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Let's Talk About High-Value Care

Several experts from Dell Medical School, Santeon, Diabeter Nederland and Erasmus MC gathered on 26 November to discuss the challenges of high-value care (HVC) during the ongoing EIT Health Summit Series.

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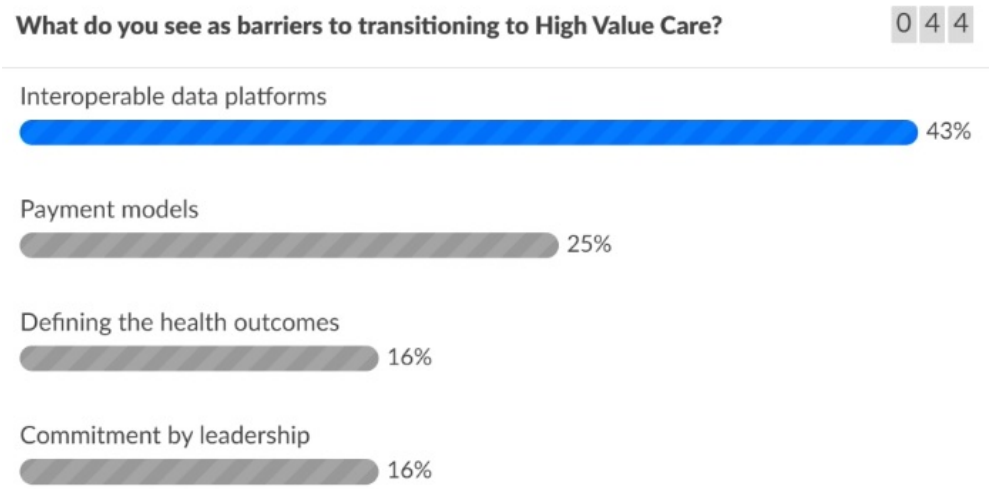
The session focussed on three main HVC areas: outcomes; incentives and rewards; and cultural change. Led by Dr Christina Åkerman of Dell Medical School, the session started with Pieter de Bey, Director at Santeon (the winner of the 2020 VBHC Prize) talking about his organisation's experience of introducing HVC and the benefits of bringing patients into the decision-making process. Later Henk Veeze, Senior International Medical Director, Diabeter Nederland and Jan Hazelzet, Professor Health Care Quality & Outcome of Erasmus MC, joined in to discuss incentives and rewards in this space.

In the beginning, a poll was launched about the barriers to transition to HVC. The public initially voted for interoperability being the biggest barrier (about 40% of respondents), followed by payment models (about 25%). Defining health outcomes and commitment by leadership each were chosen by about 16% of respondents.

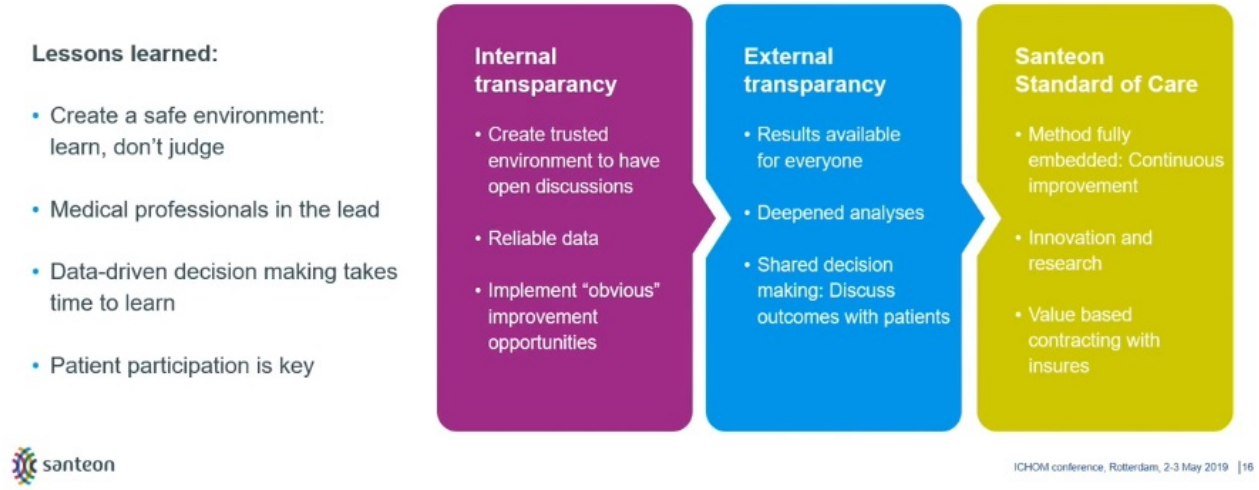


Source: EIT Health

Santeon's Experience

Pieter de Bey told the audience about how the standardised improvement cycles grounded in the value-based healthcare model were working in Santeon's system of seven hospitals. There are 15 patient groups where the cycles are run, including breast and other types of cancer, stroke, diabetes, etc. The latest addition here is COVID-19 group. De Bey stressed that those cycles were centred around patients and not around medical procedures, which is very important.

Based on the lessons learnt during its VBHC journey, Santeon's improvement team goes through different phases: first, internal transparency must be achieved, then it should be extended to external environment, which eventually leads to developing own standards of care. De Bey also highlighted the benefits of Santeon's network model of seven organisations, as it helps them compare results and learn from each other.



Source: Peter de Bey's presentation.

Along the way, it is important to create a safe environment to implement the HVC principles. One needs reliable data, but initially there is no such thing for any patient group. It takes time to collect and analyse the data, but after several improvement cycles it is getting better, with more knowledge and more trust.

Asked about how value was defined at Santeon, de Bey explained that for any new patient group, first a score card with outcomes was standardised, different for each group. These cards are then fine-tuned according to individual patients' needs. Santeon also uses ICHOM standard sets as a starting point.

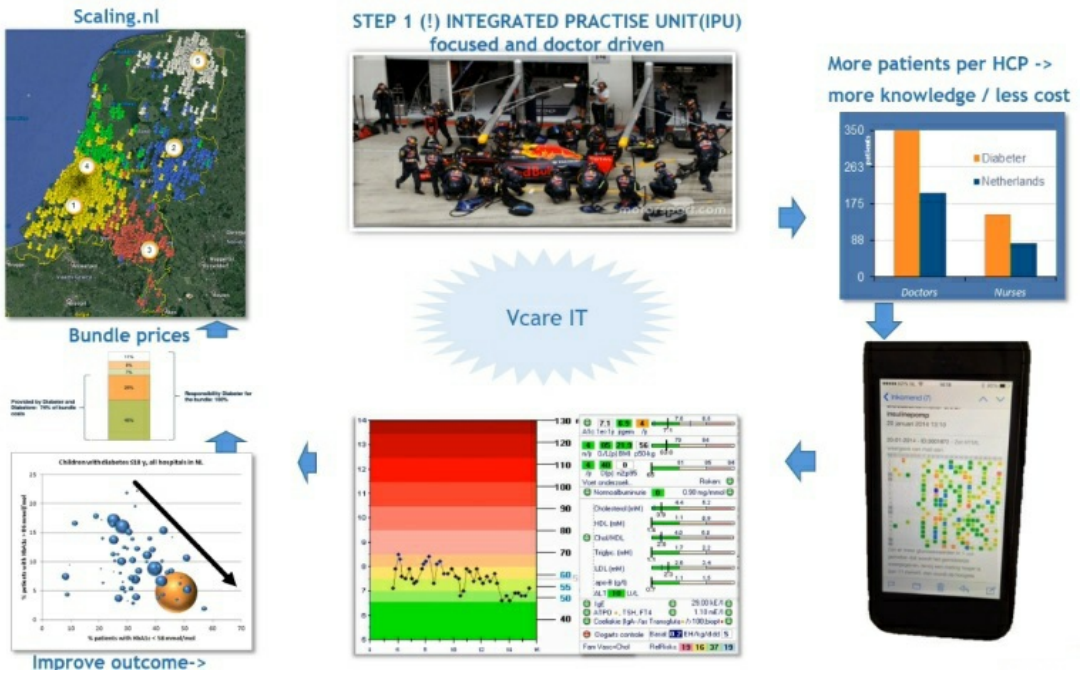
Notably, at the early stages of HVC implementation, Santeon had not invested in supporting technology solutions. Instead, they tried to utilise the data available in the electronic medical records system and assigned responsible data managers to oversee this process. According to de Bey, there is no need for expensive IT solutions at the initial stages.

Prompted by a question from the audience about the impact all that knowledge had on the hospitals, de Bey commented that the knowledge by itself was motivating. "It brings back the idea of why professionals do their jobs," he said noting that it was an opportunity for health professionals to work on their own development and growth, gaining insights on the outcomes. In this context, he insisted that it was not that difficult to overcome the resistance in staff. Even though it implies additional effort and takes time, if the change is led by those who are enthusiastic, they infect their less willing colleagues with this enthusiasm.

Diabeter Nederland: Integrated Diabetes Care

Diabeter is a pioneering organisation in the Netherlands in diabetes care, focussed on the patients, eHealth solutions and unique patient experiences. In 2006, it moved out of a hospital, obtaining its own healthcare licence to get payments back from the insurance companies. It was able to establish a welcoming environment with round tables for consultations, a practice that was not possible in the hospital setting.

The most important part of Diabeter is to have an integrated practice unit, a cross-discipline team working together in one place while in hospitals they currently all work in different managerial silos. "With a focussed team it's just like the Olympics – if you focus, you get better, and if you get better, you get smarter and also more efficient," according to Henk Veeze. Thanks to the technology, the staff can now treat twice as many patients as any other facility across the Netherlands or Europe. As such, there is also twice the patient load and twice the experience.



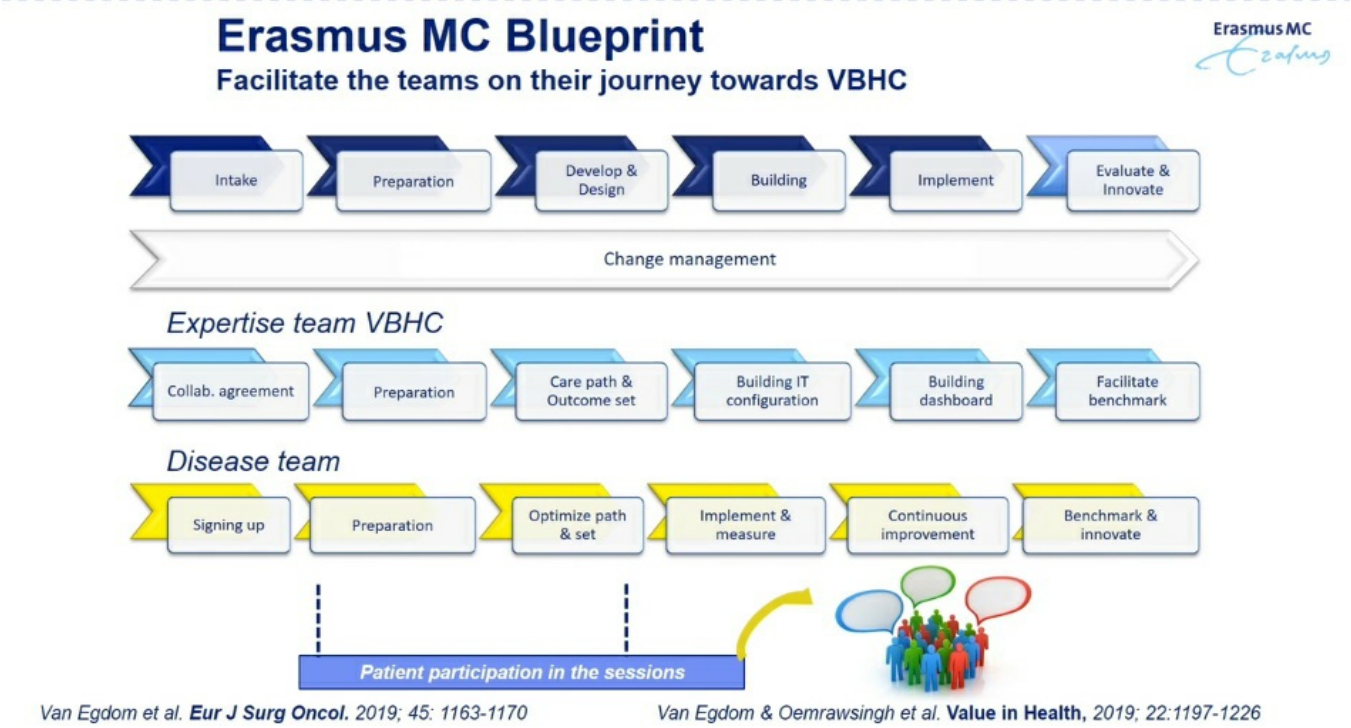
Source: Henk Veeze's presentation.

Diabeter works around IT solutions, and a lot of data are shared with the patient who can get their results on their smartphone in 5 min and watch how they progress. The same data is sent to Diabeter's dashboards, and if there are deviations, they are immediately addressed without the need to wait for several months for the patient's next consultation.

Since Diabeter is 'its own' entity, it also owns all the financials, i.e. all the costs on IT, real estate, staff, etc. Thus, it knows exactly what is its cost-per-patient, or per different types of patients, or per age groups. Together with outcomes, this makes the VBHC structure. All this knowledge may help predict future outcomes and how much the complication costs can be reduced in the future. This is the basis for collaboration with insurance companies, with which Diabeter now signs long-term, 10-year contracts. These contracts are ceiling-free, i.e. with no budget limits, which enables the organisation to put all the effort needed to get a normal life expectancy and a life without complications for the Type 1 patients.

Erasmus' HVC 'Ambassadors'

At Erasmus, a large university clinic in the Netherlands, the focus is on the disease orientation, rather than medical discipline orientation. The clinic started its VBHC journey about 5-6 years ago by organising seven pilot disease teams of the most enthusiastic professionals in diverse set of diseases. They are now the 'VBHC ambassadors.'



Building upon these teams' work, a blueprint for other teams (about 30 now) was designed to facilitate the VBHC implementation, including stages from the formation of a team, through analysis of current carepath, to design of the outcome set together with patients. The results are measured, and these measurements are used for individual improvement and improvement of the processes. The ultimate goal to have completely integrated care.

The Erasmus' ambassadors were later joined by early adopters, and the critical mass was reached. Next comes the most difficult challenge, i.e. to engage the silent majority of the staff. It requires a different approach and is more complex to work on. If in the beginning you can make mistakes, with silent majority everything should be working more or less smoothly, to convince and encourage them to join the HVC flow.

Erasmus works on VBHC projects not only internally but also with several hospitals abroad, through a so-called European University Hospital Alliance, which helps the participants to consolidate the effort in the field of VBHC (read about how one of the Alliance's members, Vall d'Hebron University Hospital in Spain, is building its own VBHC blueprint).

The internal rewards within the Erasmus' approach are reflected through the flow initiated by the ambassadors and then spreading to the organisation as a whole. On the VBHC path, the dedicated team would require first management and then clinical support, then IT support, then facilities, and eventually the whole hospital becomes involved. This joint effort makes the needed culture change possible.

Payment Models

After their presentations, the panellists proceeded to discuss their payment models and whether those included risk-sharing agreements. Diabeter, for example, uses this approach in their cooperation with the insurance companies. It takes the risk to reach the outcome, otherwise it has to pay back. If the target is reached, then the price is compared with all the other competitors in the Netherlands, and the organisation gets the profit share of the difference.

Another possible profit share for Diabeter is based on its performance and how it corresponds to long-term projections. The organisation gets a small profit share from the possible reduction in the future cost of dialysis, amputations, etc.

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To ensure efficiency of such long-term contracts, having a long-standing relationships with insurance companies is of greatest importance, Veeze stressed. The organisation achieves this by ensuring transparency of all costs, from labour expenses to payments. In other words, the key element of success here is being able to display the real cost of healthcare and clearly outline the areas that need improvement.

At the same time, Erasmus generally uses one type of contract, a rather complicated one, and one bundled payment, but there is an insurance company, with which it shares losses. There are about three diverse indicators the hospital is using in its interaction with insurance companies: one is medical, one is quality of life, and one is patient experience.

Notably, at this point of the session the public was polled again, and the results changed: after the discussion, payment models were voted by 38% of respondents as the main obstacle on the way to VBHC, and interoperability was pushed to the second position with 30%, followed by commitment by leadership and defining the health outcomes with about 16% each. Commenting on the updated results, Hazelzet expressed his surprise noting that while payment models were very important, he did not believe they were a barrier. Contrarily, de Bey was not surprised to see the change in the poll results, but pointed out that defining a relevant payment model could be not only an obstacle (from a hospital perspective) but also an additional stimulus for HVC. Diabeter agreed that from the payer's side HVC payment models might have been a challenge because so far this aspect was not yet well-developed, hence its implementation was difficult.

Digital Care and Interoperability

Continuing with the topic of switching to virtual care, the experts agreed that while it was a useful practical tool, especially since the start of the pandemic, the patients' perception of this format should be taken into consideration, i.e. virtual care should only be used if patients were comfortable with it. Also, remote care does not diminish the importance of face-to-face meetings.

Talking about the lack of interoperable data across the EU, Hazelzet gave an example of SNOMED standards that were still not published in French or German. He stressed that if the EU was able to introduce the GDPR in all official languages, it should be able to do the same for SNOMED. De Bey agreed that interoperability was a very important issue and pointed out that techniques – and relevant training – were needed for clinicians to register data as well as having a feedback loop back to the professionals, so that it could really help the clinical process.

In conclusion, the panellist were invited to share an advice to those who want to start their own HVC journey. The insights the expert outlined were: focus, choose one thing to do best, and then be daring enough to do it; think big, start small and then improve with small steps; and – don't reinvent the wheel, use the knowledge you already have, define the outcomes with patients and then discuss them with your team.

You can watch the full recording of the HVC Session here until January 2021.

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