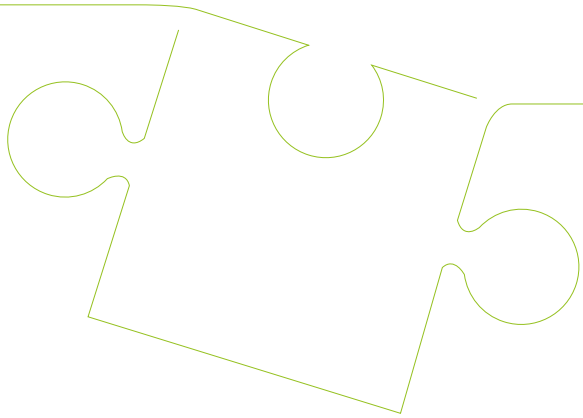
- Governance/organisation:
  The MC team culture is anchored in the imperative on continuous improvement – the conviction that you never stop learning. MC has developed a unique organisational structure of the Integrated Practice Unit (IPU), called the 'Martini principle'. The principle includes a strategy that focuses on outcome measurement, team collaboration and continuous improvement. Every six months, the treatment team reviews and discusses the results of the treatments. A discussion between peers also makes it possible to deal openly with one's own results and those of the other practitioners.

- Outcome-based contracting:
  Yes – within the organisation. The MC applies a unique remuneration system that incentivises improved results and team cohesion.

- IT platform:
  The MC works with Philips VitalHealth QuestLink IT solution to collect patient-reported outcome data.

- A great tip that you don't find in the textbook:
  Outcome measurement is an investment in the future. The results are becoming more and more important every year. Therefore, it makes sense to start early and not get lost in perfectionism. If things don't work as hoped, you can always readjust them.

  (The case study was written with the support of Dr Burkhard Beyer.)



The University Hospital Basel using the example of breast cancer

- Patient centred/patient-oriented:
  With the idea of VBHC as a forward-looking concept, the University Hospital Basel (USB) took the first step towards value-based medicine at the end of 2017. Oriented towards the ideas and preferences of patients, the USB started with the introduction of the first PROM survey for breast cancer patients. As of January 2022, the USB collects PROMs for more than 20 medical conditions in over 6,000 patients.

- Measuring and using outcomes:
  Specialised breast care nurses discuss the digitally recorded PROMs with the patients. This quickly reveals where there is a need for action and where the treatment pathway needs to be adapted. Taboo and intimate areas, family roles and other aspects affecting the quality of life are comprehensively covered. The standardised ICHOM set for breast cancer serves as a basis, taking into account the daily quality of life of the patients in addition to clinical course data.

- Coordination/integration of care:
  At the USB, the involved departments are integrated along the individual treatment pathway. In the example of breast cancer, all processes of all integrated disciplines* as well as the standardised outcome measurement are organised around the patients so that the desired added value can be achieved together. (*breast surgery, diagnostic radiology, gynaecology, oncology, pathology, plastic surgery, psycho-oncology, radio-oncology, senology, specialised care).

- Governance/organisation:
  Based on the experiences and learnings of the various clinics and centres, a 'VBHC ecosystem' has been created at the USB. The analyses from aggregated PROM data are discussed with the medical staff and care professionals within the framework of annual reporting. From this reporting, necessary adjustments for treatment can be derived. Quarterly updates with updated figures, biannual discussion forums for interested parties and an international symposium most recently organised in 2021 consolidate the claim of a VBHC concept that is anchored across the whole hospital. VBHC elements can be found in the hospital reform 'USB Plus', implemented in 2021, with the formation of six medical departments, following the structure of the organ system. This restructuring means that clinics and centres can respond more specifically to the needs of patients and are no longer subject to the static structural division into surgery, medicine and cross-sectional functions.

- Outcome-based contracting
  For hip joint arthrosis, lung and prostate carcinoma, the mapping of the 'value equation' models for outcome-based payment in the Swiss health care system is being evaluated in various projects. Collaborations with other stakeholders from the pharmaceutical/medtech sector and health insurers are central to this process, in which financial and PROM indicators, the incentivisation of service providers through PROM-based quality data and innovative, VBHC-based payment models are evaluated on an exploratory basis.

- IT platform:
  The USB is working with the Berlin-based digital company Heartbeat Medical in a development partnership.

- A great tip that you don't find in the textbook:
  Including all directly or indirectly involved professionals (nursing staff, medical staff, administration) in the implementation of VBHC aspects is a key to success. In addition, the change should be made understandable and tangible through open and regular communication at all levels.

  (This case study was written with the support of Dr Florian Rüter).

2.3.2 Further case studies

The following case studies and projects along the patient pathway show the diversity in how VBHC can be implemented in practice.

Oak Street Health (US)

Care Continuum:
Primary care
Added value for patients:
Focus on prevention and inclusion of social care
Special feature:
Social factors play an important role for the population group served and are part of the care plan here

Oak Street Health is a primary care provider with about 25 centres for adults who use Medicare (= health insurance specifically for older people). Oak Street operates predominantly in communities where there is little to no quality healthcare. Oak Street's care is based on a new organisational model that follows Porter's VBHC principle of moving away from service volume towards patient benefit. The innovative model removes all risk for patients from insurance providers; i.e. in the event of an avoidable hospital admission, Oak Street Health is held financially responsible. Focus lies on prevention. Patients should stay healthy for as long as possible. To achieve this goal, Oak Street Health offers, among other things, psychotherapeutic measures or transport to and from appointments, in addition to classic primary care services. In addition, Oak Street organises events for the elderly to meet not only their health needs but also their need for social contact (interplay of health and social care). With this model of care, Oak Street Health has been able to reduce hospitalisations by 44 % since 2013.

Santeon clinics (Netherlands)

Care Continuum:
Hospital
Added value for patients:
Actively involved in shaping service
Special feature:
Patients are part of the improvement teams

The private hospital chain Santeon covers about 11 % of care in the Netherlands with its 7 hospitals. In 2016, the chain started to measure outcomes, costs and relevant process indicators for five patient groups and to compare them within the chain. Since then, the 'Samen Better' (Better Together) programme has emerged. The care programme now covers 15 disease profiles. The programme involves one improvement team working together for one illness at a time. The improvement team consists of a health professional, a project manager, a data analyst and a person affected by the illness. Together they determine the characteristics of the patient group, the treatment options and the scorecard. Based on the scorecard, the results are measured, analysed and discussed with the hospitals in the chain. This is a continuous learning and improvement process that is repeated every six months. By comparing results and working methods between Santeon hospitals, the number of reoperations due to post-operative bleeding or wound infections has been reduced for women with breast cancer, for example.

Swiss Medical Network and Biel Hospital Centre (Switzerland)

Care Continuum:
Hospital
Added value for patients:
Shorter hospital stays
Special feature:
Focus lies on patient pathways, which has a positive impact on patient satisfaction, costs and quality

Working together with the private hospital group Swiss Medical Network (SMN) and the Biel Hospital Centre, Johnson & Johnson has gained initial experience in moving towards VBHC in the specialist area of orthopaedics, in projects to optimise patient pathways. The aims of the programme are to optimise the outcomes of medical treatments, improve patient experience and reduce costs at the same time, as part of the Triple Aim approach. The participating Swiss hospitals are having a positive experience with the programmes, and it has been expanded to include the recording of PROMs. The SMN Clinic La Providence in Neuchâtel has been able to reduce the length of hospital stays in hip and knee operations by up to 40 % by mobilising patients more quickly and thus promoting faster recovery. Implemented correctly, this leads to cost savings while increasing patient satisfaction. Further pilot projects are planned to record PROMs in other specialties.

Hôpital de La Tour (Switzerland)

Care Continuum:
Hospital
Added value for patients:
Focus lies on the specific, measurable added value for patients in terms of their quality of life and health outcomes
Special feature:
From the beginning, La Tour focused on the horizontal integration of teams and a lot of individual responsibility

Patients have individual needs and different health goals. With the VBHC approach, the Hôpital de La Tour combines the medical excellence of ultra-specialised healthcare teams with personalised treatment pathways. For doctors, nurses and therapists, VBHC means increased and integrated collaboration in 'centres of excellence' with a focus on designing and improving specific care pathways. Patients can therefore be sure that they will receive exactly the right care, which will really benefit their condition and bring them closer to their health goals. This approach requires consistent measurement of outcomes. The measurements consist of patient-reported and clinical indicators and take into account the service costs incurred. Thanks to the measurements, the health teams at the Hôpital de La Tour can continuously improve care pathways and align them with patients' individual health goals. A recently published study showed how the expected added value in terms of quality of life and outcomes of patients is realised.

Living Lab in Ageing and Long-Term Care (Netherlands)

Care continuum:
Nursing and care homes
Added value for residents:
Residents and their relatives help to shape their everyday lives
Special feature:
A Living Lab is a real laboratory, a new form of cooperation between science and society that focuses on mutual learning in an experimental environment. Here, studies are conducted in real time and findings are immediately put into practice

When a new quality framework was introduced in the Netherlands in 2017 to maintain and improve the quality of care in nursing homes, the idea of using the Livings Lab methodology was formed. 'Good quality' is resident-centred and delivered in a network of residents, family members and staff. The Living Lab in Ageing and Long-Term Care aims to support this process. It involves the key basic idea that care homes are allowed to be 'learning' organisations. This means the organisation can adapt more quickly to a constantly changing environment and still take into account the complexity of care services. The aim of this initiative is to create an open learning and improvement climate in care homes. To achieve this goal, the Living Lab in Ageing & Long-Term Care brings together residents and family members, staff care home managers, as well as researchers and lecturers (working at a university, a university of applied sciences or a vocational training institute).

ParkinsonNet (Netherlands)

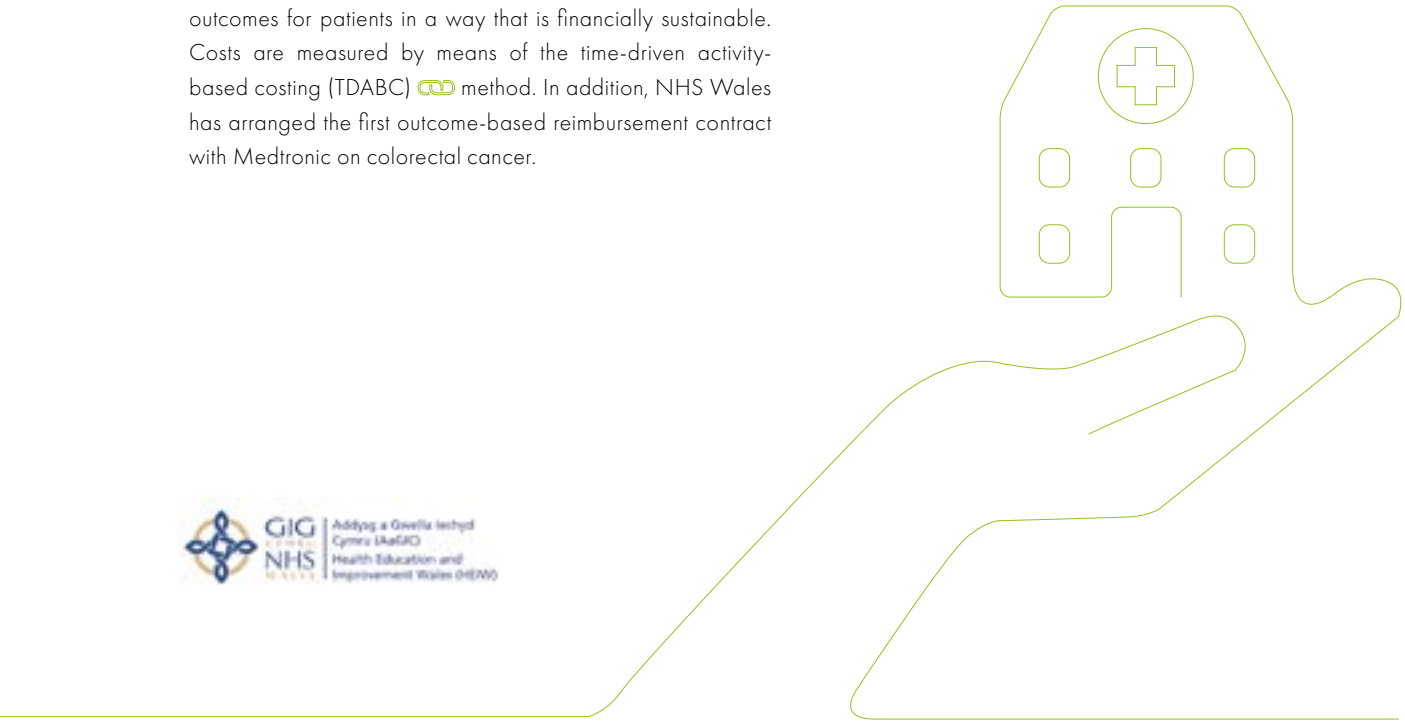
Care Continuum:
Outpatient care and home care
Added value for patients:
No interruptions to healthcare and a stable care network
Special feature:
Involvement of experts covers all over the Netherlands

ParkinsonNet was founded as a network in 2004 by physiotherapists and is being adopted as a model by more and more countries. The aim of this network is to offer patient-centred and cross-institutional care for people with Parkinson's disease, i.e. care along the patient pathway. In the Netherlands alone, more than 3,400 providers are now part of the network. By improving collaboration within the different specialties and providing specific training to increase the expertise of relatives, ParkinsonNet enables an optimal network of Parkinson's specialists and contributes to high-quality care. Study results show that savings of EUR 530 per patient are achieved due to a lower number of complications, a lower mortality rate and fewer physiotherapy treatments. This means that, in 2019, a total of more than EUR 12,000,000 was saved with 23,000 patients.

National Health Service (NHS) Wales – Value in Health (United Kingdom)

Care Continuum:
Healthcare system
Added value for patients:
The right care, at the right place, at the right time
Special feature:
A state-mandated reform that is supported nationwide

NHS Wales (= national health system of Wales) launched Value in Health in 2019 as a national programme to implement the value-based approach in Wales. The vision is to create a framework that allows all healthcare organisations to work together to improve health and outcomes for the people of Wales. Outcomes that are considered to be particularly important are developed together with patients. Data is collected in a central system, which provides timely and relevant information to citizens, clinical teams and organisations. This should enable patient-centred decision-making and improve outcomes for patients in a way that is financially sustainable. Costs are measured by means of the time-driven activity-based costing (TDABC) method. In addition, NHS Wales has arranged the first outcome-based reimbursement contract with Medtronic on colorectal cancer.



Reflection questions for Chapter 2:

- Where do you see similarities and differences in the approaches of the case studies listed in comparison with your situation?
- From which example can you learn the most?
- If you were to be assessed today on the six VBHC elements, where do you currently stand in terms of (1) patient-centred/oriented (2) outcome measurement (3) governance (4) integration/coordination (5) outcome-based contracting (6) IT platform?

Further case studies described in detail can be found in the EIT paper 'A handbook for Pioneers' from page32.

2.3.3 Lessons learned from existing initiatives

Below we have compiled some of the lessons learned by VBHC pioneers. They are designed to help you proactively manage the risks of your project.

Mindset (culture of the organisation)

- The step towards VBHC is always associated with a paradigm shift and requires a new mindset with a focus on patient outcome and the ambition of continuous quality improvement. This poses challenges for every organisation and every person. Many structures and processes that are currently generally accepted are subjected to critical examination. In addition, the shift from volume-based to outcome-based care will take time. Do not be deterred by these challenges but allow a culture of learning to emerge and do not avoid critical discussions. Consistency is the key to success. Small but consistent steps lead to your goal. Every day you work towards your vision.
- With VBHC we strive to continuously improve and learn. Measuring outcomes makes this possible and allows us to question and adapt our own processes and actions. This is not about singling people out for criticism. Outcome measurements are never meant to evaluate individuals or their work. Rather, they support the learning process that serves the overall goal – improving care.
- Change feels uncomfortable for many of us and can trigger anxiety. Regularly picking up on concerns and worries in teams, as well as open and transparent communication, are therefore central.

Patient orientation

- Define and identify patient/person groups to be prioritised (possible criteria: high costs, common conditions such as diabetes, unsatisfactory outcomes such as poor patient feedback, etc.) for which you are the first point of contact in the system. For these patient groups, you are in the lead for the patient pathway.
- Actively invite patients to participate in shaping the VBHC process, e.g. by setting up a patient council.

Defining and measuring indicators

- Use existing, validated standards (e.g. standard sets from ICHOM) and do not try to reinvent the wheel.
- Define a system and indications for data collection at an early stage (no data collection until it is clear what added value/purpose it is intended to serve).
- Try to define a maximum of 5 performance indicators per team and keep an eye out for unexpected effects (Hawthorne effect).

- Recording outcomes is a fundamental element of VBHC, but it also means additional workload. Automate what is possible so that outcome data can be easily captured, analysed and shared.

- Benchmarking creates positive competition and added value for the organisation. Based on this data, Hospital A can exchange best practice with Hospital B, learn from each other and continuously improve. In addition, the outcome data can be used for clinical research.

Governance

- Create a culture of learning and improvement by gradually incorporating the necessary processes for quality assurance and improvement (in small iterative steps with built-in PDSA cycles).

- Ensure that all relevant parties have a common vision and definition of value. Decisions are made centrally and the improvement teams have freedom in implementing them.

- Define an approach to standardising data, clinical protocols, work systems, etc.

- Define how decisions are made.

- Define who has data sovereignty.

Coordination/integration

- Analyse gaps, interruptions in treatment pathways and start to focus on the continuum of care.

- Coordinate and harmonise your efforts with all providers along the care continuum by holding round tables and discussions to improve care provider relationships.

Reimbursement

- Define incentive structures (distribution of risks and rewards), performance management frameworks, etc.

- Bring care teams to the table when drafting value-based contracts to ensure from the outset that the contractual requirements are workable in reality and in line with best practice.

- Compensation is the last element to be introduced; make a phased plan, initially without financial deductions or 'penalties'.

3 Further information and useful links

For everyone who wants to know more:

Title	Key words	Form	Access	Link
Handbook for Pioneers	Value-based healthcare, Europe, case studies, implementation	Digital report	free	
What is value in healthcare?	Value, value-based healthcare	Digital report	fee required	
What is best for ESTHER	Patient engagement, elderly people, chronic care, patient pathways	Digital brochure	free	
Defining and Implementing Value-based healthcare: A Strategic Framework	Value, value-based healthcare	Digital report	free	
Race to Value – Oak Street Health	Oak Street Health, primary care, VBHC	Podcast	free	
Value-based healthcare – Wales leading the way	NHS Wales, VBHC	Podcast	free	
Health at a Glance OECD Indicators	OECD, PROMs, PREMs, breast cancer	Digital report	free	
Defining value in 'Value-Based healthcare' Opinion by the Expert Panel on effective ways of investing in Health (EXPH)	European Commission, definition, expert opinion	Digital report	free	
Integrated Practice Units: A Playbook for Health Care Leaders	M. Porter, VBHC, implementation	Digital report	fee required	

Title	Key words	Form	Access	Link
The third health care revolution: a new pardigm for better value health care	Muir Gray, value, VBHC	Digital presentation	free	
Public Health & QI Toolbox	Support tools, improvement tools, toolbox	Website & downloads	free	
Redefining Healthcare	M. Porter, E. Teisberg, VBHC	Book or e-book	fee required	
About the living lab	Elderly care, nursing home, quality	Video	free	
The Dutch outcome-based payment model of ParkinsonNet: A case study	Parkinson's disease, case study, VBHC	Digital case study	free	
Swiss Association for VBHC	Switzerland, association, VBHC	Website	free	
Patient-Reported Outcome Measures (PRMs): An international comparison	PROMs, comparison, countries, Bertelsmann Foundation	Digital report	free	
Benefit-oriented competition in the Swiss healthcare system	Value, value-based healthcare, Teisberg, Switzerland	Digital report	free	
Measuring Patient Value after Total Shoulder Arthroplasty	Total shoulder arthroplasty, PROMs, VBHC, value-based healthcare, patient benefits; quality; costs	Study	free	

Examples of questionnaires
and useful links

Title	Info	Language	Link
International Consortium for Health Outcomes Measurement	Over 30 illness-specific standard sets	English	
Oxford Knee Score	12 questions, illness-specific	English	
Oxford Hip Score	12 questions, illness-specific	English	
QISA – Quality Indicator System for Outpatient Care	13 thematic volumes with indicators, illness-specific	German	
SF-12	12 questions, quality of life	English	
SF-36	36 questions, quality of life	English	
Oswestry Disability Index (ODI)	10 sections, quality of life on lower back pain	English	
EuroQol Group Instruments	Various instruments	multi-lingual	
PROMIS Germany	Translated and validated questionnaires	German	
Heartbeat Medical	Description of the most common questionnaires	German	
Adjumed Scores	Available questionnaires in Switzerland	German	
NHS Digital	Patient Reported Outcome Measures (PROMs)	English	

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Anthony Staines
Patient Safety Program Director – Head of the 'Patient Safety' programme at the Federation of Vaud Hospitals

Arnaud Chioléro
MD PhD, public health physician and epidemiologist, director of the Population Health Laboratory (#PopHealthLab), University of Fribourg

Burkhard Beyer
Senior physician at the Martini Clinic at the UKE (Hamburg)

Christian Baum
Responsible for Processes and Quality at the Biel Hospital Centre

Christoph Meier
Professor, Clinic Director at the University Hospital Zurich

Dino Cauzza
CEO of Swiss Medical Network

Florian Rüter
Head of Quality Management and Value Based Healthcare at the University Hospital Basel

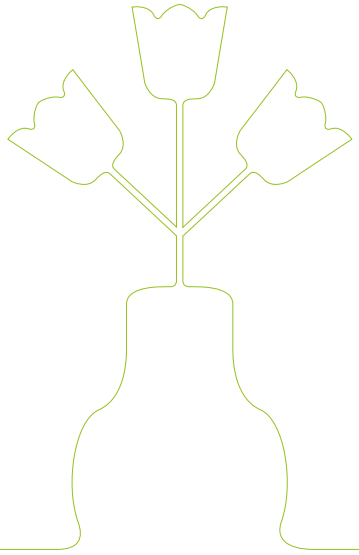
Florian Rossiaud-Fischer
Director for Innovation & Strategic Partnerships at the Hôpital de La Tour

Kristian Schneider
CEO of the Biel Hospital Centre/Centre Hospitalier de Bienne

Pascal Briot
Head of Medical and Quality Management/Finance Management at the University Hospital in Geneva

Sophie-Christin Ernst
Resident at the Zurich Triemli City Hospital Eye Clinic and Research Assistant at the Werner H. Spross Foundation for the Promotion of Ophthalmology

Susana Sanchez
Head of Quality Management at Solothurn Hospitals AG



**To enable you to use all the links in the document,
this QR code will take you to the online version of the guide.**

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