



Ministerie van Volksgezondheid,
Welzijn en Sport

Outcome based healthcare 2018-2022

Outcome based healthcare

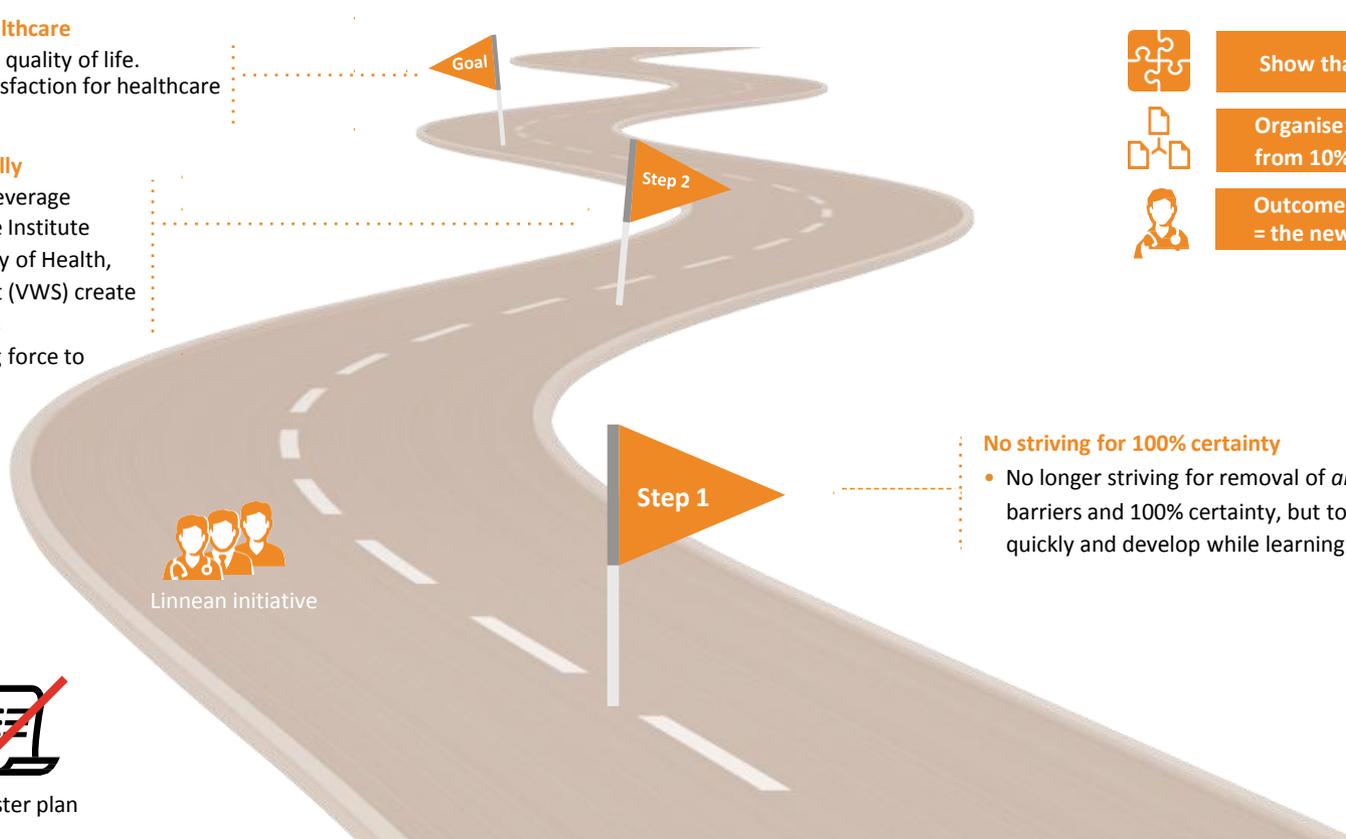
- Improving patient quality of life.
- Increasing job satisfaction for healthcare providers.

Getting started locally

- 10% pioneers as leverage
- Dutch Health Care Institute (ZiNL) and Ministry of Health, Welfare and Sport (VWS) create room for pioneers
- Patients as driving force to activate demand



Master plan



Show that it is possible!



Organise:
from 10% to 100%



Outcome based healthcare
= the new norm(al)

No striving for 100% certainty

- No longer striving for removal of *all* barriers and 100% certainty, but to start quickly and develop while learning.



ICT
standards / € / privacy



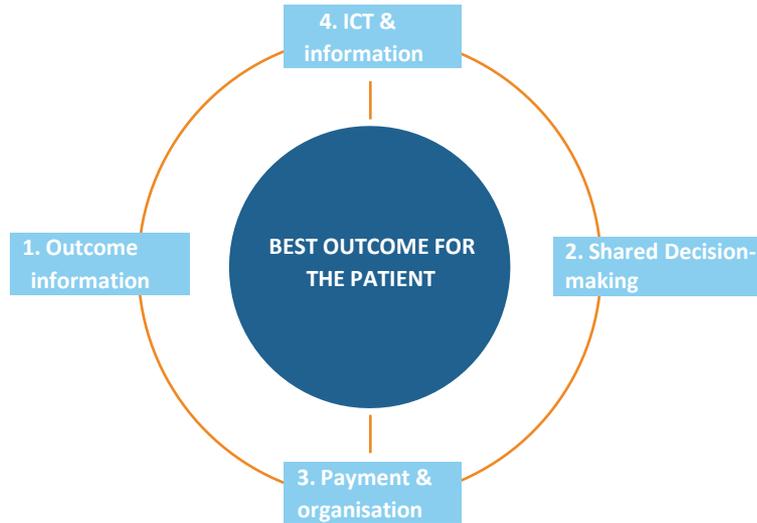
Regulatory pressure
experienced difficulty



Rewards
finances / funding

A national and international movement





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1. This is why outcomes matter

Every patient deserves the healthcare best suited to his or her personal situation. The most suitable care is the result of the most suitable treatment. The most suitable care requires patient and healthcare provider to have insight into the outcomes that are relevant for the patient.

Healthcare providers traditionally focus on clinical outcomes. Standard outcome measures include survival, while patients often feel other factors are at least equally important.

For patients with breast cancer, the development of self-image and sexual function, in addition to survival, are important factors in their lives. In brief, outcome information (both medical and non-medical) provides insight into the consequences of treatment for quality of life and enables patients and healthcare providers to discuss the matter. An example of relevant outcomes for breast cancer patients is presented in figure 1.

Insight into these outcomes allows healthcare providers and patients to make shared decisions about care or treatment.

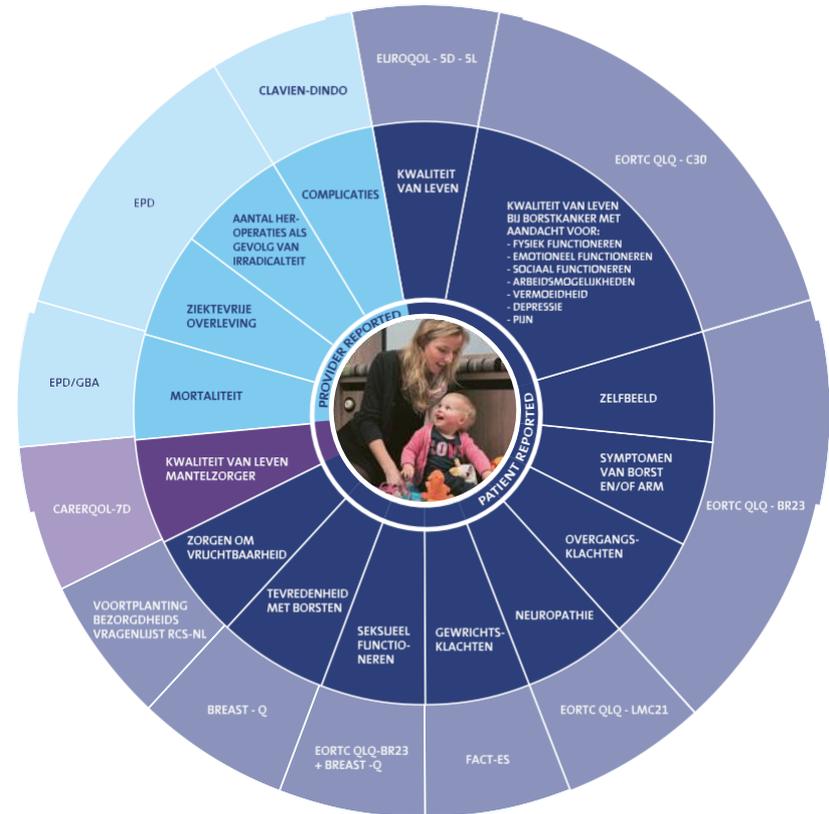


Figure 1 Standard set for breast cancer. (source: Erasmus MC)

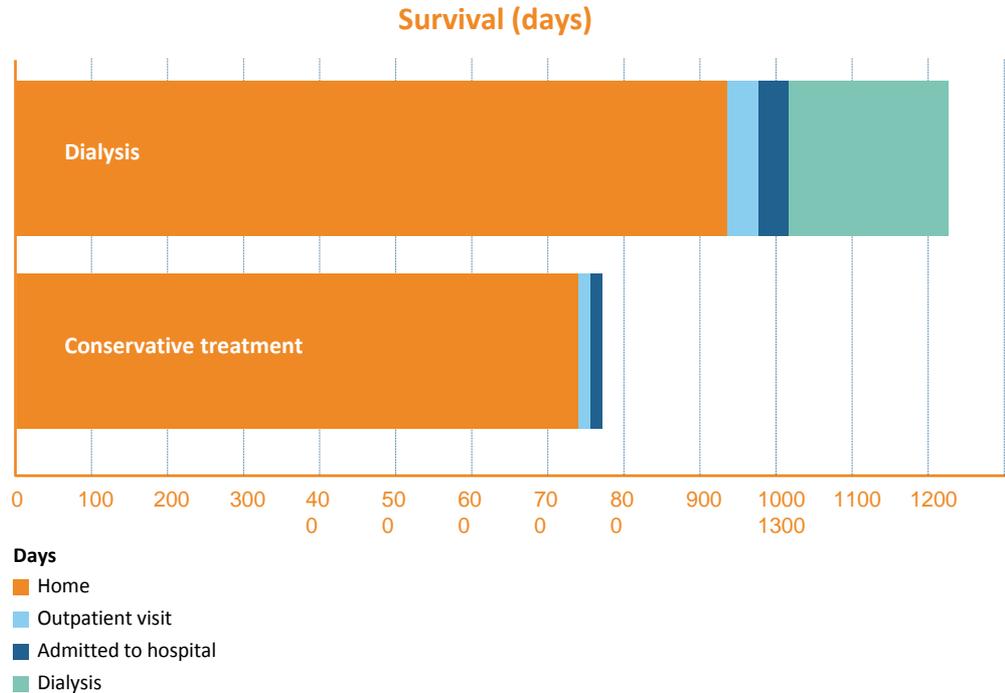


Figure 2 A significant portion of the life days gained thanks to dialysis by older patients is spent in the hospital (Source: Verberne et al, Am Soc Nephrology, October 2017)

The use of outcomes helps provide insight for both patients and healthcare providers. Furthermore, it supports shared decision-making regarding treatment. The decision not to treat can sometimes be a good option.

In the Sint Antonius hospital, healthcare providers discuss the impact of dialysis on daily life with older patients. For example, what is the added value of dialysis if you need to spend half the time you gain in the hospital? Figure 2 shows that older patients on dialysis spend a substantial amount of time in the hospital. Insight into these outcomes helps patients and healthcare providers make shared decisions about whether or not to start dialysis.

What constitutes a relevant outcome for patients is based on the interaction between the patient and the healthcare provider. Making a shared decision about what is the best fit for the individual patient at that moment.



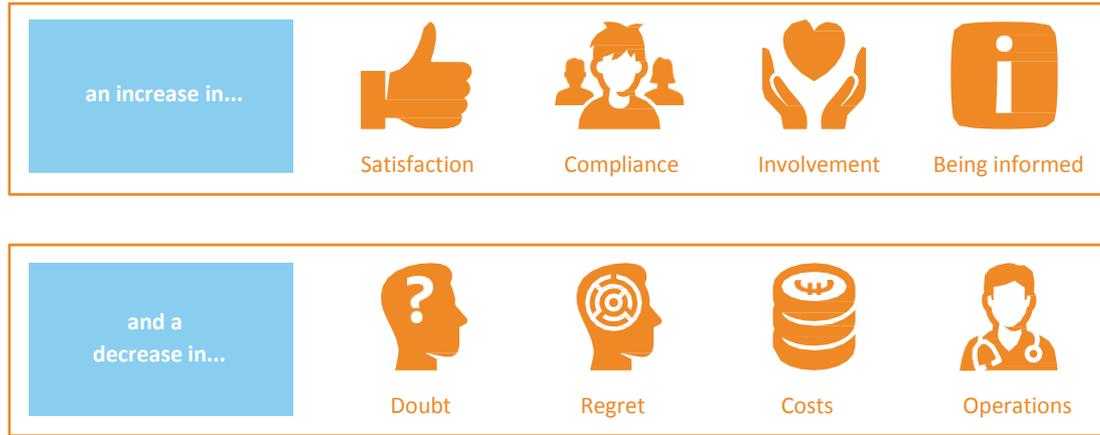
Figure 3 Example of a consultation room dashboard for Head and Neck oncologists from the Erasmus MC. The dashboard shows how this patient compares with other patients. Outcomes are compared within a group of patients, showing whether the patient is doing better (green), the same (blue) or worse than 50% of the comparable patients. Furthermore, the dashboard displays personal development compared with the previous measurement.

Outcome information has significant added value for both healthcare providers and patients if it is accessible during consultations. This is also true for the post-treatment phase and the course of symptoms.

Figure 3 shows how this may look for a healthcare provider and patient. This information helps patients and healthcare providers answer questions such as: ‘Is what I’m feeling strange?’ and ‘What can I expect after a treatment?’

The example is of an interactive dashboard, visible directly in the hospital EHR, providing healthcare providers and the patient with real-time insight into the most recent patient-reported outcomes.

Shared decision-making leads to...



... and the use of outcome information supports shared decision-making.

Sources

- Stacey *et al.*(2017), Decision aids for people facing health treatment or screening decisions;
- Knops *et al.*(2013), Decision aids for patients facing a surgical treatment decision: a systematic review and meta-analysis;
- Veroff (2013), Enhanced Support For Shared Decision Making Reduced Costs Of Care For Patients With Preference-Sensitive Conditions.



Patient

Patients indicate they are better prepared for the discussion with the healthcare provider, have a better discussion with the healthcare provider and a better feeling about the discussion.

'Everything is addressed this way'



Healthcare provider

Healthcare providers indicate the consultation is more effective this way: they address relevant issues more quickly and topics that previously remained under-examined. This allows healthcare providers to give the patient more suitable attention and care.

'I can't do without it any more'

2. From ambition to agreements to action

Coalition Agreement ‘Confidence in the future’

The Coalition Agreement states that, among other things, new reforms are unnecessary, but further improvement is. A number of issues are addressed by this approach:

- The importance of healthcare professionals focusing on outcomes rather than interventions.
- Focus on the development of outcome indicators.
- Broader approach by professionals and organisation of networks.
- ‘Shared decision-making’ and ‘contribution to quality of life’ as starting points.
- Quality (more) central to healthcare purchasing.

Administrative framework agreement for specialist medical care 2019-2022

The Ministry of Health, Welfare and Sport has made both financial and content-level agreements for further improvement of care with parties in the specialist medical care field. A number of content-level agreements relevant to this approach:

- Parties support the ambition of providing insight into outcomes for 50% of the disease burden and using this information.
- Further elaboration is coordinated with the programme ‘Outcome information for shared decision-making’ executed by the Dutch Health Care Institute on behalf of the Ministry of Health, Welfare and Sport.
- Reducing regulatory pressure creates room for success.
- In order to promote shared decision-making in the consultation room, parties will need to proceed with already initiated programmes and measures.
- ICT as a boundary condition for making the right information available to healthcare providers, patients and health insurers at the right time.

Four-pronged approach

In the letter to parliament of 6 December 2017¹ a commitment was made to send this approach to the House of Representatives in the spring of 2018. This letter already announced the four developments:

1. More insight into outcomes
2. More shared decision-making
3. Organisation and funding of care is focused more on outcomes
4. Better access to relevant and up-to-date outcomes information

Next, the reasons for the Ministry of Health, Welfare and Sport’s selection of these domains and who will notice the consequences of these activities in daily practice are outlined. Subsequently, the efforts the Ministry of Health, Welfare and Sport will undertake together with field partners and how the results will be made visible is addressed.

¹ House of Representatives Committee Letter regarding Request for update in the matter of Care quality (Parliamentary paper 31765 no. 289).



Workstream 1

More insight into
outcomes

3.1 More insight into outcomes

1. What is the motivation?

Currently, little outcome information is available either to healthcare providers or patients. What is relevant to patients is largely unknown. Of all the indicators provided to the Dutch Health Care Institute, about 15% pertains to outcomes, and 3% to patient-reported outcomes². The administrative burden and limited support from (smart) ICT solutions for healthcare providers and patients is an area for attention within this context.

3. What is the intended goal?

- An agreement has been reached on which outcomes must be measured for half of the disease burden by 2022.
- Healthcare providers are given room to use these outcomes as they see fit.
- Parties are familiar with agreements about use of outcomes and validation of said use.
- Governance of quality registries promotes efficiency.

²Dutch Health Care Institute figures.

³Specialist medical care umbrella organisations.

⁴Initiative by pioneers in the field who met at the ICHOM congress in Washington in 2017.

2. Who will notice the consequences?

Healthcare providers and health insurers are not always certain of which outcomes are truly relevant to patients. This means they cannot address the impact a treatment has on the patient's personal circumstances adequately. It prevents healthcare providers from improving care further. Additionally, they indicate that registering current indicators has limited added value for them. On the other hand, patients are lacking key information required to make well-informed decisions about treatments, but also about choosing a healthcare provider and / or treating physician.

4. Which parties are involved?

- Patient organisations.
- International consortia (such as ICHOM or PROMIS).
- Specialist medical care umbrella organisations³ (hospitals, doctors, nurses).
- Linnean initiative⁴.
- Hospitals and clinics.
- Dutch Health Care Institute.
- Health insurers.

Goals	Action items	Measurement
Patients and healthcare providers know which conditions are part of the approach.	<ul style="list-style-type: none"> Defining conditions that together represent 50% of the disease burden. Determining impact, number of patients and healthcare providers. Making agreements findable. 	<ul style="list-style-type: none"> Transparency monitor. Evaluating while learning pilot programme (see Annex 1).
Patients and healthcare providers know which outcomes are relevant.	<ul style="list-style-type: none"> Determining relevant outcomes and developing/adjusting indicators. Making results findable. Making agreements about management of the indicator sets. 	<p>Indicators:</p> <ul style="list-style-type: none"> Number of outcome sets developed. Number of participants in outcome measurements (patients).
Healthcare providers are given room to use these outcomes as they see fit.	<ul style="list-style-type: none"> Cutting what is no longer necessary. Measuring the result. 	<ul style="list-style-type: none"> Number of healthcare providers stimulating use.
Parties are familiar with agreements about use of outcomes and validation of said use.	<ul style="list-style-type: none"> Make agreements about use of outcomes in the consultation room and multidisciplinary meetings Make agreements about transparency of clinical and patient-reported outcomes for patient insight, learning and improving, benchmarking, selecting a consultation room, care purchasing, care evaluation and scientific research. Making agreements findable. 	<ul style="list-style-type: none"> Experienced regulatory pressure; the experienced added value must outweigh the experienced effort.
Governance of quality registries increases efficiency.	<ul style="list-style-type: none"> Mapping ongoing change initiatives and stakeholder analysis. Parties appoint an independent committee before 1 July 2018; the Committee will submit a recommendation to the Ministry of Health, Welfare and Sport no later than 1 November 2018. <p>The Ministry of Health, Welfare and Sport will decide on follow-up actions in consultation with field parties.</p>	



Workstream 2

More shared
decision-making

3.2 More shared decision-making

1. What is the motivation?

Many patients currently do not feel treatment decisions are a shared choice. Almost all patients (94%) want to be involved in this decision. The way this happens in daily practice differs per consultation room, and per multidisciplinary meeting. Healthcare providers are increasingly addressing this patient desire and learning from it, but the development of best practices remains fragmented. Shared decision-making about care and treatment is not yet a common good for all healthcare providers. Its position in the curricula of (continuing) medical education for healthcare providers is currently also limited.

3. What is the intended goal?

- More than ever before, healthcare providers and health insurers are focused on shared decision-making.
- Patients know that they can share in the decision and are supported better than before.

⁵ Patient federation (2017).

⁶ ZonMw (2016).

2. Who will notice the consequences?

Based on a survey of over 7,900 patients, 14% of patients feel they are insufficiently involved in the process. Furthermore, 48% of patients are only given one treatment option, and 37% have difficulty discussing personal preferences with a doctor⁵ or nurse.

The fact that developing best practices remains fragmented means healthcare providers have an urgent need to bundle knowledge and experiences to accelerate the movement⁶.

4. Which parties are involved?

- Patient organisations.
- Providers of decision aids.
- Providers of medical education.
- Specialist medical care umbrella organisations (hospitals, doctors, nurses).
- Linnean initiative.
- Health insurers.
- Netherlands Organisation for Health Research and Development (ZonMw)
- Dutch Health Care Institute.

Goals	Action items	Measurement
<p>Patients know that they can share in the decision and are supported better than before.</p>	<ul style="list-style-type: none"> • Start campaign stimulating shared decision-making. • Continue and scale up local initiatives. • Proof of concept 'use of outcome information in the consultation room' with the seven Santeon hospitals. • Continue development of decision aids with attention for usability in care process. 	<ul style="list-style-type: none"> • Transparency monitor. <p>Indicators:</p> <ul style="list-style-type: none"> • Relative number of patients that experiences shared decision-making.
<p>Healthcare providers and health insurers are now more focused on shared decision-making.</p>	<ul style="list-style-type: none"> • Include shared decision-making in the Dutch Medical Treatment Act. • Support care cooperation to promote attention for the link between health skills and shared decision-making. • Make agreements about securing shared decision-making as an integral part of (continuing) medical education. • Platform for bundling existing knowledge and experiences and facilitating learning from each other. • Encouraging shared decision-making in the quality standards by the Dutch Health Care Institute. • Clear information about the possibilities for rewarding shared decision-making. 	<ul style="list-style-type: none"> • Relative number of patients who feel sufficiently involved. • Relative number of patients who are presented with multiple treatment options. • Relative number of patients who discusses personal preferences with the doctor.



Workstream 3

More outcome based
organisation and
payment

3.3 More outcome based organisation and payment

1. What is the motivation?

The healthcare provider's interests are not focused enough on outcomes. Health insurers have the duty to purchase good care for their clients. They generally do this annually, with a large variety of healthcare providers. This care purchasing is often based on volume agreements. Furthermore, these types of agreements - almost without exception - only apply within the care organisation's own organisational framework. The sum total of all care process activities in the patient's entire chain is often insufficiently clear. There is a growing number of examples of experiments with more outcome based purchasing in the Netherlands. Learning from these examples is still limited.

3. What is the intended goal?

- The interests of healthcare professionals must be focused on care outcomes.
- A substantial percentage of contracts between care insurers and healthcare providers is focused on outcomes.
- Pioneers and best practices are shared, findable and usable for other parties to learn from.
- The entire chain of care plays an important role in the organisation of care by healthcare providers.

2. Who will notice the consequences?

Patients have noticed that the current organisation of care provision in the chain does not adequately address their personal circumstances. After all, current practice means it is not in the healthcare provider's best interest to look for solutions beyond organisational borders, as these affect the organisation's own bottom line.

Care insurers and healthcare providers only make limited purchasing agreements regarding quality and outcomes, and this remains a complex, pioneering endeavour. Perhaps because the current system only facilitates this to a limited degree. Insight into best practice example projects is not yet easily accessible in all situations. Furthermore, care insurers still have relatively limited insight into the efficacy and cost-effectiveness of care for individual patients.

4. Which parties are involved?

- Dutch Healthcare Authority (NZA).
- Patient organisations.
- Hospitals and clinics.
- Health Insurers Netherlands (ZN):

Goals	Action items	Measurement
<p>Outcomes play a substantial role in healthcare contracting.</p>	<ul style="list-style-type: none"> • Inventory of and visits to field initiatives focused on improving patient outcomes. • Monitoring: what do contracts look like, and what are the effects? • Share best practices to allow national dissemination, for example via roundtable sessions. • Investigate any boundaries, including if care pathways cross sectors or care organisations. • Start experiments if boundaries to funding are identified. • Examine the effect of multi-year contracts on outcome based healthcare. • Showcase best practices, e.g. purchasing based on outcomes. 	<p>Indicators:</p> <ul style="list-style-type: none"> • Number of insurers participating in approach Outcome based healthcare 2018-2022. • Number of healthcare providers participating in approach Outcome based healthcare 2018-2022. • Availability of implementation support.
<p>Organisation of care is based on the patient's entire chain of care.</p>	<ul style="list-style-type: none"> • Inventory of and visits to field initiatives focused on improving patient outcomes. • Research: what do cooperative ventures look like? • Share best practices to allow national dissemination, for example via roundtable sessions. • Research into ICT support for rewarding outcomes. 	



Workstream 4
Better access to relevant
and up-to-date outcomes
information

3.4 Better access to relevant and up-to-date outcomes information

1. What is the motivation?

There are currently few tools available for reporting, reviewing and comparing care outcomes. ICT and information systems do too little to facilitate the transition to outcome based healthcare. This means the correct information is not always available in the right place. Ongoing initiatives are currently working on (national) standards, but standards for e.g. outcome definitions and sharing outcome information are currently beyond the scope. The (possibility for) exchange of outcome information for learning purposes is also very limited.

3. What is the intended goal?

- All patients can report their outcomes.
- Data management (collection, storage and processing of data) is well organised and can be scaled up.
- All persons and organisations involved in patient care have access to outcome information.
- Outcome information is safely available for other purposes, taking privacy guidelines into account.
- Outcome information is available nationally at the aggregate level.

2. Who will notice the consequences?

Patients and healthcare providers only have a limited ability to report and review outcomes, and cannot easily use outcome information to make a shared decision about the most relevant outcomes for the patient. Patients cannot yet use such information to help them select a consultation room.

Healthcare providers cannot yet use sufficiently relevant and up-to-date outcome information to improve their care process, at both a patient and process level.

4. Which parties are involved?

- Quality registry administrators
- Linnean initiative.
- Current initiatives (incl. MedMij, Registratie aan de Bron, VIPP, Zorgladder).
- Patient organisations.
- Hospitals and clinics.
- Netherlands Organisation for Health Research and Development (ZonMw)
- Dutch Health Care Institute.
- Healthcare provider

Goals	Action items	Measurement
All patients are able to report their outcomes.	<ul style="list-style-type: none"> Facilitating and stimulating the development of (smart) tools for patients to report outcomes and feedback. Practical implementation support for all hospitals and clinics. Safeguarding patient's own management of health data. 	<ul style="list-style-type: none"> Transparency monitor. <p>Indicators:</p> <ul style="list-style-type: none"> Number of tools developed for outcome reporting. Number of healthcare providers using tools for sharing and discussing outcome information. Number of patients with access to these tools. Availability of outcome information for developed outcome sets. Experienced ease of use of data exchange. Experienced ease of use for patients. Experienced ease of use for healthcare providers. Experienced ease of use for care insurers.
Data management (collection, management and processing) is well organised and can be scaled up.	<ul style="list-style-type: none"> Investigate whether current mode of data collection and management is compatible with working with outcome information. Participation in data model pilot World Economic Forum. Scaling up proof of concept for accelerated automated derivation of outcome and quality registration from source registration. Facilitating experiments with data collection and management. Stimulating use of existing sources for outcome information. Elaborating recommendations by independent exploratory committee on quality registration governance. 	
All persons and organisations involved in patient care have access to outcome information.	<p>Facilitating and stimulating:</p> <ul style="list-style-type: none"> development of tools for providing access to patients and for shared decision-making. user-friendly access to outcomes for healthcare providers access to outcomes for care organisations. integration of registration and use of outcome information in existing systems. Implementation support. 	
Outcome information is safely available for other purposes, taking privacy guidelines into account.	<ul style="list-style-type: none"> Place topics of data privacy and data security on the agenda when developing and studying concepts for data management. 	

4. Change management approach



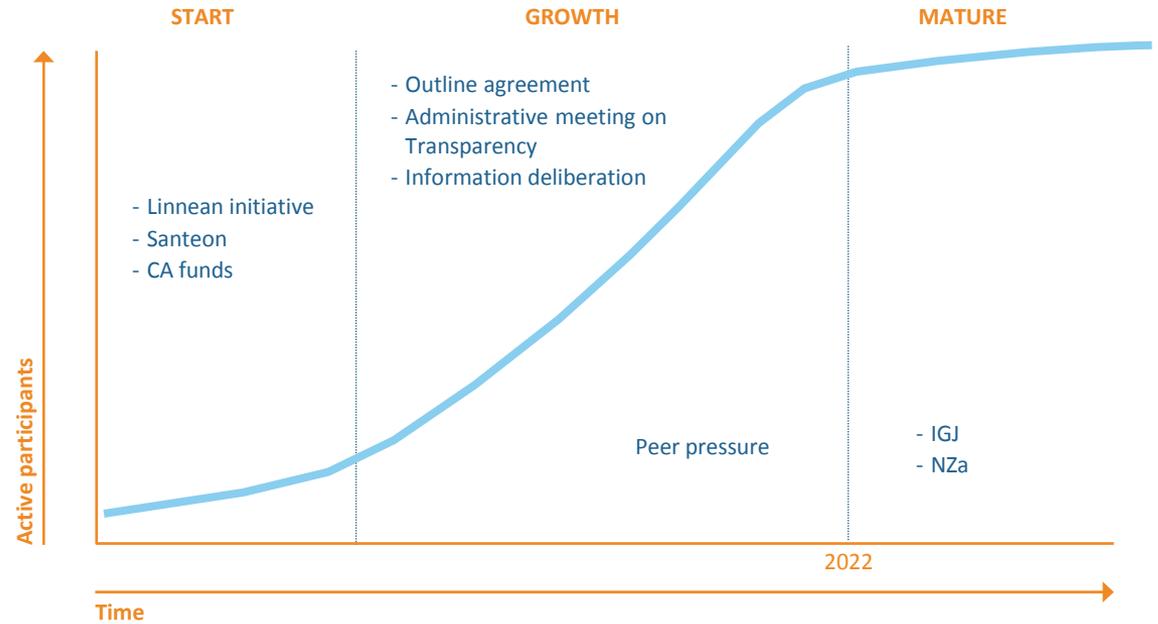
The plan is based on an 'snowball effect' in three phases:

- 1 Awareness**
 - Communication ambitions and creating expectations.
 - Attention for pioneers and followers, both within and between care organisations.
- 2 Involvement & promotion**
 - Learning from each other in daily practice.
 - Exploring organisation of regional support with parties including NFU, NVZ and ZKN, using existing care networks and bottom-up implementation of best practices where possible.
 - Connecting to (existing) local and regional care networks together with patients.
 - Connecting to existing initiatives and projects, such as Beslist Samen, Linnean, Santeon, VIPP and Zorgladder.
 - Immediately addressing organisational bottlenecks in local initiatives; make structural solutions available.
 - Improving quality registry landscape.
 - Invite pioneers as ambassadors.
 - Stimulate regional meetings.
- 3 Internalisation**
 - Create location(s) for knowledge, experience and implementation support.
 - Address administrative bottlenecks via evaluation of Administrative Meeting on Transparency.

Snowball effect

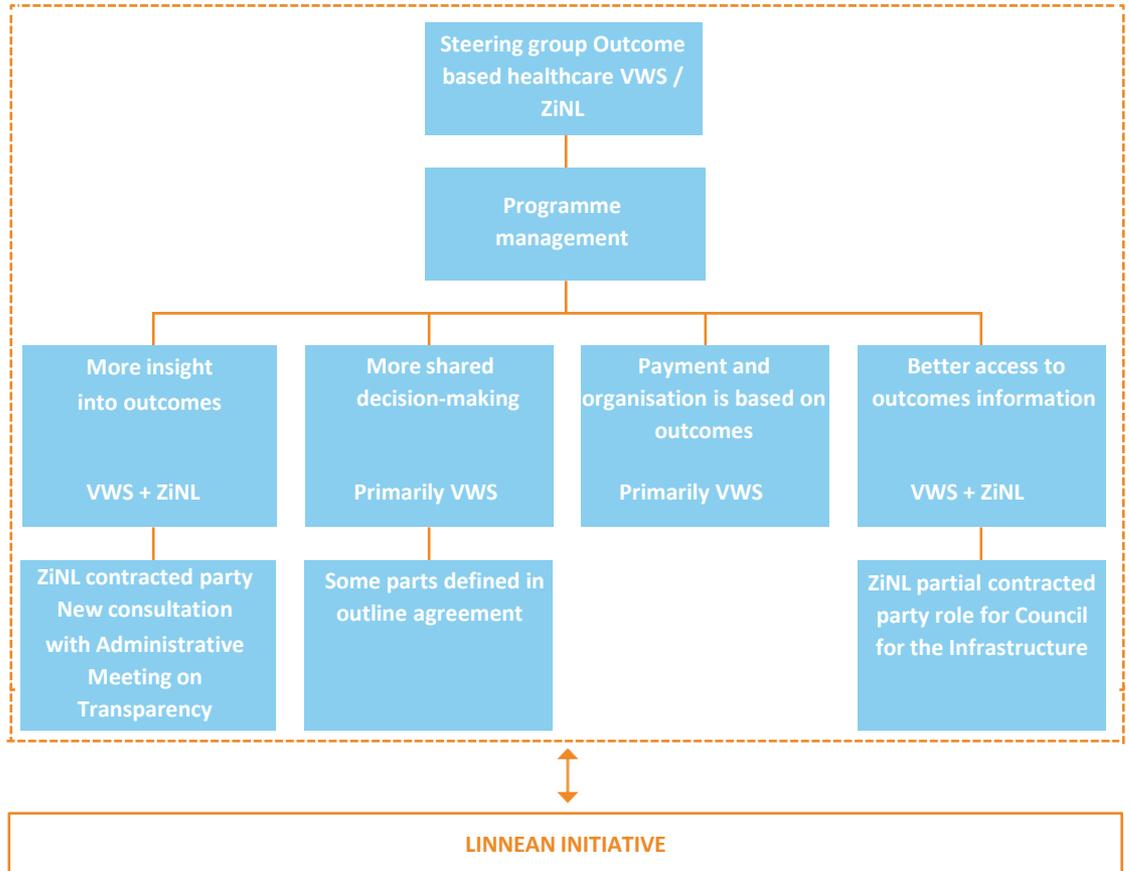
This approach is based on a growth in the number of involved parties over time based on an 'snowball effect', as displayed in the figure. This approach focuses its energy on the pioneers, but persuades field parties to join in.

During each phase of the plan, stakeholders are mobilised in order to further the snowball effect. The expectation is that this will generate a degree of peer pressure due to an increase in the number of involved organisations during the growth phase, which will make followers more willing to join up with developments.



5. VWS takes the lead

- Dependence of agreements in administrative bodies beyond scope of responsibility and steering:
 - Administrative Meeting on Specialist Medical Care;
 - Administrative Meeting on Transparency;
 - Council for the Infrastructure;
 - MedMij, Registratie aan de Bron, VIPP, Zorgladder steering groups (see Appendix 2 for comments).
- VWS leadership and bottom-up mobilisation of energy in the field to engage board members.



6. Additional funds in the coalition agreement

Coalition agreement

The goals as described will be realised via, among other things, use of the € 70 million additional funds agreed upon in the coalition agreement to 'reward outcomes';

Planned spending

The funding will be used within the four lines of development and for all overarching activities. Table 1 shows how funding will be distributed.

- In workstream 1, the focus is on developing and updating guidelines, development of outcome measures, and adapting international standards for use in the Netherlands.
- Workstream 2 focuses both on making information understandable for patients and on equipping professionals with the necessary skills and information.
- In workstream 3, the emphasis lies in research into bottlenecks and providing opportunities to address them.

- Workstream 4 also focuses on the development of technical standards, and the efficient and user-friendly organisation of the collection, process and use of outcomes information.
- Additionally, umbrella funding is provided for supporting changes, monitoring and evaluation, and for programme management.

Workstream	Description	2018	2019	2020	2021	2022
1	• Additional funds to include outcomes in professional guidelines		2,000	1,500	1,500	1,500
	• Focus on standardisation of (generic) PROMS and translation.	1,500	1,000	1,000	1,000	
	• Starting initiatives in other sectors.		1,000	1,500	1,500	1,000
2	• A cooperative venture with the Santeon hospital group to support outcome indicators in practice and learn from the experience, benefitting all healthcare providers.	1,500	1,500	1,500		1,500
	• Campaign, platform learning from each other, limited health skills, shared decision-making in curricula and quality standards		1,500	1,500		
3	• Monitoring: what do contracts look like, and what are the effects?	250	250	250	250	250
	• Best practices and scaling up			250	250	250
	• Research to promote insight into different methods for contracting and organisation.	250	250			
4	• Prolonging programme Registration at the source, standardisation of PROM collection, standardisation of tools for shared decision-making.		1,500	1,500	1,500	1,500
	• Reducing regulatory pressure, improving balance of benefit vs. experienced burden.	650	650	650	1,000	1,000
	• Experiments with different methods of data collection (inspiration: personal health train).	1,000	1,000			
	• Support for implementation of GDPR for outcome indicators and shared decision-making.	500				
Overarching	• Contribution to the Dutch Health Care Institute: Outcome transparency for shared decision-making.	2,000	2,000	2,000	2,000	2,000
	• Implementation support for NFU, NVZ, FMS, ZKN: utilise knowledge to help all hospitals and clinics benefit.	1,500	1,500	1,500		
	• Scaling up solutions.			1,000	1,000	1,000
	• Transparency monitor.	350	350	350	350	350
	• Study effect of approach on better care.	250	250	250	250	250
	• Budget for 2021 and 2022 will be set based on progress and results.				2,650	5,650
	• Execution costs (APK): including project secretary to manage to plan.	250	250	250	250	250
Total		10,000	15,000	15,000	15,000	15,000

Table 1 Distribution of investment funds.

Annexes

1. Remit: Evaluating
while learning

2. Project descriptions

Annex 1

Evaluating while learning

Remit 12: Outcome based healthcare (previously VBHC)

Context

Patient care all too often focuses on the intervention, rather than on the impact of said intervention on the patient (outcome). This is due in part to how purchasing agreements are made, as the emphasis here lies primarily on volume (output). Additionally, there is a lack of information on outcomes for many conditions. Therefore, the step towards outcome based healthcare requires a major effort from the sector as a whole.

The coalition agreement states that, among other things, new reforms are unnecessary, but further improvement is. A number of issues are addressed by this approach:

- Focus the interest of healthcare professionals on outcomes rather than interventions.
- Focus on the development of outcome indicators.
- Broader approach by professionals and organisation of networks.
- 'Shared decision-making' and 'contribution to quality of life' as starting points.

Therefore, the Ministry of Health, Welfare and Sport feels it is time for the next phase. The basic point of departure for this next phase is that more information becomes available than is currently the case on outcomes which are relevant for patients, so that the patient can make a better choice about 'which consulting room he or she ends up in' and that, subsequently, 'the right decisions can be made together'.

The use and registration of care outcomes in the Netherlands is in its early stages. This means that adequate execution of policy evaluation requires a baseline measurement. In this baseline measurement, we inventory which definitions of outcomes and registrations of outcomes are currently in use in curative healthcare. How insurers use these outcomes to steer contracting is explicitly part of this baseline measurement. Finally, we select a number of conditions for which outcomes will be defined during the course of the programme. Insight into the development of these new outcome definitions will provide an impression of the progress of the policy programme.

Purpose

Therefore, the Ministry of Health, Welfare and Sports has defined a plan of action in addition to existing policies regarding transparency, quality registries and the development of outcome information. The plan for Outcome based healthcare 2018-2022 has the goal of providing insight and access (for both patients and healthcare providers) to relevant outcome information for at least those conditions that jointly represent half of the disease burden in curative care.

This outcome information must be easily findable and understandable for both patients and professionals. Findable means the information is offered to both patient and professional, or is accessible via digital aids at their disposal. For the patient, this may entail a personal health environment, or the hospital portal. For the professional, this may be his or her workstation. Understandable relates mainly to the patient. The patient must be able to understand the information provided; this includes patients with poorer health skills. For example, by presenting the information as an infographic or movie. This allows the new information to be implemented in practice, and it can be used at any time to support a shared choice of the most suitable care.

The plan for Outcome based healthcare 2018-2022 strives to achieve this goal via four workstreams, addressing goals for patients and healthcare providers:

- More insight into outcomes.
- More shared decision-making.
- More outcome based organisation and payment.
- Better access to relevant and up-to-date outcomes information

The Dutch Health Care Institute is tasked (Outcome transparency for shared decision-making) with organisational and content level preparations to ensure all conditions that as many outcomes as possible for all conditions that fall within the scope of the plan may be reported, and that the information collected is available to both patients and healthcare professionals. This requires the development of outcome definitions.

In order to realise these goals, the Ministry of Health, Welfare and Sport works closely with ongoing initiatives⁷ in the sector in order to make the move towards outcome based healthcare a reality.

⁷ Projects including Beslist Samen, Linnean, MedMij, Registratie aan de Bron, Santeon and Versnellingsprogramma Informatie-uitwisseling Patiënt en Professional (VIPPP).

Framing the evaluation

Care in all its forms impacts people, both patients/clients and healthcare providers. This applies to both curative and long-term care. The Outcome based healthcare 2018-2022 plan will initially be limited to curative care. Furthermore, we will initially focus only on conditions jointly responsible for at least 50% of the disease burden within curative care.

In part, this involves ongoing evaluation within the context of the Evaluating while learning pilot programme⁸. This provides an opportunity to adjust policy along the way, if its efficacy proves insufficient or the implemented policy does not achieve the desired momentum. The starting principle is the involvement of field parties (both care organisations and patients) and addressing the international context.

This phase of policy and evaluation is focused on the short to middle term, with an emphasis on the creation of the margin conditions (availability of outcome measures). The overall Outcome based healthcare 2018-2022 plan focuses on the longer term, when the actual shift towards outcome based healthcare is monitored.

⁸ Ministry of Health, Welfare and Sport (14 September 2017). Letter to Parliament - Ministry of Health, Welfare and Sport policy evaluation pilot programme

Evaluation

The main question for this policy evaluation is:

- How can the government best facilitate the intended number of outcome definitions for 50% of the disease burden?

Underlying sub-questions are:

- How and in what way does involving the care field (both healthcare providers and patients) contribute to realising the intended outcome definitions?
- How and in what way does addressing the international context contribute to realising the intended outcome definitions?
- In what way have policy measures contributed to the development of outcome sets?

Method

The study is focused on the question of how effective policy is in achieving the formulated goals. The study will be performed in part during the course of the programme. This means that evaluation outcomes of the study can be used to adjust policy during its implementation.

The evaluation of the Outcome based healthcare 2018-2022 plan is based on the method of 'realistic evaluation'. This approach looks at policy as change models. Although change models are an inherent part of policy, these often not addressed explicitly.

Policy is focused on achieving momentum for an expected mechanism.

Realistic evaluators focus on exposing the mechanisms activated by a policy measure, and on determining in which context these result in a specific effect (see figure 4). Furthermore, the context within which these mechanisms arise is always considered. The combination of these two factors results in a specific effect.

Performing a realistic evaluation is empirically / technically identical to traditional social sciences research. Hypotheses are defined about the effect of a specific policy measure on a specific outcome, which can subsequently be tested empirically. By focusing particular attention on the context, this method allows consideration for the intended regional approach: why does policy work in one region, while it is less effective in another?



Figure 4 Conceptual representation of Realistic Evaluation

Process approach

The evaluation explicitly involves executing bodies, care actors and patients. This constellation of participants respects the context in which the effect must be achieved.

The evaluation is supervised by an independent party that will shape the process, containing representatives from all relevant parties.

Schedule

Action	When
Engage independent contractor in ongoing evaluation	June - September 2018
Start preliminary evaluation	September 2018
End preliminary evaluation	31 December 2018
Perform ongoing evaluation	2019 through 2021
Retrospective evaluation	2022

Annex 2

Project descriptions



Implementation of uniform care documentation (initiated by the NFU), with the goal of create a single core data set (continuity of care record) and unit of language based on international standards (e.g. SNOMED CT) and classifications (e.g. ICD-10).



An agreement set for safe, interoperable and reliable data exchange between personal health environments and healthcare provider information systems (*with a specific focus on use in PGO*).



Implementation of national standards, including the Basic Care Dataset (core data set for Registration at the source), medication process standards and standards for exchanging data with a PGO (MedMij).