National Institute for Public Health
and the Environment
Ministry of Health, Welfare and Sport

Pioneer sites move towards *Triple Aim*

Interim Report, National Population Health Management Monitoring Scheme, December 2014

In 2013, the Netherlands Ministry of Health, Welfare and Sport designated nine regional innovation initiatives as pioneer sites in a nationwide effort to achieve 'better health care at lower cost'. The sites were put forward by several Dutch health care insurance companies. The regional collaboration initiatives are now implementing project plans to accomplish the Triple Aim (better health, improved quality and cost control) (Drewes et al., 2014). This fact sheet, based on documents and interviews with programme managers and steering group members, charts the progress made by the pioneer sites so far.

Planned change in small steps

All nine pioneer sites endorse the Triple Aim objectives but have adopted different project designs and strategies to achieve them. Whilst implementing specific adaptations aimed at health care improvement, the sites maintain an overall focus on the Triple Aim programme for change. Thinking outside the confines of the traditional agencies and levels of care, they seek to alter cooperative practices and organisational cultures in ways that move towards the Triple Aim.

It takes time and energy to create new cooperative structures and to jointly develop population health interventions. Progress is not always visible straightaway in the form of concrete projects or adaptations. Pioneer sites also vary in the numbers of local interventions that are actually part of the pioneer site activities. Since that could partially obscure the results of some initiatives, we will take it into account in our eventual process and outcome evaluations.

The brief texts below review some of the accomplishments of the pioneer sites up to now.

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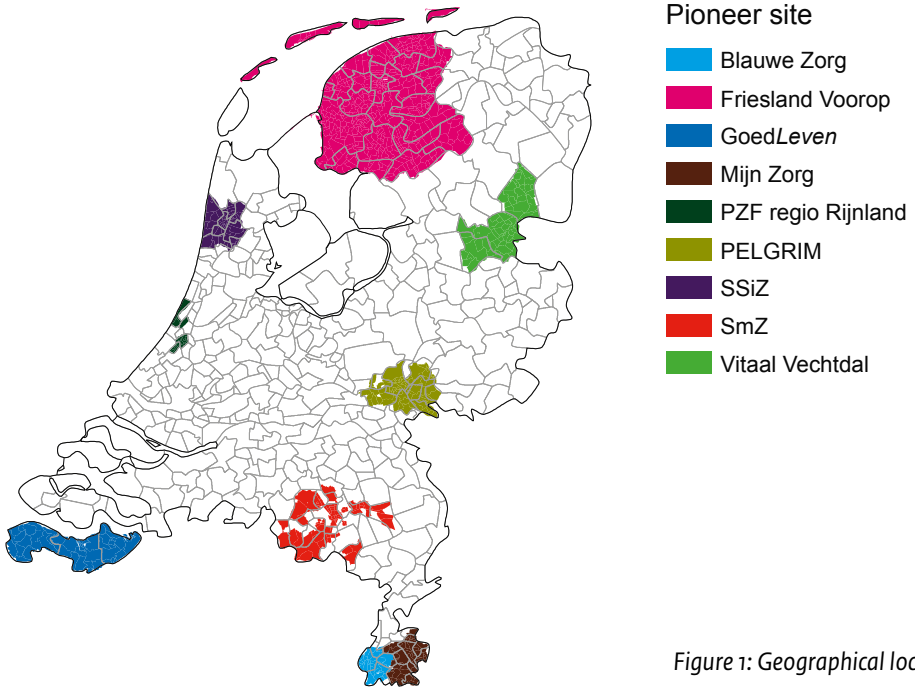

Figure 1: Geographical locations of pioneer sites

Pioneer sites in search of optimum organisational structures

The Dutch pioneer sites are networks, each of which is comprised of a steering group, one or more working groups and sometimes an executive or management committee. The composition and the duties of steering groups may change over time. Several sites are still seeking the best organisational structure to work with. Some sites have created project-level legal entities and are exploring new forms of pioneer site organisation in order to secure consistent funding and ownership.

Varied forms for public participation

Steering group members report looking for effective ways of engaging the general public. The most common approach has been via the regional advocacy organisation for health care clients known as Zorgbelang, which is represented in eight of the nine pioneer site steering groups. Each site allocates different tasks to Zorgbelang. In the province of Limburg, for instance, the regional Zorgbelang organisation Huis voor de Zorg provides workshops to raise awareness of the roles individual citizens can play. In Gelderland, Zorgbelang conducts assessments of patient experiences. Some pioneer sites have shifted the emphasis from health care clients to the wider public. In Friesland, the regional Zorgbelang organisation has drawn up a policy paper for the Friesland Voorop pioneer site which formulates a citizens' vision on how health care should be organised in 2020. The site GoedLeven in the Zeeuws-Vlaanderen region has set up an online community to engage the public in the ongoing development of the site.

Securing funding opportunities for pioneer sites and health care innovation

Thus far, health care activities carried out in the pioneer sites have largely been reimbursed by insurance companies under the auspices of the Health Insurance Act (ZVW). A few projects, such as integrated mental health care, have been funded under the Dutch Healthcare Authority's (NZA) Policy Guideline on Innovation, and projects such as Last-Phase-of-Life under research grants from the Netherlands Organisation for Health Research and Development (ZonMw). Programme management activities receive funding from the reserves of the former Dutch Voluntary Health Insurance Funds (RVVZ) or are conducted under the Regional Primary Care Support Structure (ROS). Other strategies are also pursued to defray the additional costs of projects, such as requiring investments from the participating agencies. The site Vitaal Vechtdal has developed a health insurance policy of its own that allows room for investment in activities such as preventative care. Considerable discussion has arisen about any shared savings achieved by the sites, and in particular about legal and regulatory obstacles to making distributions or to reinvesting the savings in prevention or other activities. Although such disputes have not yet impeded progress in the pioneer sites, they could well do so in the longer term.

Blauwe Zorg has two basic focuses. The first concerns *adaptations to health care services* and comprises two projects: Anderhalvelijnszorg ('primary-secondary interface care') and Pharmacy. The primary-secondary pilot project was launched in 2013. Specialists from five secondary care disciplines (internal medicine, neurology, orthopaedics, dermatology and cardiology) hold fortnightly patient consultations in five GP surgeries for people with non-acute health symptoms. In May 2014, the project was expanded and relocated to two urban clinics in Maastricht. The Pharmacy project will be contractually implemented from July 2015. The second main focus involves *behaviour interventions* in health care provision. Three regional workshops were conducted by Huis voor de Zorg in 2014, and these spawned three subprojects: Drug Cost Transparency, Support Tools for Shared Decision-Making, and Individual Self-Responsibility.

Goed*Leven* implemented three projects in 2014. In an initiative called the Get Moving to Live Well Expedition, pioneer site participants literally 'got moving' in a trek to Goed*Leven*, during which they discussed the pioneer site with one another and with the general public. From October 2014, they implemented the Pharmacy Project, in which 80% of regional GPs began switching their patients to less costly cholesterol and blood pressure drugs. Later that month they launched the Last-Phase-of-Life Project, which encourages timely reflection and discussion about the final phases of life, in order to raise individual awareness about ensuring one's own say in that phase. Beyond these three population health interventions, pioneer site participants are now being invited to come forward with their own project proposals. An online community is also being established to engage the general public in co-creation for the further development of the pioneer site.

Populatie Zorg en Financiën (PZF) regio Rijnland began an initiative to improve information provision through data linkage. The completion of a knowledge infrastructure in 2014 enabled continuous extraction of data from the record systems of GPs, pharmacists, hospitals and clinical laboratories. Linking such data sheds light on associations between treatment procedures, outcome measures and health care costs. The emerging insights are discussed in various bodies in order to plan follow-up measures and interventions, which can then be used in devising modules to support decision-making by patients and care professionals. In 2015, such interventions will be introduced for cardiovascular risk management, COPD, diabetes mellitus and geriatrics.

Friesland Voorop appointed expert groups in 2012 with focuses on various target populations or medical specialties as well as on infrastructural resources. Several groups were later transformed into population health projects. De Friesland health insurance company takes the expert group recommendations into consideration in making health care purchasing decisions. Pioneer site projects also resulted in tenders issued by De Friesland in 2014 for six primary-secondary interface centres for wound care services in the region, for an integrated care package for vulnerable older people and for intergrated care protocols for several chronic diseases. An experiment with bundled payment in perinatal care will begin in 2015. Regional-level coordination has been agreed in working groups of GPs and specialists that deal with referrals and downward substitution of services in seventeen surgical or other procedures to be delivered in primary care from 2015 onwards.

Mijn Zorg implemented five projects in 2014. GPs, specialists and pharmacists focused on cost-effective prescribing behaviour for three drug categories. A primary-care-plus centre called PlusPunt was established for low-risk cardiology patients. Depending on the respective business cases, PlusPunt is to be expanded with ear, nose and throat care, dermatology, internal medicine and minor surgery. Lifestyle coaching has been introduced to support people at high risk of chronic illness in changing their lifestyles. Surveys have been conducted to improve patient-centredness in the care to people with diabetes or chronic obstructive pulmonary disease (COPD) and to hospital inpatients. An additional project supports people with diabetes in self-managing their illness.

Samen Sterker in Zorg (SSiZ) engages secondary care specialists in primary care settings (specialist outreach consultations) and monitors GP referral behaviour. Patients with more serious COPD conditions receive support from a respiratory nurse specialist to avoid hospital admission. Training courses on managing atrial fibrillation have been introduced to enable stabilised patients to be referred back for treatment in primary care. A pilot project began in June 2014 in which primary and secondary care practitioners perform joint triage in accordance with the practice standards recommended in Een Goed Begin ('off to a good start'), an advisory report from the Dutch Health Care Inspectorate (IGZ). A geriatric project provides services that include proactive vulnerability screening by geriatric nurses in nine GP surgeries. Cost-effective drug prescription is promoted by a new policy on interpractice drug formularies and by a pharmacotherapy committee. An integrated mental health care programme known as Vicino NHN has also been established in the northern North Holland region.

Vitaal Vechtdal bases its work and thinking on the premise of 'behaviour and health'. In 2014 it developed a special Vitaal Vechtdal health insurance policy in collaboration with the Achmea health insurance group and health care partners and enterprises in the Vecht valley. Some benefits provided by the policy are reduced regional rates, expanded cover and preventative care services. Older residents of the catchment areas of four general practice groups are screened for dementia, loneliness and polypharmacy, and appropriate follow-up care is then provided to vulnerable clients. In a new project called Better In Better Out (BIBO), practice nurses screen patients who may need knee or hip surgery, as timely intervention could enable an earlier return to independent living with lesser degrees of functional loss. A longitudinal survey was initiated to chart the vitality of regional residents (baseline assessment in 2014). A regionally based pharmacy has also been established.

PELGRIM concentrated on two projects in 2014. It engaged a musculoskeletal GP to ensure close-to-home care and cost reductions. The doctor has one or two consultations with a patient, makes a diagnosis, provides treatment or referrals if needed and draws up recommendations for the patient's GP. The second project, Goed Thuiskomen ('coming home safely'), was begun in September 2014 to improve the coordination of care for people older than 65 after discharge from hospital. A care coordinator contacts them promptly after their return home to arrange the necessary care and support.

Previous publications (in Dutch with English abstracts):

Drewes HW, Heijink R, Struijs JN, Baan CA. Landelijke Monitor Populatiemanagement. Deel 1: Beschrijving proeftuinen (National Population Health Management Monitoring Scheme. Part 1: Description of Pioneer Sites). Bilthoven: National Institute for Public Health and the Environment (RIVM), February 2014.

Heijink R, Drewes HW, Struijs JN, Baan CA. Landelijke Monitor Populatiemanagement. Deel 2: Ontwerprapport (National Population Health Management Monitoring Scheme. Part 2: Scheme Design). Bilthoven: National Institute for Public Health and the Environment (RIVM), April 2014.

Slimmer met Zorg (SmZ) began by initiating a pharmacy project in 2013. It designed two drug formularies for patients with diabetes or cardiovascular risk (in collaboration with secondary care specialists) and for patients with asthma or COPD. Since late 2013, quarterly reflective data has been made available on generic and therapeutic substitution in three drug categories. Another project called Eerstelijnsplus ('primary care plus') was launched in which secondary care specialists provide advice on diabetes or on asthma and COPD in specialist outreach consultations; stabilised patients with a low burden of illness are treated in disease management programmes in their GP practices. SmZ also examined organisational structures in 2014. Towards the end of the year it began working in three independent strategic service sections, each with its own development and innovation agenda. The aim is to devise smaller-scale collaborative arrangements, to capitalise on synergies and to differentiate the paces of innovation.

The National Monitoring Scheme

The RIVM has been commissioned by the Netherlands health ministry to monitor the progress of the nine pioneer sites, with a particular focus on:

1. Design, implementation and experiences in the sites.
2. Developments at the sites in terms of target population health status and the quality and costs of health care.

Data:

1. Health care record systems and health insurance claims data.
2. Client questionnaire (N > 26000).
3. Interviews with stakeholders (N > 100).

Products:

1. June 2015: report on the baseline assessment of the Triple Aim and experiences in the operational process.
2. 2016–2017: interim reports on specific topics.
3. Mid-2018: report on the follow-up of the Triple Aim and experiences in the operational process.

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