VALUE AGENDA NL
ValueBasedHealthCare

Value Agenda NL 2021

Getting reimbursement of health care in line with value creation

#ValueAgendaNL

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Preface

The Value Agenda NL, set out to accelerate Value Based HealthCare implementation in the Netherlands by creating the right climate for VBHC initiatives to flourish. The working session 2021 laid down the ground rules for the Value Agenda 2022 to implement pay for patient outcomes and pay for innovations with patient value, faster.

A tradition: the Working Session, commenced. The initial Working Session with Prof. Porter, PhD. in 2017, with Dr. Bohmer and Prof. Cripps in 2018 and in 2019 with Prof. Teisberg, PhD, led to key actions to stimulate leadership and culture. The topic of the 4th edition of The Value Agenda NL was suggested by Prof. Porter, PhD years ago. Together with an expert group and cases in practice by Dennis van Veghel, PhD and Paul Cremers, PhD, the importance of paying for outcomes and innovation was discussed.

Although focused on The Netherlands, the Value Agenda Working Session draws lots of attention internationally and impresses and inspires many. We observed over 122,000 visitors around the world interested to learn more on the Value Agenda. All professionals in healthcare are invited to read The Value Agenda NL report and respond to the key actions stated. The impact of the Value Agenda is achieved by the community using and implementing the ideas and suggestions in the Netherlands and beyond.

To move VBHC forward in 2022, key for providers, payers, patients, industry, and the health systems alike is to pay for patient outcomes and innovations that benefit patient value. In 2019, bundled payments set foot in the top 3 important calls for action for the future. Now, in 2021 we try to align payment with value. In a video on the working session 2021, Prof. Porter, PhD elaborates on paying for patient value.

"Bundles must reward innovation that matters to better patient value"
Prof. Michael E. Porter, PhD.

The practical application of the bundled payment concept has been getting steam. Throughout the years, organizations have been attempting to find models to pay for outcomes, pay for innovation and pay for integrated care. Some (inter)national key examples of successful attempts[1]:
A Pay for outcomes: OrthoChoice – Diabeter.
B Pay for innovation: UCLA Health - Dana Farber – Santeon.
C Pay for integrated care: Oak Street Health.

1 *Key examples provided by Value Based Healthcare Center Europe and the Center for Life Science and Health of The Decision Institute*

Preface

What challenges do we need to overcome?

1 **The current healthcare system also rewards for poor outcomes.** Contracts and payments must be aligned with doing the right thing for patients.

2 **The current system stimulates duplication and lack of coordination.** The interests of key stakeholders must be aligned with patient value too.

3 **The current system supports the wrong cost cutting.** "Patients are not cars" - Virginia Mason. Dealing with variation is key in each industry; especially in healthcare variation in patient groups cannot be neglected. It is critical to be aware of this variation to be able to cut the right costs or invest to better manage the variation at hand. Otherwise, cost cutting strategies can have serious negative effects on both outcomes and costs.

4 **The current budget system hampers the good new innovations by industries and doctors/teams.** Focus on outcomes and the costs will follow[2]. We think that paying for outcomes, innovation and integrated care is an important topic that demands more work and effort. In May 2022 (5th Edition) we will discuss the topic of paying for healthcare again with the objective to improve. Therefore, we like to encourage you to share thoughts and ideas with us. The new generation of healthcare professionals is here. We are very excited to see what the session in May 2022 will conclude about the Dutch healthcare payment models[3].

2 The stated problems appear in The Netherlands but also apply internationally

3 More information on cost reductions in Dutch Healthcare on YouTube: VBHC Pioneering Series of The Decision Institute with Prof. dr. Fred van Eenennaam – Resilience of the Dutch Healthcare system

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Executive Summary

This year marks the fifteenth anniversary of the book 'redefining health care' that started the journey of value based healthcare around the globe. Many countries are now building experience when it comes to value based healthcare implementation, but off course challenges will always remain.

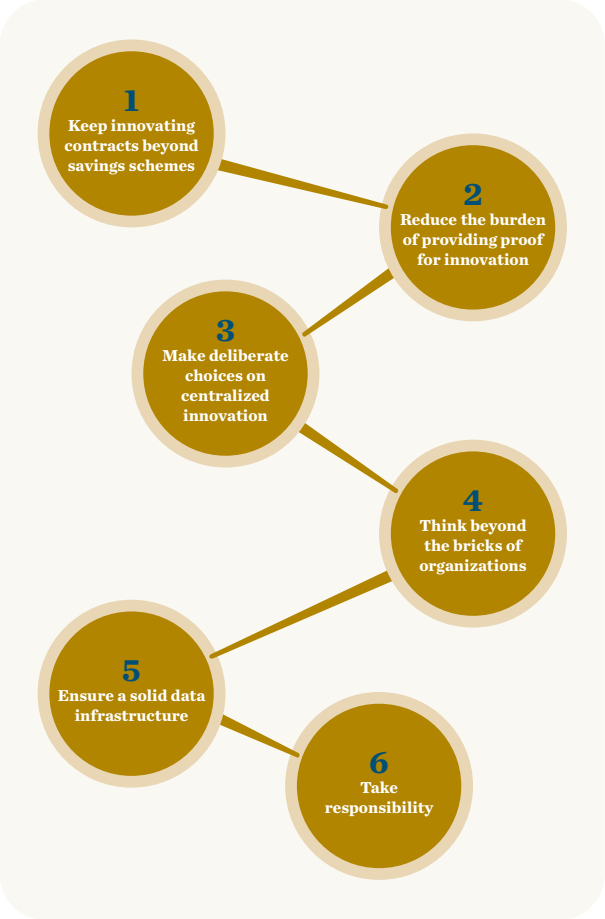
The Netherlands is an early adopter of value based healthcare and a frontrunner in the implementation of this concept in practice. Since the announcement of the Dutch government in 2017 on their ambition on transparency on outcomes the number of VBHC initiatives really took off exponentially; especially measuring outcomes that matter to patients has been put on the map.

Now that more and more teams are embracing VBHC and its way of organizing care, the challenges with regards to our current health care system and the way we traditionally organize care are much more visible and tangible. The Value Agenda NL, initiated in 2017 and kicked-off by Prof. Porter, was set up to address these challenges with 25 key decision makers of all stakeholders in healthcare and formulate calls to actions for the coming year. In 2018, Dr. Bohmer and Prof. Cripps shined their light on a practical and appropriate actions and solutions to respond to these calls to actions for each of the stakeholder's groups present. Last edition of the Value Agenda NL, we had the pleasure to welcome founding mother Elizabeth Teisberg to help and guide us to formulate these calls to action on the topic of 'Leadership & Culture' as well as 'Universal Measurement'.

One of the main challenges in the Netherlands, being the topic for this year's Value Agenda NL, has to do with the way we reward and pay for health care. At this point, care activities (volume) are the basis for payment, not the outcomes that are achieved for patients. In order to maximize patient value, payment should also be in line with this fundamental goal, otherwise innovation is hampered, and conflicting incentives can be observed.

This years' Working Session resulted in six calls to action to work on payment reform, getting payment more in line with value creation (see calls to action summary in the figure below). Also, the main calls to action on the other topics of the Value Agenda can be found in the report as well.

The 16 calls to action will assist in creating the right climate to let VBHC initiatives move forwards and flourish. Now it is time to encourage everyone in healthcare to respond to these actions and help moving the needle together by putting patient value first!



Introduction

The need to improve patient value and change the way we organize and deliver health care is greater than ever before. The COVID-19 pandemic clearly showed us the limitations of the healthcare system and the reasons for change. On the other hand, the pandemic has been an accelerator of change where innovations are implemented much faster because of these challenging times. A big question is how we can unlock this innovative and collaborative power, fundamentally changing health care delivery, without needing a crisis to initiate this. Part of the answer lies in the way we create incentives and how we pay for healthcare. It is not by coincidence that the theme of this years' Value Agenda NL Working Session was "paying for outcomes and paying for innovation".

The Working Session to set the Value Agenda for the Netherlands is key to generate actions to take VBHC implementation to the next level and to accelerate VBHC implementation in the Netherlands by creating the right climate for VBHC initiatives to flourish. In 2017 Harvard professor Michael Porter, founding father of VBHC, set out the Value Agenda for the Netherlands. In 2018, Dr. Bohmer and Prof. Cripps carried the torch, setting the Value Agenda for the Netherlands for 2018, emphasizing the need for leadership and culture. During the third edition of the VBHC Working Session in 2019, founding mother of VBHC Prof. Elizabeth Teisberg inspired and helped to formulate the next actions for the Value Agenda for the Netherlands to stimulate the right value-based climate.

In each of the previous years, the topic of bundled payments scored in the top-3 topics, marking its importance. This year, October 5th, 2021 marked a turning point shifting the conversation for the Working Session towards paying for outcomes and paying for innovation. With a group of 25 multidisciplinary professionals and leaders in healthcare in the Netherlands, the Working Session resulted in new insights, recommendations and (pre-)conditions, to be found in this report. Due to COVID-19, the working session was split in two sessions. This report covers the insights of the first session and will be used as starting point and input for the second part in May 2022.

Progress 2020-2021

Since the previous edition of the Value Agenda NL, a lot of progress has been made on VBHC implementation, sometimes despite and sometime due to the pandemic. Before diving into the central theme of this years' Working Session, we provide you with a short recap on each of the six Call for Actions of the Value Agenda, touching upon the emphasis that is observed or needed on each of these topics.

Call for Action	Visible trend
I. Leadership & Culture **Lead role in VBHC implementation are fulfilled by broad range of specialties**	Increased adoption of 'demand thinking' from patient perspective
II. Integrated care **Closer collaboration across care lines for tailor made care at the right place**	Building (regional) care networks to provide patient-centered care
III. Universal measurements **PROMs are gaining traction fast**	Expansion of implementation of existing outcome sets
IV. Bundled payment **Major consensus on removing the production stimulus**	Increased emphasis on including outcome measures in contracts
V. Patients' choice **Mixed weaker overall choice and more patient treatment choices**	Large focus on Shared Decision Making in the consultation room
VI. Complex Care **Prevention of worse and preventing from start**	Focus on (secondary) prevention based on complexity / risk profile

Progress 2020-2021

Call for action I - Leadership & culture
Lead role in VBHC implementation are fulfilled by broad range of specialties

The attention for doctors' and nurses' leadership in VBHC departments and teams has been increasing. Due to VBHC approaches we see that positive health is growing in dealing with healthcare. Furthermore, the needed leadership of doctors for teams and the support and collaboration with industry has become apparent during the pandemic. This can also be observed in the growing attention for public private partnerships to stimulate and accelerate innovation.

Although, the still existing weakness of leadership is clear. A leading culture towards cross specialty and team management for stratified groups of patients is observed and resulted in increased patient value. Leadership also focuses more on the link between primary-secondary-tertiary care collaborations and slowly finds its momentum to achieve the right patient stratifications.

Call for action II - Integrated care
Closer collaboration across care lines for tailor made care at the right place

First of all, primary care starts to use more stratifications. For example, Afferden and Oak Street Health type of approaches adopted these stratifications and take responsibility for a high-burden patient population. Secondly, a lot more attention is observed for 'providing care at the right place at the right time'. This has resulted in numerous initiatives of which most focus on the collaboration between 1st and 2nd line care, making deliberate choices on making sure the right patient (by using patient segments) is cared for in the right setting. Another movement that was observed, accelerated exponentially by the pandemic, was the monitoring and caring for patients in their home setting. For multiple conditions care was provided at home as the alternative of providing care in a hospital was simply not an option. Naturally, the use of e- and tele-health was a major contributor to make this possible, but it is also fair to stress out, that even with very limited technology, care teams were able to provide care in alternative ways and setting, showing the true power of collaboration, and moving the needle. The immense agility and dedication of care teams was shown during the pandemic, providing a positive outlook on the ability of our healthcare system to change, a topic that is often challenged.

Progress 2020-2021

Call for action III - Universal measurements
PROMs are gaining traction fast

We see successful Dutch projects in Value Based HealthCare implementation being copied more often and sometimes even surpassed by VBHC next wave adopters. The room for Quality of Life and specific patient outcomes are added. The debate on the technical IT ability to collect, monitor and visualize patient reported outcomes remains, while the clinical value of the use of PROMs is increasing attention and recognition. Many initiatives are now bridging the gap of monitoring and discussing PROMs with patients to using it for shared decision making and acting on it by intervening (not always meaning providing more care).

Call for action IV - Bundled payment
Major consensus on removing the production stimulus

The 235 successful VBHC implementations and the study on saving 1 billion euros has shown early evidence on the contribution of VBHC to create a sustainable healthcare system.

Payers and leading providers have been experimenting with bundled payment types of contracts in innovative but careful ways. Most times, the financial impact was not significant at first, so the focus of the agreements was mostly on gaining trust, monitoring the contract, and learning to improve. Despite this more careful start, many pilots did successfully decrease health care expenditures while maintaining or improving outcomes. Notably, the complexity of shared saving agreements increases with the complexity of the medical conditions. However, using the possibilities of e-Health and technology as a means not an end, results into payers starting to support the initiatives at scale for chronic care over different consecutive cycles of care (oncology, rare diseases, palliative care, COPD etc.).

Progress 2020-2021

Call for action V - Patients' choice
Less time to discuss more

The number of treatment options is growing fast, targeting patients more effectively or specifically. A great development that allows for more tailored approaches and less waste or unsuccessful treatments. Despite the growing treatment options the lack of available capacity in health care staff hampers the room for discussion about treatment options. So, while options are growing, the room to discuss these options remains limited and is potentially decreasing. Shared Decision Making is key, but requires enough time and the right (outcome) data for each treatment option.

Call for action VI - Complex Care
Prevention of worse and preventing from start

A few lessons can be drawn from the COVID-19 pandemic. Especially the teamwork and the need for teamwork focused on patients/social context and have strongly improved. The need for prevention and involving patients in terms of social context, as part of delaying with care, has seen great progress. The necessity and urgency of a focus on (broad) prevention is also gaining traction nationally as clearly indicated by the recent report of the Netherlands Scientific Council for Government Policy on sustainable healthcare). The Netherlands Scientific Council for Government Policy showed that efficiency gains ("doelmatigheid") and more health care personnel is no longer enough to bend the curve[4]. The focus on prevention for chronic patient groups and/or delaying or even preventing complex care is expected to have an enormous impact on the sustainability of our healthcare.

4 WRR Rapport: Houdbare Zorg. Mensen, middelen en maatschappelijk draagvlak https://www.wrr.nl/publicaties/rapporten/2021/09/15/kiezen-voor-houdbare-zorg

Where COVID-19 meets VBHC

As said, COVID-19 has once again showed that our current health care system needs to change in order to be sustainable. On the other hand, the pandemic already has been an accelerator of change and the approach to deal with COVID-19 actually showed various fundamental similarities with VBHC.

First, the pandemic has showed what a focus on organizing care for a single disease (in VBHC terms: a single medical condition) and tracking outcomes for that condition can bring (despite all the societal consequences of this prioritization). Secondly, all stakeholders felt the urgency to take immediate action which resulted in an almost instant and obvious offset to collaboration and fighting the disease together (in VBHC terms: integration of care and aligning all stakeholders on maximizing patient value). Finally, innovations were implemented at a much faster pace, which would otherwise still be on the 'to be reviewed' or 'too costly' pile.

All in all, the pandemic triggered an urgent response which crossed all traditional health care boundaries to organize the best possible care for COVID-19 patients. Three important focus areas in this (re)design of care can be observed:

1. **Measuring outcomes and continuously improving those;**
2. **Stimulate innovation and implement fast so that patients benefit without delay;**
3. **Integrate care and stimulate collaboration.**

These three focus areas are also observed in the exploration and application of alternative reimbursement models in healthcare. In practice, we saw that multiple organizations who pioneered with alternative (value-based) reimbursement has a focus on paying for either outcomes, innovation, integration of care or any combination of the three. Therefore, we chose to use these three focus area's as framework for the Working Session.

Central theme of 2021

Getting reimbursement of health care in line with value creation

Alternative reimbursement models in health care are gaining more and more traction over the last decade. It has become apparent that the current and main used payment model, fee-for-service (FFS), is not aligned well with value creation and is not sustainable. The fundamental discrepancy is because payment is linked to services provided, rather than the results achieved by the integrated set of services provided. Together with a budgeting system this results in four patient value compromising consequences:

1. **Duplication and fragmentation** is stimulated – as each service is reimbursed, regardless of its effect, there is no or very little incentive for efficient care or prevention of unnecessary care.
2. **Poor outcomes are being rewarded** on two main levels – First, payment is not linked to outcomes achieved, poor and good outcomes are both paid for in an equal fashion depending on the amount of care activities. Additionally, if poor outcomes result in the need for additional services or interventions, this (potentially preventive) care is reimbursed as well.
3. **Good new innovations are hampered** – innovations are often not implemented because of the extensive need for evidence of its value and assessment of its financial impact. Furthermore, many care innovations that do get implemented result in a financial loss for the initiator of the innovation (see the previous points as preventing services means no revenue comes from that service), proving practical barriers for innovation.
4. **Costs are being cut in the wrong way** – the current reimbursement system puts an emphasis of reducing costs of services that are not being paid for or 'expensive' services, not looking at the value addition of these activities. These cost cutting strategies not only have a potential hazardous effect on outcomes, but also the seemingly illogical risk of increasing costs per patient episode.

As can be observed, our current reimbursement model is not (fully) in line with value creation, too often even hampering optimal care delivery (with few exceptions for specific conditions for which FFS could work). Therefore, the key question during this years' Working Session was: **How to align reimbursement best with patient value creation?** In a lively discussion the participants shared their knowledge, experience and recommendations on three important questions related to this topic:

- **How can we reward or pay for good outcomes?**
- **How can we stimulate innovations that improves patient value (and reduce cycle times)?**
- **How to encourage integration of care?**

But besides the challenges that we face moving towards value-based reimbursement, promising steps are already being made. At the beginning of the Working Session we had the privilege to listen to Dr. Dennis van Veghel (director of the Dutch Heart Registration) and Dr. Paul Cremers (program manager of the Dutch Heart Network) on their experiments on value-based reimbursement, their successes and learnings. Please find a short recap of their experiments in the exhibits below.

After these inspiring talks, showing what already is possible when it comes to paying for value, the participants worked in groups to share the do's and don'ts specifically on the three key questions as posed above. In a plenary discussion the key findings and recommendation with regards to these three key questions were extracted and discussed. The key findings are summarized in the next section.

Key recommendations to align reimbursement with value creation

When it comes to alignment payment with value creation, numerous barriers and potential solutions were pointed out in the discussion. We tried to summarize the discussion in six key recommendations for the transition to pay for value.

1. Keep innovating contracts beyond shared savings schemes

Many agreements that move towards rewarding value instead of activities use the principle of shared savings, a great model to redeem savings that are realized. A major barrier in practice is that savings that are realized rarely flow back to the team that is responsible for the improvements made. It is crucial to address this issue in practice as it can be perceived as a demotivator when other parties redeem the savings that you have created. To move beyond the current shared savings schemes a few recommendations can be made:

a. Contracts that have a *multi-year span* can help to provide financial room upfront for care providers to start the improvement cycle, but also allow for a realistic timeframe to realize expected savings;

b. Upfront *discuss how savings are shared* to make sure the responsible team is rewarded for their efforts. It is wise to couple these savings to next innovative efforts to further improve care delivery. Not only does this motivate the responsible team, but it can also be an accelerator to find new solutions for wider health care challenges, for instance gains in efficiency can also help in the challenge of shortage of care personnel.

c. Discuss with the payor how to deal with at least two *other scenario's*. For example, when outcomes are improved, while no financial savings are realized. How to stimulate and incentivize these patient value improvements? Or when costs are increasing (at similar or worse outcomes). Who is bearing the financial risk in that scenario?

2. Reduce the burden of providing proof of innovation

A widely supported point of attention was the ever-growing need of research and evidence for any innovation to be implemented. Not only each stakeholder (and even multiple levels within organizations) has his/her own requests with regards to a business/value case and need for evidence, also a broader range of innovations is subjected to this request for evidence. This truly hampers patient access to these great innovations and optimal care available. To help speed up innovation other methods (instead of lengthy RCTs) can be used for the assessment of innovations or gaining evidence parallel to implementation could help. Next to these assessments, it is important to provide early evidence of VBHC contributions with regards to outcome improvements and/or cost savings.

Key recommendations to align reimbursement with value creation

3. Make deliberate choices on centralized innovation

Another discussion point was the way innovations/pilots are sometime scattered across the nation, giving the impression that various organizations are (re)inventing the same wheel. Therefore, it was recommended to consider whether an innovation can be initiated locally, and which innovations would benefit from a centralized/concentrated approach. For the latter there is the perception that central infrastructure and resources are missing and/or insufficient, which therefore potentially hampers scaling up best practices.

4. Think beyond the bricks of organizations

The third recommendation was on moving beyond the status quo of organization of care, transitioning from institutions towards networks of care. Not only does this entails the stimulation of coordination of care and a shared responsibility for outcomes, this also helps with getting reimbursement aligned with the entire care delivery value chain.
To be able to make this transition, it is key that care providing organizations must make (difficult) trade-offs and decide which conditions have full focus and more importantly, which conditions should be shrinking and, in the end, laid-off? A crucial additional question here is to also assess for which conditions it is most important to really integrate care.

A side note that was made at various points during the Working Session, also when it came to these organizational tradeoffs, was that insights in true costs for a patient episode (independently from reimbursement) would help in making these tradeoffs. Not only would this unlock a large potential of new ways to improve health care on various levels (just as the increased awareness on the nominator of Porter's equation has done so), this was also deemed relevant for the transition towards value-based reimbursement.

Although, moving towards organization of care in networks truly helps aligning all care teams across the care chain with the main focus on outcomes and maximizing value, this holds a major challenge as well. In practice, better alignment of care teams over the patient journey initially means more work and makes it harder to reach consensus across the team. Reimbursement on the basis of value created over the full care cycle could also drive and stimulate collaboration and coordination because of adding shared financial responsibility.

Key recommendations to align reimbursement with value creation

5. Ensure a solid data infrastructure which allows to share uniform data

A recurring topic in almost each discussion and linked to almost all recommendations made was on data and IT. From the point of view of reimbursement, it was deemed to be one of the most important preconditions. Although being an extensive topic, four key components were highlighted during the session:

a. *Consensus on outcome definitions is crucial*

The importance of measuring health outcomes that matters to patients is evident. Over the past decade, outcome sets for many health conditions are developed and can be easily accessed. Still, many organizations tend to develop an own outcome set or apply many tweaks in existing sets resulting in the lack of consensus or differences in definitions (even when using a similar outcome set, it frequently happened that different definitions are used in practice). Having less variation in the outcome definitions is key to scale up (also value-based reimbursement models) and ensure/stimulate better interpretation of data.

b. *Invest in data infrastructure*

Both within care organizations and nationally there is a growing need for a better data infrastructure. A large opportunity for care providers is to support in registration of outcome information in a structured way in the EMR and being to extract the right data in an efficient and effective way. The main opportunity posed from a national point of view was the need for a centralized data infrastructure (like registries) for various conditions.

c. *Enable data sharing*

Thirdly, for value-based reimbursement models, it is mandatory that the datapoints included in the agreement can be shared for monitoring purposes and to draw conclusions on the value created and accompanying reimbursement. Besides monitoring an agreement, sharing insights from the data for learning and improvement purposes should be enabled for all parties, while being keen on data privacy and data processing rules and regulations.

d. *Create comprehensive data (visualizations)*

Outcome data is used in various settings. Visualization and creating the right dashboard serving the right purpose is absolutely essential for the optimal usage of data. A dashboard for contract monitoring purposes is completely different than a dashboard for team specific improvement or benchmarking.

Creating the right data infrastructure was one of the most promising developments because it is a precondition for many topics in the transition towards outcome-based healthcare. Therefore, it was posed to consider forcing progress on this topic, for instance by making supply of data by organizations mandatory (f.i. not data supply means less to no reimbursement over time).

Key recommendations to align reimbursement with value creation

6. Take responsibility: don't end up in a coordination stalemate

One of the more difficult topics during the Working Session was on accelerating implementation. Everybody agreed that improvements/innovations should be implemented quicker and scaled up faster, but it remained unclear who should take the lead in the coordination role. On the one hand there was an ask for national guidance and a framework by policymakers and government, while on the other hand there was a key drive that the professionals should be the driving force. Naturally, the top-down vs. bottom-up approach discussion made his entrance as well. Even though no consensus was reached on the best approach or action, there was a consensus to move forward and not await or expect and await others to act first and end up in a stalemate.

Next to these six key messages there was a true sense of urgency that was not only felt, but also openly discussed during the Working Session. The program of Outcome-Based Care by the Ministry of Health Welfare and Sports, various reports by policymakers (a.o. Dutch Care Authority, Social-Economic Council) and the recent report of the Netherlands Scientific Council for Government Policy show that changing the way we think about and deliver healthcare is crucial for a sustainable future of healthcare. Feeling like we are already in overtime, the fair question was raised whether the pressure on our healthcare system maybe wasn't high enough yet?

This fairly simple but fundamental question resulted in a great discussion in which each stakeholder replied that the urgency to change is apparent, felt, was a clear call to act now, not tomorrow. Multiple directions and actions were stated with regards to the broader transition towards outcomes-based healthcare. These directions and recommendations are summarized in the next section to provide an update on the entire Value Agenda NL.

Key recommendations on the other calls for action 2021

Based on both the progress observed over the last year(s) and this years' Working Session, we have extracted and summarized the main recommendations on the other topics of the Value Agenda NL to finalize the Value Agenda 2021.

Call for action I. Leadership & Culture

Recommendation 1 **Grow VBHC leadership attributes for nurses**

Recommendation 2 **Use benchmarking stimulating a learning culture to maximize patient value**

Call for action II. Integrated Care

Recommendation 3 **Use more patient stratification in primary care**

Recommendation 4 **Move beyond traditional care lines to form care networks**

Call for action III. Universal Measurements

Recommendation 5 **Expand the use of uniform outcome set; do not reinvent the wheel**

Recommendation 6 **Improve user operability for working with PROMs**

Call for Action IV: Bundled Payment

Recommendation 7 **Keep innovating contracts beyond savings schemes**

Recommendation 8 **Reduce the burden of providing proof for innovation**

Recommendation 9 **Make deliberate choices on centralized innovation**

Recommendation 10 **Think beyond the bricks of organizations**

Recommendation 11 **Ensure a solid data infrastructure which allows to share uniform data**

Recommendation 12 **Take responsibility: don't end up in a coordination stalemate**

Call for action V. Patient Choice

Recommendation 13 **Lack of available capacity is hampering patients' choices**

Recommendation 14 **Patient choice based on specific treatment options, joint consent and patient engagement must keep increasing**

Call for Action VI: Complex Care

Recommendation 15 **Invest in both primary and secondary prevention for patients at (high) risk**

Recommendation 16 **Provide more cost information to medical teams next to outcome information**

Next steps

In May 2022 the second part of the Working Session will take place on the important topic to get reimbursement of health care in line with value creation. During this second session, the directions and remaining questions will be assessed by a multi stakeholder group of key decision makers in health care to formulate the key actions to be taken, not only on how we should, but also how we could pay for health (care).

If you would like to provide your input (e.g. challenges or hurdles to overcome) and/or would like more information on previous or coming Working Sessions, please contact Mire van Holsteijn at m.vholsteijn@thedecisiongroup.nl. Also, make sure you follow our media channels below to stay up to date on the latest information on the Working Session and VBHC news.

1. De Value Agenda NL LinkedIn Group
2. Website The Decision Group
3. Website Value-Based Health Care Center Europe
4. Website Value-Based Health Care Prize

Finally, in our collaborative journey of continuously maximizing patient value, please act upon this Value Agenda. Getting payment in line with value creation will be a true game changer in healthcare. It will unlock a wealth of innovative ideas to improve outcomes that matter to patients and create an execution climate by breaking down implementation barriers.

Partner perspective

An aging population, increasing number of patients with a chronic condition, increasing labor shortages and growing number innovative therapies & technologies. If nothing changes, a serious health care crisis is inevitable. We must ensure that healthcare remains affordable without compromising on quality. Transforming healthcare into value-based healthcare is necessary. Eliminating inefficiencies to allow caregivers to focus on what really matters: appropriate care for the right patient. The end goal should be to continuously improve the outcomes that really matter to the patient while optimizing costs.

This years' Working Session was co-created by three organizations that are highly motivated to help move the needle on outcome-based healthcare.

The Decision Group & the Value Agenda NL

The Value Agenda for the Netherlands has become more important over the years. It is applied both nationally and internationally, with the potential to decrease health care costs whilst enhancing the quality of care. As we are approaching the next phase of VBHC, in which the questions and challenges become more complex and demanding, the call for collaboration increases. Therefore, at The Decision Group, we feel the tradition of having a group of key people across the Dutch Health Care landscape work on actions each year, will help strengthen the positive VBHC implementation climate.

The Decision Group has been a leader in VBHC implementation in Europe since 2008. We build upon our experience and continuously develop our approach in light of the latest insights. Over the years, The Decision Group collaborated in over 150 unique VBHC implementation projects. Bringing together the VBHC implementation success stories and leaders in Dutch Healthcare is what makes the Value Agenda NL such a valuable initiative.

Amgen & the Value Agenda NL

At Amgen, we strive for the best outcomes for patients in a system of outcome based healthcare. Eventually we also wanted to be rewarded for the (delta)outcomes we achieve through our innovative medicines and integrated solutions. The Working Sessions - and the Value Agenda NL as a result - will bring us year-by-year closer towards an outcome based health care system. Sharing best practices, valuable discussions on what is needed and who takes which role are essential to take the next steps.

Awell & the Value Agenda NL

We are pleased to partner with Amgen and The Decision Group. Together we are at the forefront of the development and implementation of value-driven care. Together we have the ambition to transform healthcare and offer solutions to secure the future of healthcare. Our digital care pathways improve patient outcomes, increase efficiency and ensure that organizations continuously optimize their processes. Our goal is to make healthcare effective, quality, affordable and accessible to everyone. Both intramural and transmural. Now, and in the future.

Appendix 1/2

Patient outcomes over reimbursement
by Dr. Dennis van Veghel (Managing Director-manager of the Dutch Heart Registration and manager of the cardiologists and thoracic surgeons at the Catharina Hospital)

Dennis highlighted the case between the collaboration between the Catharina Hospital in Eindhoven and CZ, focusing on cardiological interventions. In this hospital a start was made in 2011 with the 'Meetbaar Beter' program, which is now embedded in the Dutch Heart Registration (NHR) in order to measure outcomes in cardiology and cardiosurgery and to focus on continuous improvement. The next step was to investigate, together with the health insurer, how this could be translated into the purchase of care. The indicators of the NHR are used for a bonus/malus methodology based on the outcomes measured. If there is a bonus, it was agreed, then the money is spent on quality goals.

As an example of the relevance of a transition to other payment models, Van Veghel mentioned that the number of treatments of patient strokes and ablations in the day center of the hospital is significantly higher than the benchmark. Care in the day center is less stressful for the patient and moreover cheaper than inpatient treatment. It does mean, however, that the hospital is reimbursed millions of euros less than the benchmark for the same clinical outcomes and is therefore missing (a lot of) income. To solve this issue, they are looking for a standard pathway that can serve as a basis for a bundled payment based on care activities and clinical and non-clinical outcomes.

Appendix 2/2

Paving the way for networked care
by dr. Paul Cremers (Program manager Nederlands Hart Netwerk)

The case of the Nederlands Hart Netwerk (Dutch Heart Network) covered a value-driven payment model based on a regional initiative in the Southern part of the Netherlands. The aim was to develop transmural care paths to continuously optimize cardiac care. To this end, networks were set up between first and second line around specific syndromes. The data collected on the results show a significant improvement in outcomes of care such as heart failure and arrhythmia. There are no payment arrangements for network care, so a three-year funding arrangement has been made available to further develop the network organization and generate more data to prove its value.
In addition, a letter of intent in concluded in which health insurers can take measures to make the consequences of innovation projects bearable for all organizations involved (hospitals and GPs care groups).

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