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Taking action to improve health for all

Bridging perspective: Developing and Validating a Tool to Assess the Alignment Between Hospital Leadership and Healthcare Personnel in the Transition to VBHC

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Background

- The fundamental **goal and purpose** of health care is to deliver high and rising **value for patients**

$$\text{Value} = \frac{\text{Health outcomes that matter to patients}}{\text{Costs of delivering these outcomes}}$$

- Delivering high value health care is the **definition of success**
- Value is the only goal that can **unite the interests** of all system participants
- Improving value is the **only real solution** to reducing the burden of health care on citizens and governments

- The questions are how to design a health care delivery system that **substantially improves patient value**, and to shift competition to **competing on value**

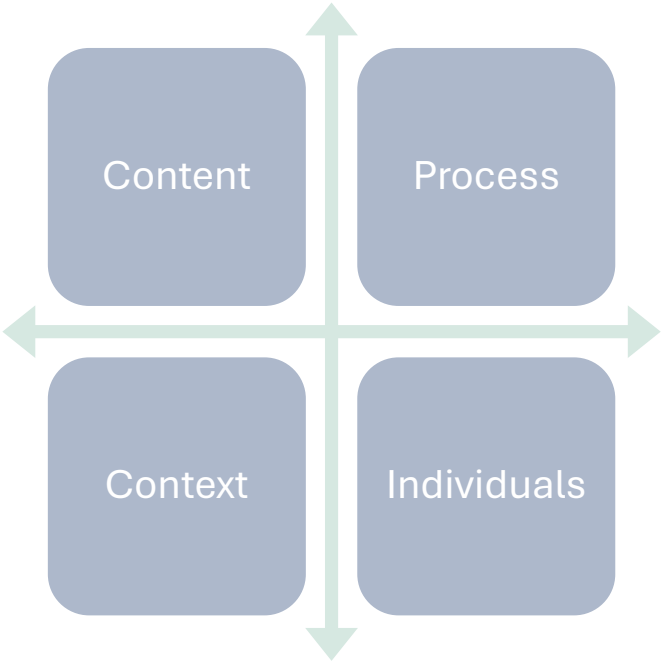
Since its introduction, many healthcare systems have initiated the process of **aligning with the VBHC principle**. Nevertheless, the **transition remains far from straightforward**.

A successful implementation of VBHC requires significant transformations, spanning from **structural adjustments** to a fundamental **shift in organizational culture**.

Several studies indicate that **organizations**, in adopting this framework, **did not implement the principles of the Value Agenda as an integrated management strategy.**

Managers tend to **underestimate** the diversity of **employee responses to organizational change** and **their role of leadership** in shaping these responses at both individual and group level.

Background



According to Wilhelm J. Coetsee (2015), ***how people react to change**, that is, positively or negatively, **is influenced by:***

- *What is being changed (**content**)*
- *How the change is implemented (**process**)*
- *The circumstances under which the change is occurring (**context**)*
- *The **individual characteristics of the change participants***

Aim

The present study aims to describe the development and validation process of an **assessment tool** designed for use within a healthcare organization during their transition towards VBHC.

The **purpose** of this instrument is twofold:

To **assess the extent to which the VBHC Value Agenda elements have been implemented** within an organization.

To evaluate the **change management strategies employed by organizational leaders** to drive and sustain the transition to VBHC.

Method

PHASE 1

Tool development

The present assessment tool builds upon the findings of our previous scoping review.

To translate operational strategies into practical questionnaire items, a series of structured sessions were organized between September 2024 and November 2024.

This process involved a multidisciplinary working group composed of 12 experts in VBHC, change management, hospital operations, clinical care, and statistics.

PHASE 2

Tool validation

To validate the findings from Phase 1 and to ensure the questionnaire's reliability, a two-round Delphi survey was carried out.

The Delphi survey involved the following steps:

(i) *Development of an online survey;*
(ii) *Recruitment and consenting of participants to the Delphi panel;*
(iii) *Two rounds of consultation on the proposed topics in the survey.*

METHOD: PHASE 1

Strategic Level	Dimension	Operational Strategies	References
Organizational vision and cultural integration	Vision, strategy and governance structures	Having an official commitment to value-based redesign from the higher levels of the organization.	[12,17,25,31,35,36,39]
		Embedding the adoption of the VBHC concept in the hospital strategy, policy documents, and planning and control.	[20,34]
		Providing formal responsibility and mandates to a steering group with hospital representatives for the implementation of VBHC.	[6,17,20,25,26,28,30–32,34–36,40]
		Empowerment of service line leadership with direct accountability and authority over programs and budgets.	[20,34]
		Developing a tailored business plan to provide a structured process that is clear, goal-oriented, and adaptable to each situation.	[10,25,34,35,40]
		Being supported by consultancies.	[6,23,35,36,40]
		Starting with "experiments" and "pilots".	[12,23,26,35,40]
		Planning and preparation before starting the implementation process.	[36,39,40]
	Anchoring the new approach to the hospital organizational culture	Staff training and education on the VBHC concept.	[6,12,20,25,32,34,36,37]
		Improving communication and information with staff about the change.	[6,23,26,34,36–38]
		Providing time for healthcare professionals to work on the project and anchoring changes to their daily work.	
		Continued recognition of the usefulness of the VBHC implementation.	
		Starting with positive results.	
		Motivating people to get them involved step by step in developing the process.	
		Involving patients and their representatives in the implementation process.	
Operational Excellence	Standardize care pathways	Defining transmural care standard.	
		Hiring additional staff dedicated to care coordination to connect the territory and the hospital.	
		Participating in peer-to-peer learning collaboratives on implementing new delivery models or enhancing care coordination.	
		Planning and attendance of periodical networking meetings.	
		Defining and optimizing Critical Pathways (CPs).	

A series of **structured sessions** were organized to **translate operational strategies** into practical **questionnaire items**.

Strategic Level	Dimension	Operational Strategies	References
Operational Excellence	Standardize care pathways	Using liaison positions (such as "intermediary managers") to enhance coordination between functional units.	[6,10,12,37,39]
		Appling the lean-methodology.	[25]
	Developing multidisciplinary teams	Engaging all professionals involved in the different levels of one patient's care	[10,20,35,39,42]
		Planning and attendance of regularly institutionalized meetings ("standing committees").	[6,12,25]
		Sharing workspace.	[25]
		Creating multidisciplinary meetings to discuss complex patients.	[10,28]
	IT support	Setting up innovative data sharing mechanisms to provide real time data to providers.	[18,19,21,22,27,43]
		Setting up care and information technology platforms to facilitate both patients and healthcare professionals.	[23,25,36,37]
		Creating dashboards containing outcome measurements, PROMs/PREMs and costs.	[12,29,31]
	Additional resources	Availability of additional support staff (data analysts/project leaders/care managers).	[10,25,36]
VBHC assessment	Clinical Outcome measurement	Identifying and collecting relevant clinical outcome measurements.	[10,12,23,25,27–32,34,36–38,40,41]
		Mapping the care processes for each respective group of patients.	[23,40]
		Benchmarking outcome data among hospitals.	[12,25,29,32,40]
		Obtaining, processing, and dispersing data in a time-efficient manner for internal reflection.	[12,29,31,32,34,41,42]
		Explaining the clinical outcome measurements more pedagogically.	[36]
		Simplifying PowerPoint presentations of outcomes measured.	[36]
	Patient-reported measures	Collecting data regarding patient reported measures (PROMs and PREMs).	[25,27,28,31,38,41]
	Costs measurement	Measuring costs based on actual resource use over the full cycle of care for the patient's condition.	
	Audit and Feedback (A and F)	Performing "Audit and Feedback" (A and F).	[28,30]

https://www.mdpi.com/2227-9032/12/23/2457

METHOD: PHASE 2

DELPHI METHOD

The Panel Members

Potential Delphi panel participants were selected based on their publications, CVs and demonstrated expertise in relevant domains. We identified four key categories of experts: (i) VBHC; (ii) management; (iii) health economics; (iv) clinical practice and research.

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Experts were invited to complete the Delphi survey via email, using a Google Forms questionnaire.

A cover letter outlined the survey's purpose, relevance, and significance. Responses were collected in real-time and anonymously.

Data Analysis and Definition of Consensus

The experts panel assessed the adequacy of the proposed items using a 5-point scale, ranging from 1 (not adequate) to 5 (completely adequate).

Data collected during the initial consultation round were used to calculate the K coefficient and establish consensus criteria among panelists.

Consensus was establishing based on the following criteria: a median (Mdn) score of ≥ 4, an interquartile range (IQR) of ≤ 1.5 or ≤ 2, and a frequency of ratings in the range [4–5] ≥ 70%.

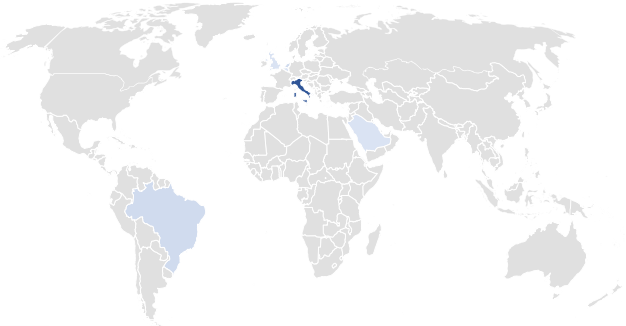
Panel responses were iteratively analyzed during exploratory and final validation stages, enabling continuous refinement of the questionnaire.

Results

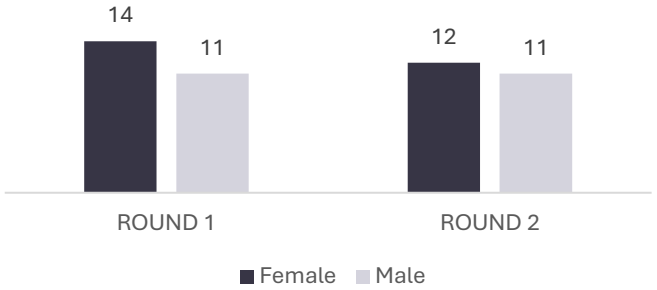
1

A total of **54 experts were invited** to participate in the Delphi survey.

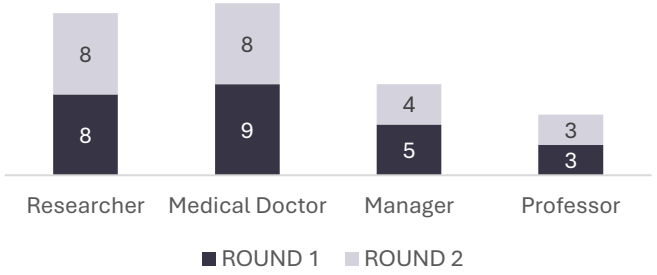
Country or Region



Gender



Job title



Results

2

The **final version** of the assessment tool is composed by **30 questions.**

Numbers of questions

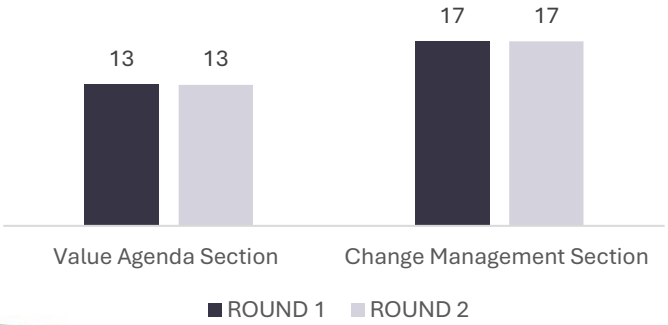


Figure 1 – Value Agenda Section: Two-Round Delphi Results

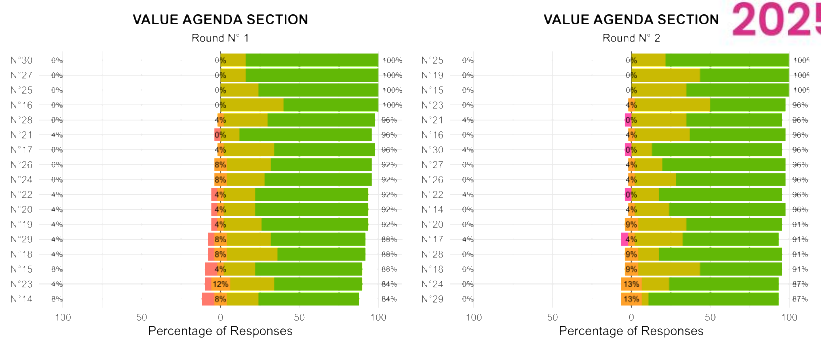
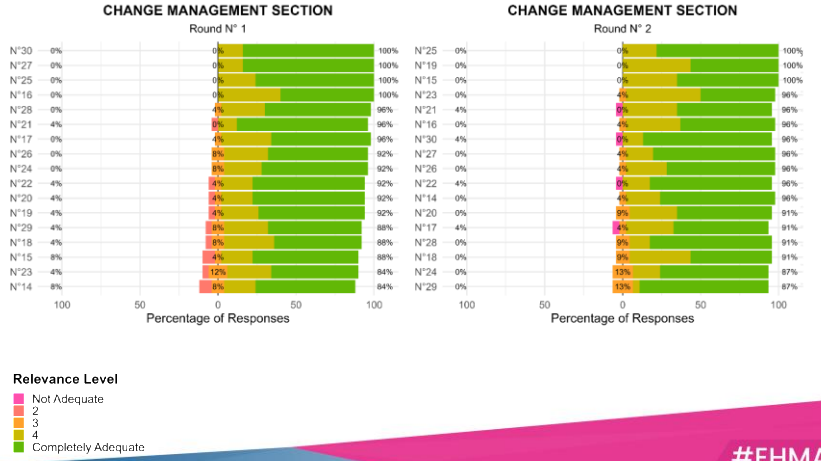


Figure 1 – Change Management Section: Two-Round Delphi Results



Main features

1

AREAS EXPLORED

Several existing tools focus on evaluating either the implementation of ***value agenda elements*** *or the* ***organizational strategies for change management****, but* ***no one integrate both dimensions within a single assessment framework****.*

ASSESSMENT TOOL DESIGN

Each level of analysis is composed by **primary questions** (such us: "*To what extent does the hospital systematically measure clinical and patient reported outcomes*?"), followed by **secondary questions** (*such us. "If so, which of the following measures are used?*").

2

3

ASSESSMENT TOOL STRUCTURE

In order to explore the **differences in alignment between hospital top management and healthcare personnel** on the issues surveyed, it was decided to structure this assessment tool as a **mirror survey**.

Limits

Study limitions

1. The outcome is influenced by factors such as the representativeness of the initial material (the result of a previous scoping review) and composition of the experts' panel.
2. The Delphi methodology is susceptible to high dropout rates due to the length of commitment and distractions between rounds .

Tool limitions

1. Our tool currently does not include questions that investigate the last pillar of van der Nat's extended strategic agenda, namely: "Build learning platforms for healthcare professionals",
2. Our tool currently does not include questions that investigate the VBHC Value Agenda pillar, namely: "Aligning Reimbursement with Value".

THANK YOU

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