ICHOM Written Interview

Gregory Katz, *Chaired Professor of Innovation & Value in Health,* **University of Paris School of Medicine**

Gregory is Founding Director of the VBHC Consortium, a nonprofit organization dedicated to accelerating the emergence of Value-Based Health Care (VBHC) to enable medical teams to evaluate, compare, improve and incentivize their results.

As lead author, his scientific publications focus on innovation management in life sciences, hospital organizations and VBHC. In 2019, he directed a report commissioned by EIT Health – a body of the European Union – entitled Implementing Value-Based Health Care in Europe: Handbook for Pioneers.

From 2007 to 2015, he was Director of Clinical Research at Ramsay Générale de Santé - a European leader in private hospitalization - and Director of its non-profit Foundation. From 2015 to 2019, he was Director of Research & Innovation at Elsan, a leading group of private hospitals in France. From 2003-2005, he was Visiting Professor at INSEAD in Fontainebleau (France) & Singapore. From 2004 to 2015, he was Chaired Professor of Therapeutic Innovation and Co-director of the Institute for Health Economics & Management at ESSEC Business School (Paris-Singapore).

Gregory's pro bono activities include Vice-President of the Eurocord Association (2004-2008), an international platform for clinical research on cord blood stem cell transplantation. He was a board member of the European School of Surgery (2009-2012), Chairman of the Scientific Board of the GlaxoSmithKline Vaccines Global Innovation Fund (2012-2015), and Chairman of the think tank Digital Leaders in Health (2018). He is the recipient of several awards, including the San Benedetto International Prize for his achievements in bioethics and humanism (2009), and was a Grand Rounds Lecture guest of honor at the UCLA Fielding School of Public Health (2015).

1. Tell us about your current role and responsibilities/key focus?

A professor at the University of Paris School of Medicine, I hold the Chair of Innovation & Value in Health. My research activities focus on patient-reported outcomes and the impact of transparent benchmarks on clinical practices. Recently, I was the academic director of the report published in May 2020 by EIT Health, a body of the European Union, entitled *Implementing Value-Based Health Care in Europe: Handbook for Pioneers*.[1] Aside from my academic life, I am the founding president of PromTime, a VBHC auditing company making health gains visible and patient choices possible. The French Ministry

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[1] EIT Health, *Implementing VBHC in Europe: Handbook for Pioneers* (Director: Gregory Katz), May 2020.
https://eithealth.eu/think-tank-topic/value-based-healthcare/

of Health commissioned my team to implement the collection of PROM data for cataracts and incentivize practitioner transparency on patient outcomes.

2. What is your background in patient-reported outcomes measurement/value-based healthcare?

Over the past five years, my team has been implementing a VBHC initiative on cataracts involving ophthalmologic surgeons in France. We have developed a safe environment with nominative benchmarks to enable surgeons to compare and improve patient health gains. To develop this approach, the French Ministry of Health and the national payer – the Assurance Maladie – introduced a financial incentive to motivate practitioners to make public the average health gain they deliver to patients affected by cataracts. The approach is original because it incentivizes transparency on outcomes - regardless of the outcomes themselves - which is another way to stimulate competition between medical teams.

3. What is the biggest lesson you have learnt regarding your experience to date with patient-reported outcomes measurement and value-based healthcare?

Implementing value-driven benchmarks requires shared metrics, nominative comparisons, and, ultimately, an independent body to coordinate operations neutrally. First, aligning participants on a standard scorecard and risk-adjustment methodology is essential in supporting decision-making for patients, providers, and payers. Second, nominative comparisons between clinicians create transparent, actionable environments for sharing best practices. Anonymized benchmarks stifle learning dynamics. Although pseudonymized comparisons are politically easier to validate between participants, they introduce a degree of opacity that may deprive patients of choosing outperforming medical teams. Third, open reports also require didactical explanations and simple layout to make data easy to understand for the layperson. Lastly, an independent third party with clear governance must be involved to oversee data collection, conduct data audits, and publish unbiased results.

4. What is the most important piece of advice you would offer a peer considering patient-reported outcomes measurement and value-based healthcare implementation?

Mobilizing internal forces is critical to overcoming resistance to change. As with any transformation, VBHC has its critics and skeptics, giving rise to such reactions as: *"We don't have time for PROMs."* In all cases, vision is not sufficient to trigger implementation. Implementation requires physician and administrative leaders working in tandem, combining medical and managerial competencies, accepting together the risks inherent to change, defining key milestones and creating traction broadly – from the operating room to the boardroom. First, it is essential to find clinical champions willing to measure their outcomes and be transparent with their peers and patients. These trailblazers are critical to selecting the specific condition and generating the momentum necessary to resolve early challenges. Second, it is important to consider whether the care team is motivated to dedicate its time and efforts to measuring outcomes and analyzing variation over time. Lastly, focusing on one specific condition is crucial to maximizing the success of a VBHC implementation. PROMs are the cornerstone of this transformation since they align teams around what patients see as important and mobilize internal forces to drive organizational change.

5. What do you think are the biggest obstacles to patient-reported outcomes measurement and value-based healthcare?

Fee for service remains the biggest obstacle that stifles the adoption of VBHC. The fee-for-service model incentivizes providers to grow service volume - not high-value care - which can generate over-medicalization and wasteful spending. Bundled payments are part of the solution. To engage

participants, value-based communities require safe environments with clear rules for data sharing to prevent retaliation and preserve trust among participants. The most significant impact occurs within an outcome-based ecosystem that allows non-punitive nominative benchmarks across participants – not to name and shame – but rather to stimulate peer-to-peer dialogue, knowledge sharing, and learning traction. Making value visible affects reputation and triggers a psychological response to leverage both competitive and collaborative behaviours. Transparent comparison does not impose hard, paternalistic norms, but rather, disseminates soft peer-to-peer signals that may be even more compelling. This peer-to-peer comparison creates a form of "*coopetition*" – a mix between competition and cooperation – where team members attempt to outperform individually, but at the same time, understand that they learn faster collectively.

6.   Where do you see the biggest opportunity for value-based healthcare to flourish?

Over the next years, a growing number of collaborations will emerge between life science companies, providers, payers, IT companies, and independent VBHC auditing organizations. These new types of partnerships will likely focus on accessing and processing real-life outcome data to demonstrate high-value care and share accountability on patient outcomes. Making value visible affects reputation and triggers a psychological response to leverage both competitive and collaborative behaviors. Economic incentives are also emerging in some European countries, mainly through outcome registries, facilitating a transparent competitive marketplace for insurers and providers to pilot bundled payment arrangements. On a separate level, we found examples where value-based procurement is reshaping commercial relationships to move beyond price and allow holistic appraisal of medical products through real-world evidence. Across health systems, services, and products, outcome reporting is being adopted and soon will be required. Becoming a VBHC early adopter opens the opportunity to learn proactively and spearhead high-value care.

7.   What advice would you offer on how to approach patient-reported outcomes measurement and where to get started?

The report entitled *Implementing VBHC in Europe: Handbook for Pioneers*[2] provides answers to this question. This user guide aims to share tools and best practices to accelerate the development of outcomes measurement. Of course, there is no one-size-fits-all solution for measuring outcomes, and all providers must make adjustments specific to their organization to customize implementation. However, we have found that VBHC pioneers do take similar steps, overcome similar hurdles, and converge on similar solutions. Based on these patterns, we have designed an implementation model called the VBHC implementation *Matrix,* which defines five key dimensions critical to most VBHC initiatives. The Matrix captures a shared language for describing, visualizing, and operationalizing a value-based program. Each of the five dimensions of the Matrix is made up of *building blocks.* First, *recording* refers to measuring processes and outcomes through a scorecard and data platform. Second, *comparing* includes benchmarking both internally as externally. Third, *rewarding* contains the way that returns on investment are incentivized, which consists of both psychological-based rewards in terms of recognition and reputation as well as outcome-based financial payment systems. Fourth, *improving* refers to organizing improvement cycles through collective learning. Last, *partnering,* refers to aligning internal forces and forging collaborations with external partners. Despite imperfections, prototyping a VBHC pilot requires starting with simple steps rather than grand solutions. By taking these early steps, health care leaders can begin to move in the right direction for success in the long-term.

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[2] EIT Health, *Implementing VBHC in Europe: Handbook for Pioneers* (Director: Gregory Katz), May 2020.
https://eithealth.eu/think-tank-topic/value-based-healthcare/

8. What are the top 3 case studies and real-world examples of patient-reported outcomes measurement and value-based healthcare implementation that would you recommend for further investigation?

Throughout our investigations, we have identified different types of VBHC leading organizations operating in Europe, such as private and public hospitals, condition-specific providers, outpatient chronic care clinics, networks of independent caregivers, health systems, third party quality registries, and private payers.

For example, Uppsala University Hospital is a large academic hospital in Sweden. Two years after launching its VBHC program, the ambulance unit succeeded in reducing time to dispatch by nearly 19% without affecting patient outcomes. The maternity care unit reduced the number of induced births by 26% with unchanged patient outcomes. Developed by the Uppsala Clinical Research Center, the Swedeheart cardiac registry was the first implementation of a registry-based randomized clinical trial, which results in modified not only indications, practices, and guidelines but also generated substantial savings for payers.

Another original case study, Good Life with osteoArthritis in Denmark (GLA:D), is about an entrepreneurial nonprofit organization training and certifying physiotherapists to deliver neuromuscular exercise to patients with osteoarthritis. Only three months after program start, knee patients reduce their intake of pain killer medications by 29%, on average. After one year, hip patients' quality of life improves by 20%, and sick leave for knee patients drops by 42%. This case illustrates the importance of both preventative and curative care for functional recovery after surgery.

Lastly, the Netherlands Heart Registry (NHR) is a nonprofit organization facilitating a VBHC program for cardiac diseases across 22 Dutch heart centers. Through public reporting, NHR serves cardiac patients and health system users in making outcome data visible. For combined aortic valve disease and coronary artery disease, the 120-day mortality dropped by 38% between 2015 and 2017. As an independent third party, NHR has succeeded in acting as a neutral facilitator to create a value-driven competition across cardiac medical centers in the Netherlands.

These case studies represent a sampling that is not fully representative of the growing number of VBHC leaders or the diversity of stakeholders in the health care sector, but rather offers highlights of some pioneers in the field.

9. What further reading would you recommend to assist our stakeholders in their patient-reported and value-based healthcare journey?

To date, more attention has been directed to *why* VBHC is critical rather than *how* it should be implemented. This is why I recommend reading our report entitled *Implementing VBHC in Europe: Handbook for Pioneers*.[3] This work is based on 240 interviews with VBHC leaders from 22 EU countries and 32 site visits to leading VBHC organizations in Europe. This handbook presents a VBHC implementation model - the "Matrix" - that defines nine steps critical to make VBHC happen. The result is a structured roadmap for organizational change and value-driven transformations.

10. Have we missed anything you would like to add?

There are good reasons to be impatient for improving health care through VBHC, but there are also reasons to be humble. VBHC is still in its infancy, and the successful implementation of outcome measurement programs takes time. Out of the 22 EU countries we analyzed in 2019-2020, only a handful are leading the way. The lessons learned from these pioneers create leapfrogging opportunities for others. Given today's hyper fragmentation of care, the only way to overcome barriers is to empower clinical teams, make them accountable for patient outcomes, and encourage them to drive this cultural shift.

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[3] EIT Health, *Implementing VBHC in Europe: Handbook for Pioneers* (Director: Gregory Katz), May 2020.
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