HealthManagement.org
The Journal
LEADERSHIP • CROSS-COLLABORATION • WINNING PRACTICES
VOLUME 20 • ISSUE 8 • 2020 • € 22
ISSN = 1377-7629

Cover Story

New Care Delivery

New Era in High Value Care in Europe

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High value care has been on the healthcare agenda for some time now, but for many, it is still a concept rather than a reality. As research from EIT Health shows, healthcare providers often lack the tools necessary for the successful transition. To address this gap, the organisation has launched a new initiative, the High Value Care Forum, that aims to facilitate the shift towards patient-oriented outcomes through education, training and best practice sharing. An expert who has been leading this initiative, talks about how high value care is achievable with small steps and in what ways the Forum can help.

The EIT Health High Value Care Forum was launched in September. Please tell us about this new project.
The High Value Care (HVC) Forum is our new strategic initiative to move the needle with regard to HVC in Europe. It will support healthcare providers and professionals to drive transformation in healthcare systems towards outcomes that have the highest impact and are of most importance to patients. This is, in fact, what a lot of national and regional health systems and healthcare providers are moving towards, but how to do it is not always clear. We hope to provide value within this domain of 'how'.

What are the specific formats the Forum includes?
We see three lines of activity. The first one is what we call the 'case study library' meant to showcase examples of successful implementation of HVC, enable sharing the lessons learnt, and inform future activity. It is not about how good a hospital is, but how it has succeeded on its HVC path: what it did, which barriers it had to overcome, the issues it faced and how they were solved, and so on. Even though we call it a 'library', our goal here is less academic and more on the practical side – to make sure that people have tools to make the HVC implementation successful.

The second area is education and training. This is something urgently required by our community, which includes top institutions and companies working in the field of healthcare and life sciences, in other words, the people who are aware of HVC's potential. Such people are still a minority, and it takes them a lot of time and effort to explain the HVC ideas to others – what it is, how to do it, what does it mean. We have talked to more than 50 stakeholders in our community, experts who have been leading these efforts in their respective organisations, and all of them said they needed to train people both within and outside their organisations. Here, it is not enough to simply define the terms. There is, of course, the system proposed by the value-based healthcare (VBHC) pioneers, Professor Michael Porter and Professor Elizabeth Tiesberg, but as I said, our endeavour is not academic. We are more interested in how to make the actual transition successful.

The third format focusses on best practice sharing through workshops and conferences. This is how the initiative started in the first place. We attended many events, and the people we met there kept talking about the need for a place where we could meet continually – a place where we could talk to each other, test approaches, report achievements. The important aspect here is that if people share their knowledge and experience, all of them can be winners. In this field, there is no competition.

Why is it 'high value' care and not the more common 'value-based' care?
There are two reasons for that. HVC is the term used for the restructuring of healthcare delivery towards measurable outcomes that have high impact and matter most to patients. In other words, HVC is about outcomes, while VBHC is about the process. We want to concentrate on the outcomes. The second reason is how Europe sometimes holds this attitude of 'nonacceptance' towards things that originate in the U.S., as VBHC does. Also, there are several countries where VBHC got some bad publicity. This was because the implementation was wrong, not because the

ideas were wrong. This created a situation where people supported the idea of working towards outcomes that mattered to patients and not only to clinicians or regulators or policymakers, but they felt very uncomfortable using the term VBHC. In any case, HVC is a widely used term. It is not our invention, and I think here in Europe, it will become common.

Considering the COVID-19 developments, why has EIT Health decided to launch the initiative now?
It does look like it is 'just in time'. However, we have been working on HVC programmes with our innovators and entrepreneurs since February 2018. Therefore, creating a platform for healthcare institutions was a natural step for us. At our annual event, the EIT Health Summit last year, the keynote speech (by Prof. Teisberg) and many topics were around outcomes that matter to patients. Furthermore, we spent eight months studying successful and unsuccessful implementations of HVC across Europe and produced a comprehensive report, "A handbook for pioneers," which hopefully will be useful to the community moving forward.

In other words, the current launch of the Forum has nothing to do with COVID-19; it hasn't happened because of COVID-19. It is common knowledge that many healthcare resources are wasted on avoidable complications, unnecessary treatments or administrative inefficiencies. Costs are increasing, and in some countries such as the U.S. or Switzerland, people have to pay a lot of money to get the outcomes they want. What HVC does is facilitate the shift towards patients paying for important services. Let me give you an example. What is important for an oncology patient is the number of days that they spend at home, but they pay for the number of days they spend at the hospital. There is a clear misalignment here, and the one who is usually penalised in the end is the patient, not the hospital or healthcare system. This is the current situation, and we as an organisation have this mandate to try and change it.

The pandemic has somewhat delayed our plans. We had everything ready back in March, but then the attention shifted to COVID-19. However, the pandemic has highlighted the value of having a holistic view of how we provide care. For example, it has never been clearer that prevention is key; the importance of diagnostics has been brought back, as it helps to avoid wrong treatments, which are both costly and harmful. Nevertheless, despite all these changes, the goals of the Forum are the same as they were before the pandemic.

Is there a possibility that healthcare providers may now be too preoccupied with the pandemic-related challenges and not have enough capacity for HVC projects?
First of all, it depends on the specific situation in each particular hospital. For example, I live in Barcelona, and when I talk to people in Madrid, the U.S., or Israel, hospitals there are indeed really busy. One of the things you learn working in a hospital system is that there is no 'on/off switch' for any transition. You start small and proceed bit by bit. You showcase some of your achievements, other people copy them, and in the end, this becomes their standard of care. This is how you transform reality, and we want to play a role here, to move that needle towards the transformation of the healthcare systems. Even if a hospital is really busy, it only means that we are delaying the change, not refusing it altogether. The goal is still worthy. This is especially important here in Europe, with our public health systems, for which we can no longer pay. This is where innovation enters the equation, because we, as a European society, want to preserve our healthcare systems, so we need to optimise the way they operate.

Fortunately, many are willing to start with small steps and eventually reach a bigger goal. Michael Porter is an academic, and he considers you as being 'HVC/VBHC' if you meet the six criteria he has defined. At our end, we don't do this. We talk to people, and if someone has done something that has a real impact on patient outcomes, we study their experience. According to our research, we can say that there are different bases for success, and it should not necessarily mean ticking all the boxes on Michael Porter's list. We want to see more patients being treated in different ways. We want to see that patient-reported outcomes and patient-reported experiences are being asked from patients, evaluated and then taken into account by the hospital management and national healthcare systems. You focus on something, measure it, and try to improve it – and then you start the cycle all over again.

One of the things you learn working in a hospital system is that there is no 'on/off switch' for any transition

In the report, EIT Health outlines a concept of the 'Implementation Matrix'. How does it fit into the HVC paradigm?
This is part of what we call the 'tools'. People do understand what HVC is, they just don't have the tools to implement it, they don't have a 'process' of what comes first, what follows, what are the barriers, what are the levers,

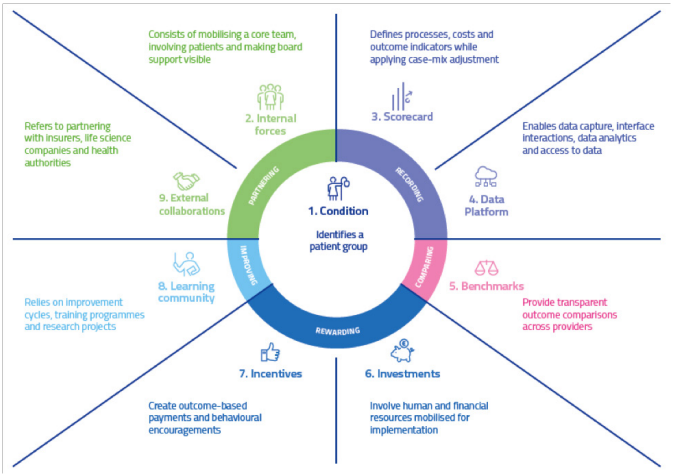

Figure 1. The EIT Health Implementation Matrix.

how to multiply the impact, and so on. The Implementation Matrix is one of those tools. We are also working on what we call a Step-by-Step Guide to explain the steps – a hospital team might need these to start their HVC transformation journey. In the end, it is all about giving people the tools to achieve their goals. This is not the job of EIT Health, national/regional health authorities, or consultants – it must be hospitals that initiate the change from within. For this, they need tools, which are simple to understand and use so that people can communicate in the same language and understand each other. There have been some very successful experiences with our startups using certain tools. Everything goes faster because they understand each other faster and identify the problems and the ways to solve them faster. The advantage of having these tools is that they can be adjusted to include any new aspect that might surface along the way. For us, the tools are a means and not the end.

The healthcare landscape across Europe varies greatly. How do you ensure the smooth application of the tools in such diverse settings?

Our tools are universally applicable. You can use them in any country and from any stakeholder's perspective. What is totally different is the reality of the places. For example, the way pregnant women are monitored and treated in Spain is not the same as in the UK. I am not talking about the quality, but about the number of visits, the specific responsibilities, etc. These are very local. But we are not aiming to have uniformity in Europe. We are interested in having better health outcomes for patients, and that's it. This goal can be reached with different approaches. If we take startups, their main goal is scalability – they do something once and then copy-paste it everywhere. In the case of HVC, the aim is not scalability, it's replicability. If something has worked in Germany, it can be implemented elsewhere, not by copy-pasting it, but by adjusting it to a particular system. On the other hand, something might have worked in Germany because of a very specific feature present there but not in another system. This helps to see that a certain approach might not be replicable, and you need to look for other ways.

During your extensive research, were there any common 'success factors' with regard to HVC implementation?

Indeed, there are several. The first one is to have support at the executive level. Why is that? Because transitioning to HVC is mostly a management challenge, not a technological one. Whenever things start to get complicated, you need to be backed up by the leadership. This is very important, especially when introducing something new. The organisation would resist because you are asking to move away from the traditional ways of working and do something different, so you need support at the highest level.

The second factor, which is also very important, is the alignment with the payment models. As I said before, if you want to have A but you're paying for B, it will never work. The hospital can do everything perfectly, but unless you support your aspirations with a proper payment model, there will be no meaningful outcome. Let me give you an example. For close to ten years, I was Director of E-Health at Sant Joan de Deu (SJD) Hospital, a major paediatric hospital here in Spain. We had what we called the 'Liquid Hospital', an initiative to radically transform the provision of care through intensive use of technologies oriented towards the patient. One of the key 'Liquid Hospital' projects related to diabetes. From the methodological point of view, diabetes is quite simple because it has a metric of the blood sugar level, so it is easy to agree on the reimbursement with the regional payors, as we did. As a rule, there are four visits to the hospital for diabetic patients each year, regardless of whether the patient is compliant with the treatment or not. On the other hand, the technology that we used allowed us to remotely monitor patient compliance, which meant that we didn't really need to see them in person four times a year. The regional system, however, only paid us for in-person visits, not for digital visits. Although we were pushing to show that the 'Liquid Hospital' strategy was efficient, our financial team disagreed. Therefore, unless this change transforms the payment part, it's very difficult to implement, especially in public systems, as was in the case of SJD. Therefore, at EIT Health, when our partners form consortiums, we always ask them to include a provider and a payor from the same region taking care of the same patients. In this case, everybody's perspectives can be aligned to ensure the desired transformation.

The third success factor is about the knowledge that is out there but is not codified. We are putting a lot of effort into codifying this knowledge, as we did with our report.

Back when I worked at SJD Hospital, I brought the Stanford Biodesign Innovation Fellowship to Barcelona. It is a great programme where interdisciplinary teams experience a full cycle of innovation to create innovations coming from hospitals. Anything you might have wanted to know about biodesign, you could find in a 1,000-page programme book. However, a participant once mentioned something that wasn't in that book, but what they learnt from a Stanford professor who supported their team. It shows that sometimes the only way to learn something is for somebody to tell you about it. No book, no guide, no article can do that. There is the knowledge that is still in people's heads, so we need to extract and codify it – to then initiate a discussion among the stakeholders on the processes, problems, solutions, etc. This is exactly what we hope to achieve.

The Forum has now been successfully launched. What are the next steps?

First of all, we focus on education and training. There are meetings to be arranged. For this, EIT Health is engaging with people and institutions who will be the 'transformers'. Currently, we are in talks with several cross-border institutions looking to join forces and support this initiative. COVID-19 is, of course, an obstacle here, but we will create small groups, and that will be the start. Also, we will release some of the content that we already have, to be discussed at those meetings.

Hopefully, we will get through to the desired way of operation, which is to offer training opportunities. We plan to publish several case studies per year with 'lessons learnt' and best practice documents that people can build upon. There will be several workshops on specific topics, such as data, payments, procurement, outcomes, etc.

To follow up on our progress, we will be building a portfolio of those cases that have 'matured' through the participation in the Forum, i.e. the workshops, training and conferences. The workshops are starting this year, and in 2021 we hope to also deliver the online training programme. Then, as soon as the situation allows – hopefully in 2022 – we're aiming for a large conference. The HVC initiative plan has been in place since March, so now we are ready to engage with the community for the benefit of everyone involved.

Conflict of Interest

None. ■