



# Appropriate Care

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# (In)appropriate?



De juiste  
zorg op de  
juiste plek

Wie durft?

## ValueBased HealthCare

### Kiezen voor houdbare zorg

Mensen, middelen en  
maatschappelijk draagvlak

WRR



Met hart voor zinnige zorg

UITKOMSTGERICHTE  
ZORG

De beste  
zorg die  
bij jou  
past.

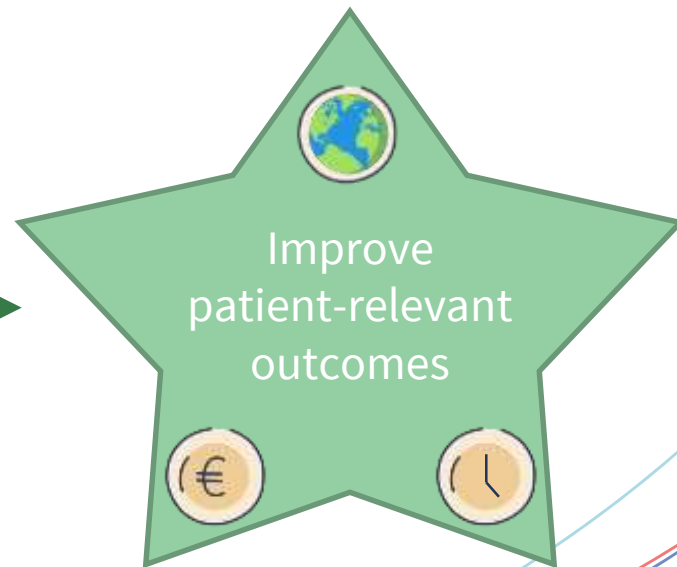
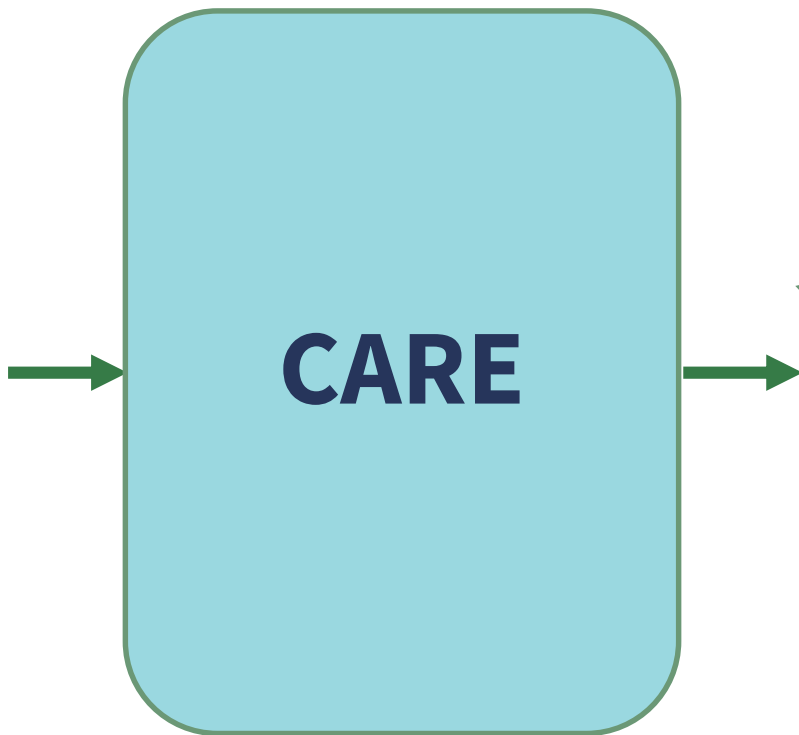
Samenwerken aan  
passende zorg:  
de toekomst is nú

Actieplan voor het behoud van goede  
en toegankelijke gezondheidszorg

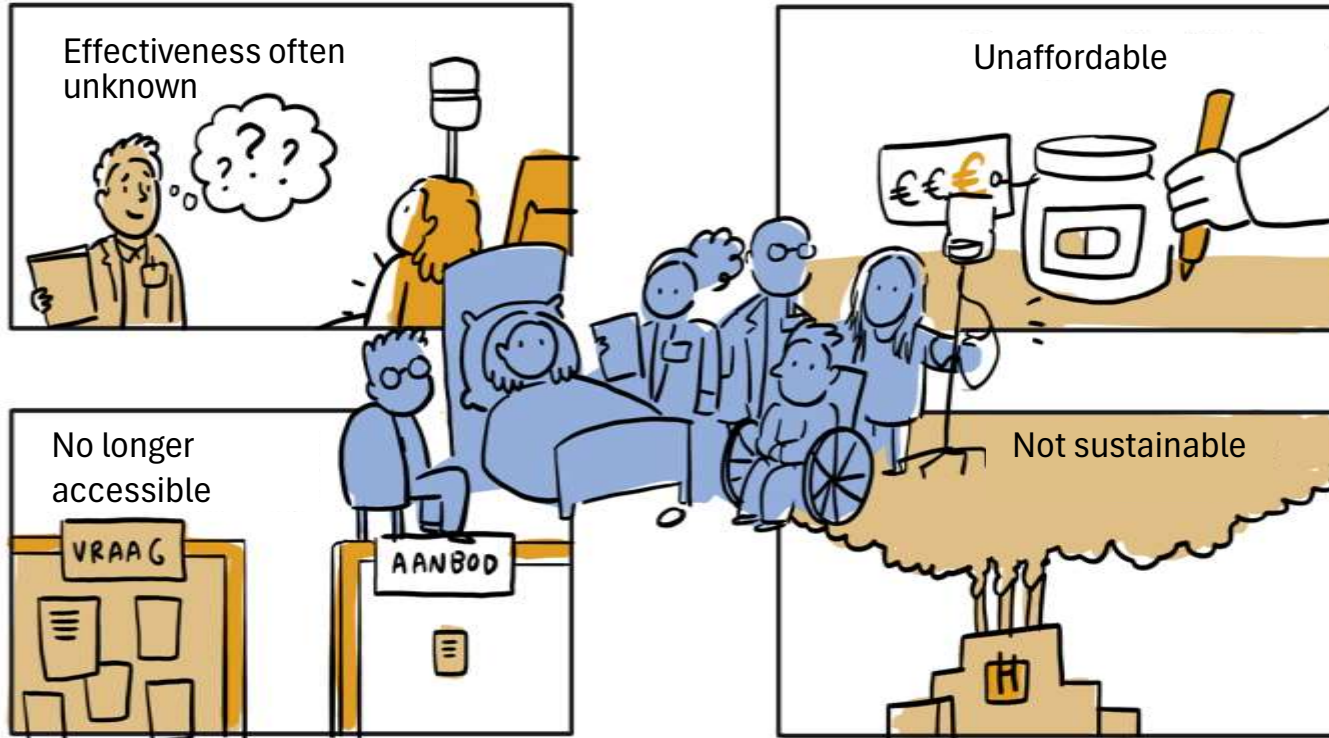
# Which care, for which patient and how provided?



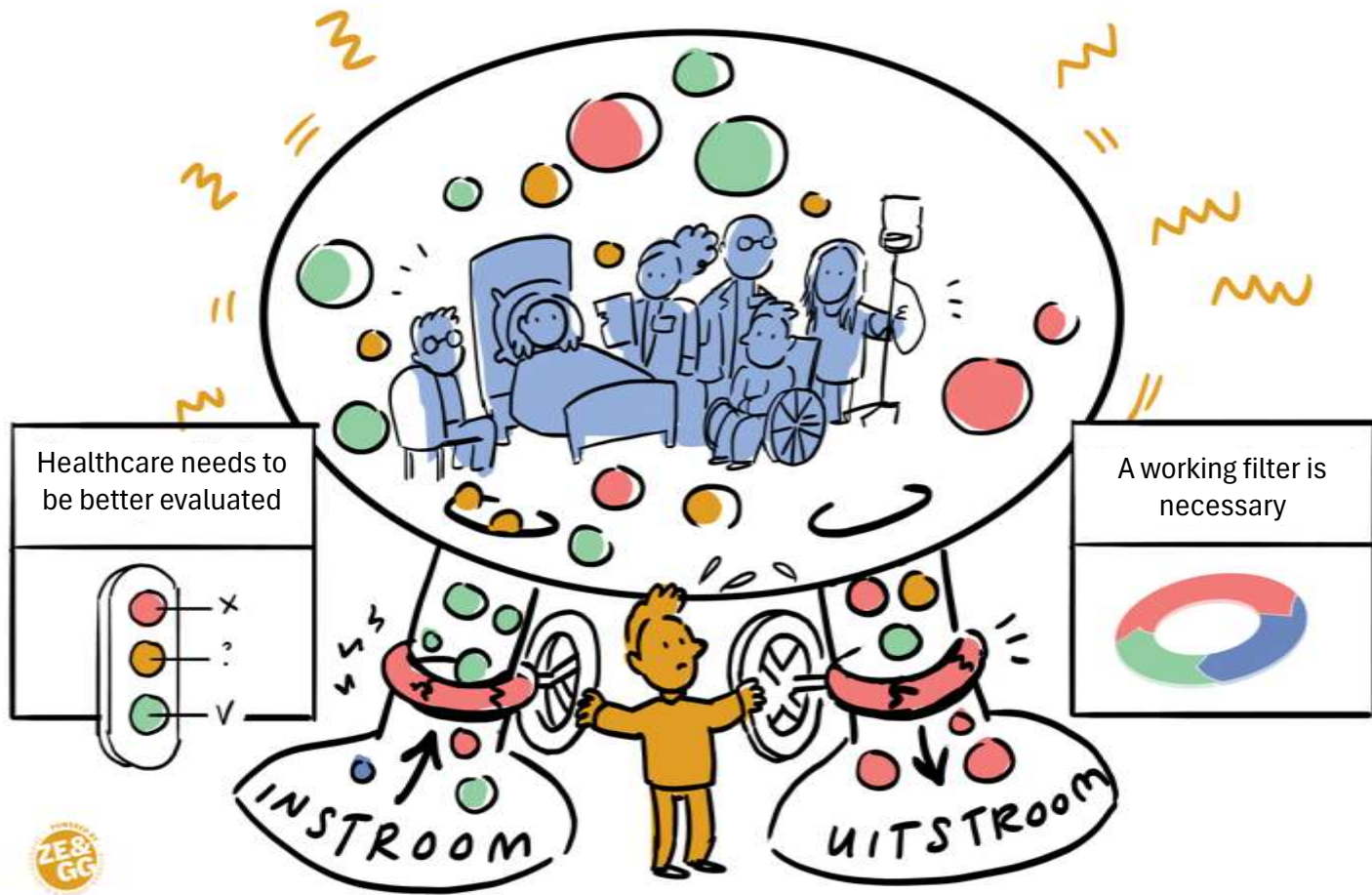
Patient  
characteristics?



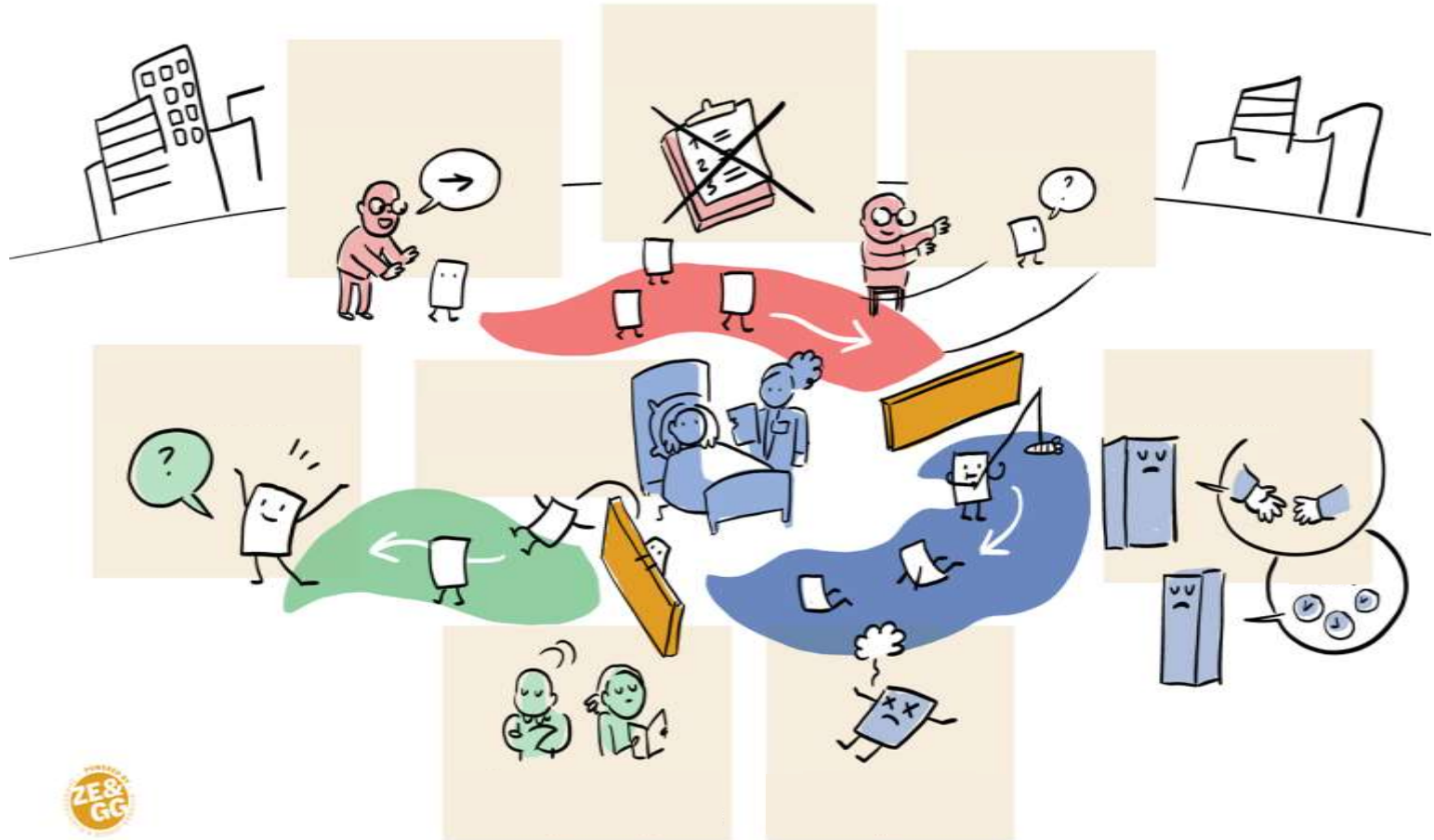
# Our healthcare system is under pressure



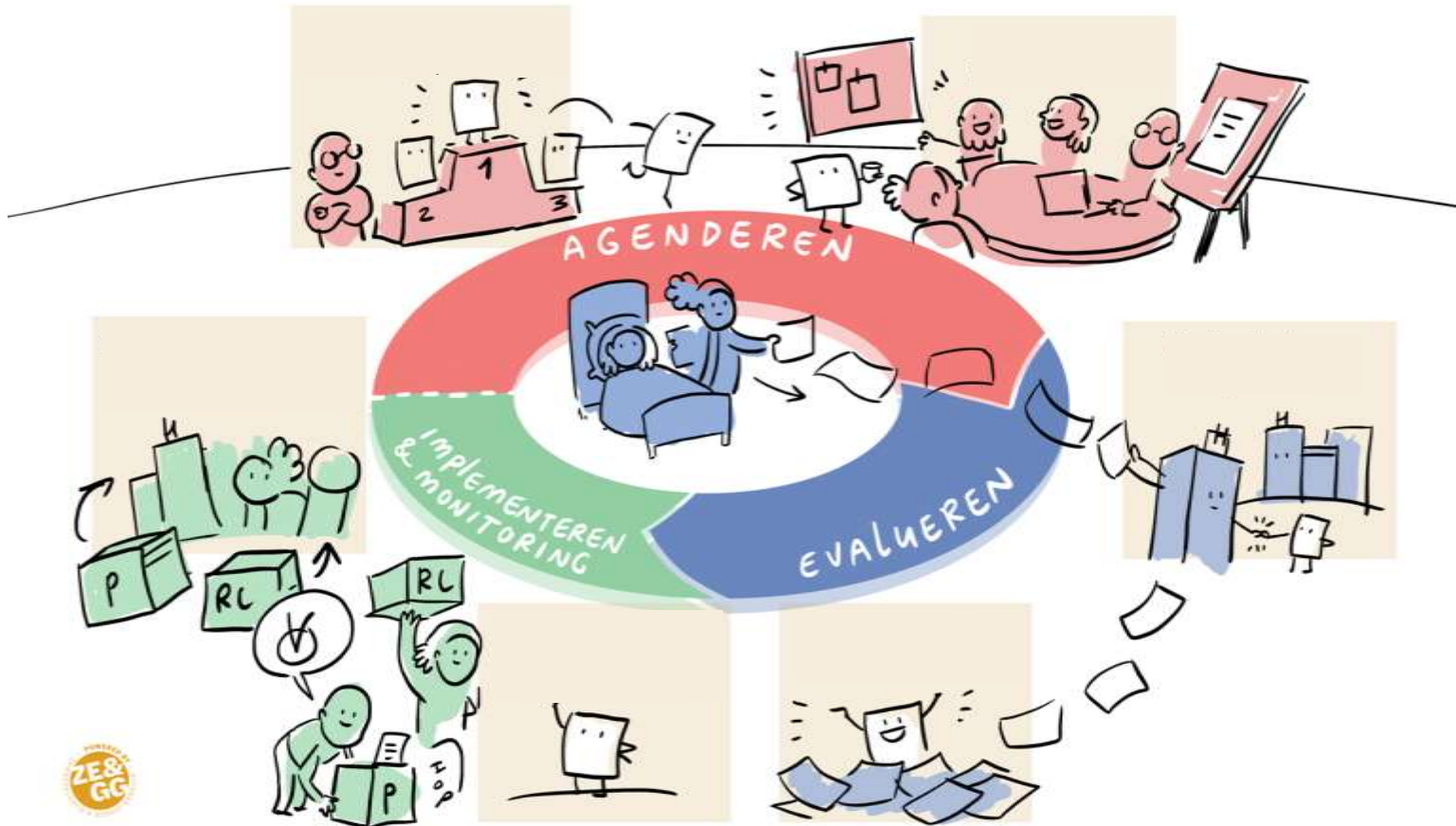
# Choices have to be made



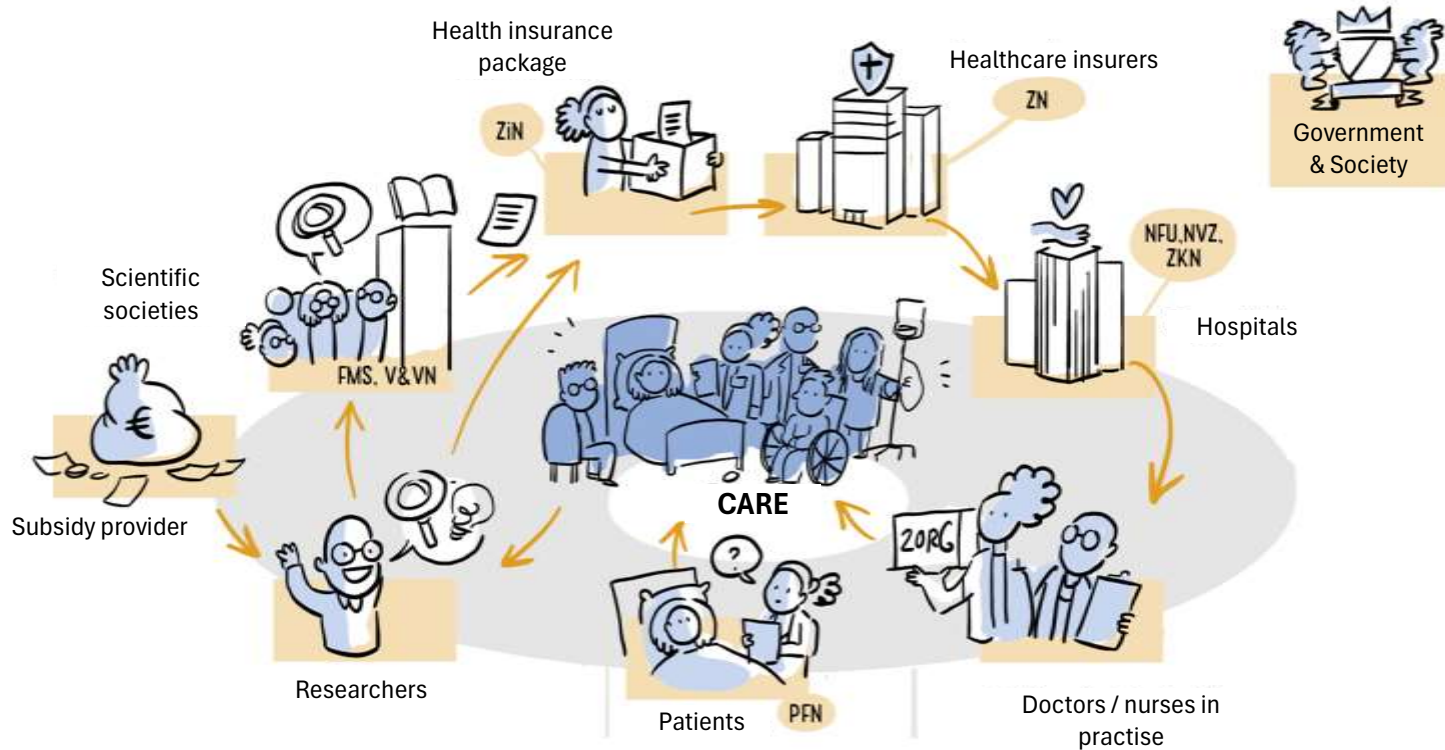
# The filters do not work properly



The ambition: proven best care with the Circle of Appropriate Care

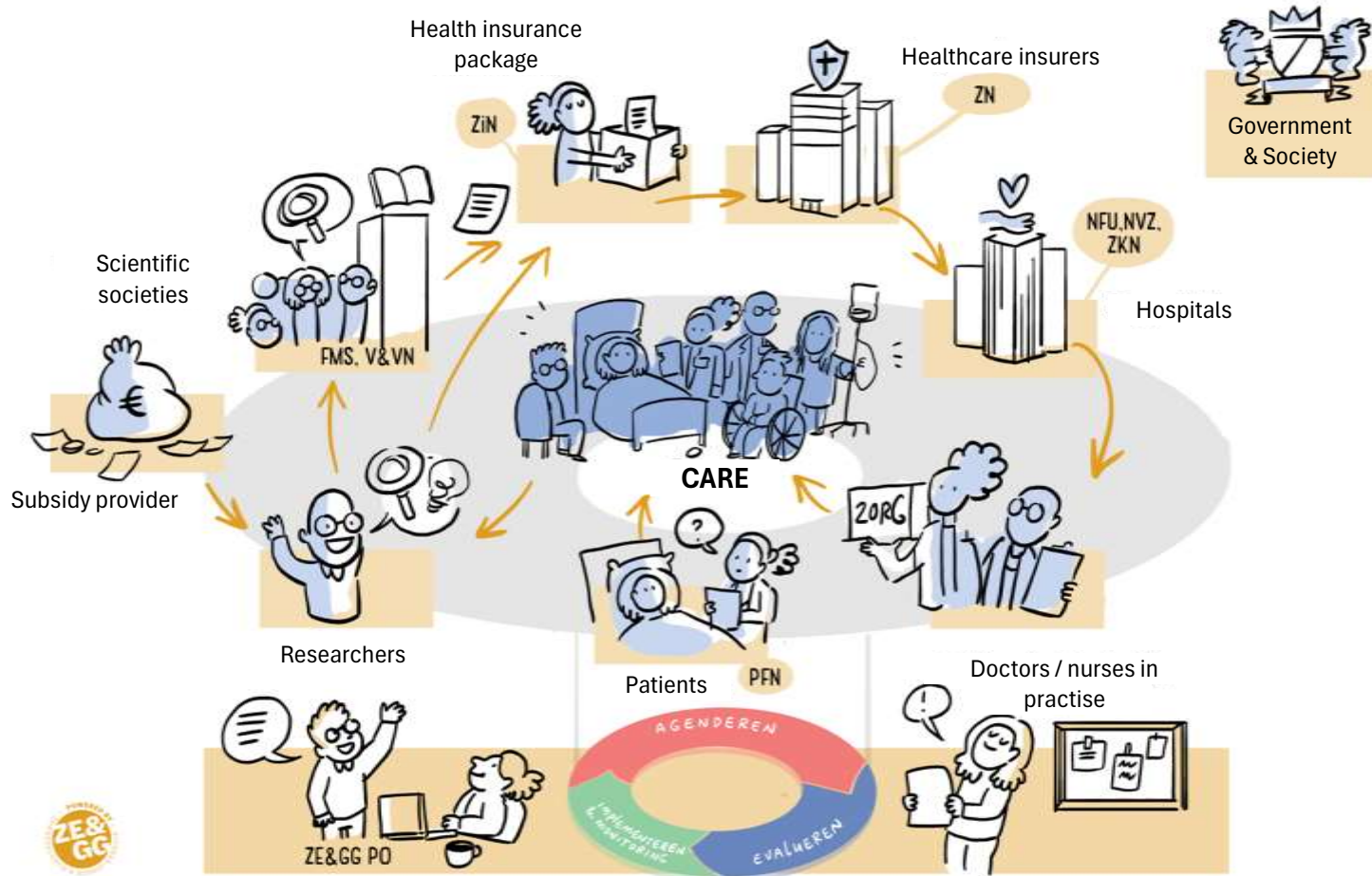


# Circle of Appropriate Care: who's in charge?

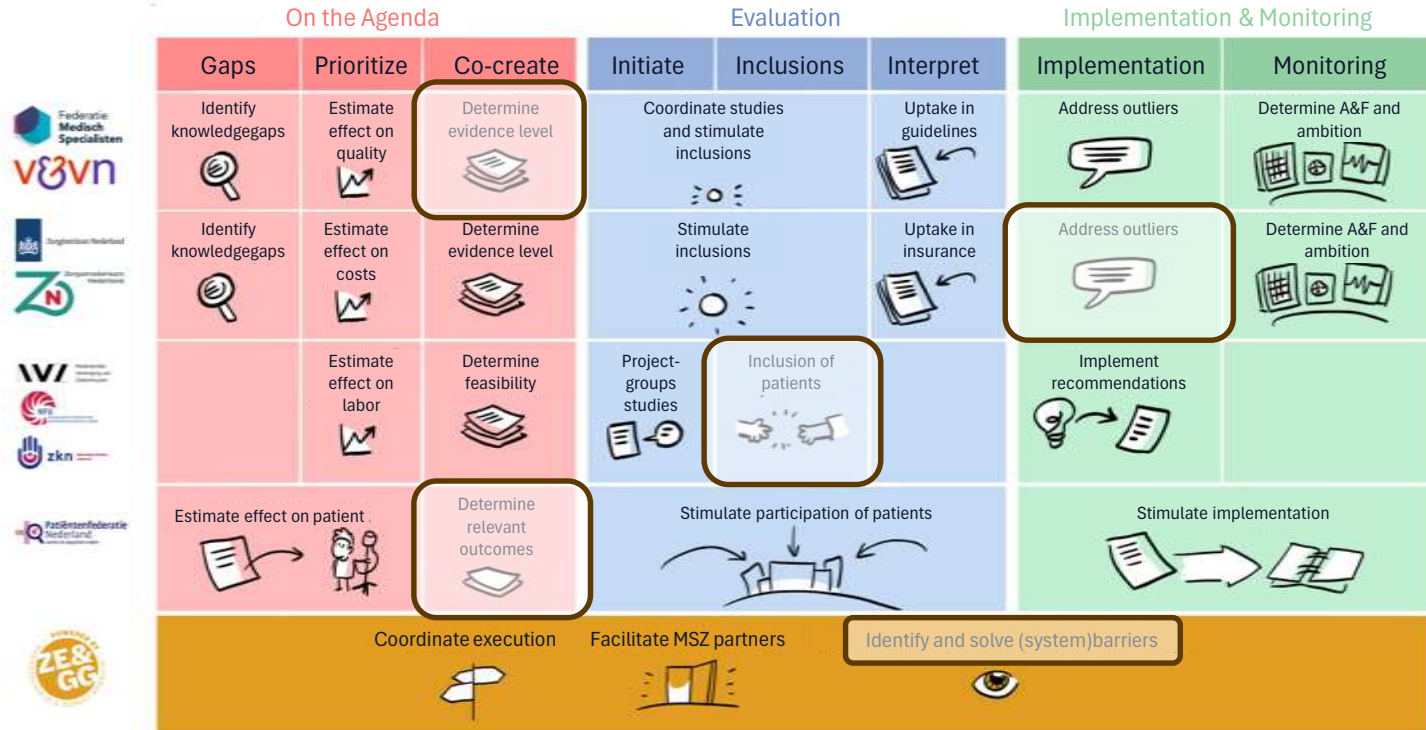




# Circle of Appropriate Care: who's in charge?



# Circle of Appropriate Care: roles of MSZ partners

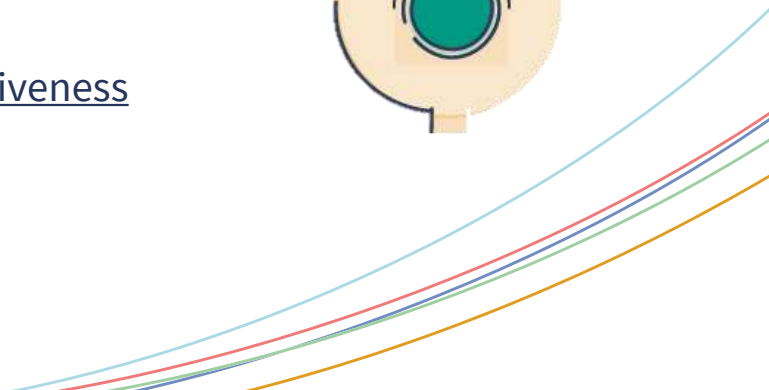
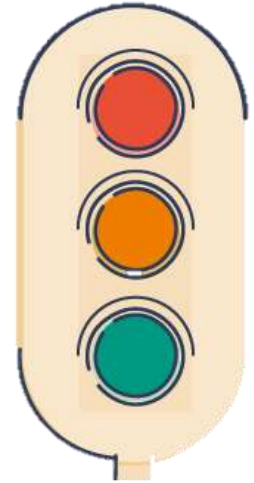


What's the result?

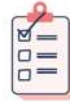
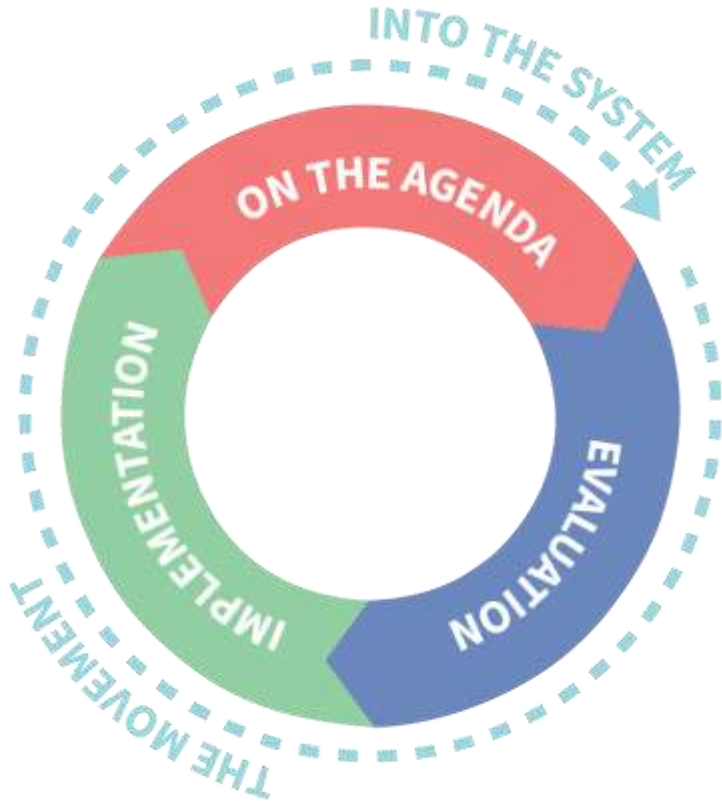


# Focus on proven effective care

1. In essence it is simple
  - a. Proven in- or less effective care should not be applied
  - b. Care of unknown effectiveness should be investigated
  - c. Proven (more) effective care should be applied
2. In practise room for nuances
  - a. Decisions can differ for different outcome measures
  - b. Decisions can differ between patients
  - c. Often deals with relative (cost- or labor)effectiveness
3. But always based on evidence



# ZE&GG: Circle of Appropriate Care



Determine which care should be evaluated

Knowledge agenda



Perform clinical trials

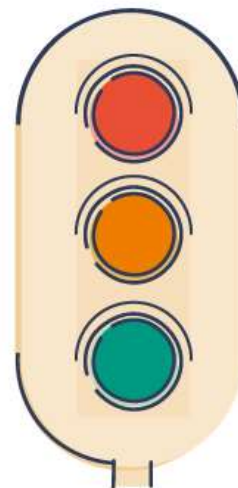
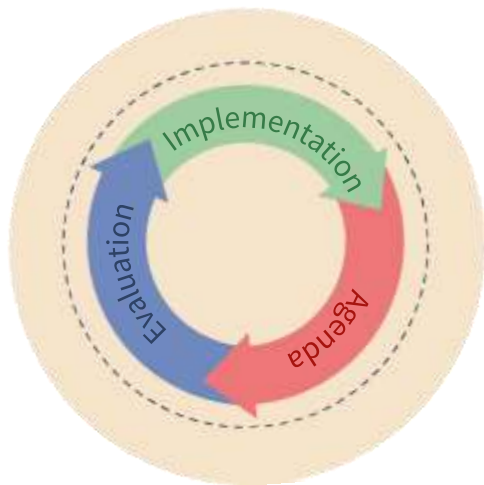
Evaluation agenda



Implement outcomes of trials

Implementation agenda

# Towards a learning healthcare system



**Do not do**

**Evaluate**

**Do**

*To make healthcare evaluation and appropriate care an integral part of the dutch healthcare system in 2028, through which the unknown is evaluated, proven effective care is implemented, low value care is stopped and patients receive the proven best care*

# How much is proven?

- Random sample van 1.567 reviews
- Harms measured in 577:

5.6% high quality evidence of benefit

8.1% evidence of harm

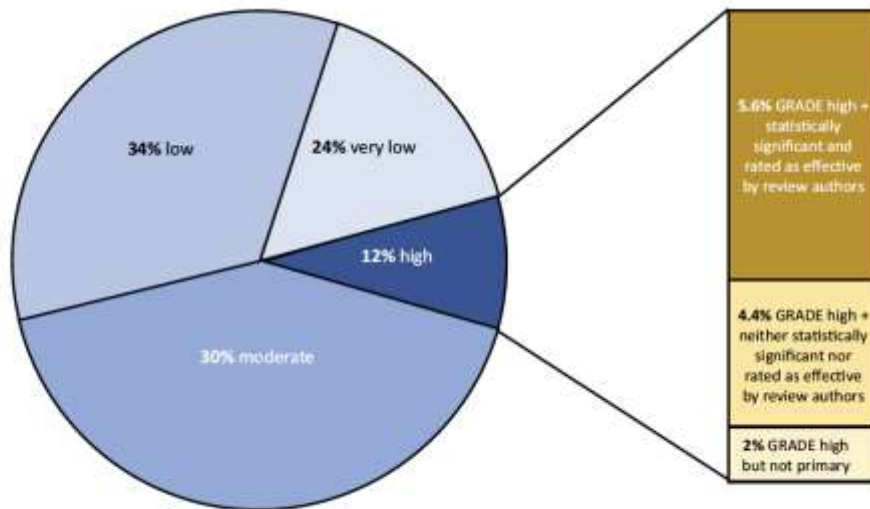


Fig. 1. Proportion of interventions according to their highest GRADE outcome (high, moderate, low, very low).

Guideline analysis 2020-2021  
 254/1911 (13%) recommendations  
 moderate/high level evidence  
 Update implementatieagenda ZE&GG, kennisinstituut FMS (2021)



# Stop pretending we know everything (better)

Recognizable challenges...?

When we have limited evidence, we pretend we know the answer

*“This is the way we always do it”*

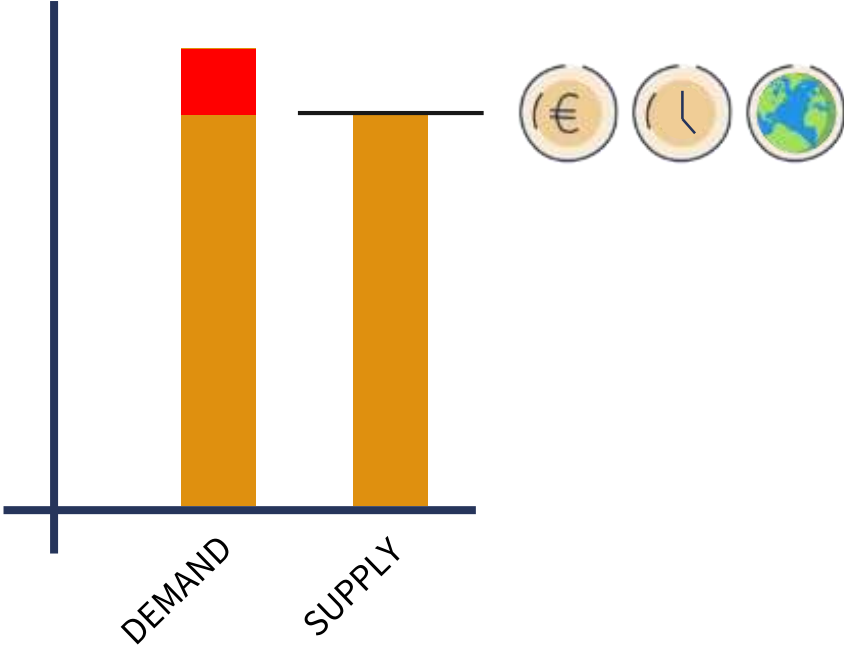
**We don't evaluate...**

When we have sufficient evidence, we pretend we know better

*“My experience is different”*

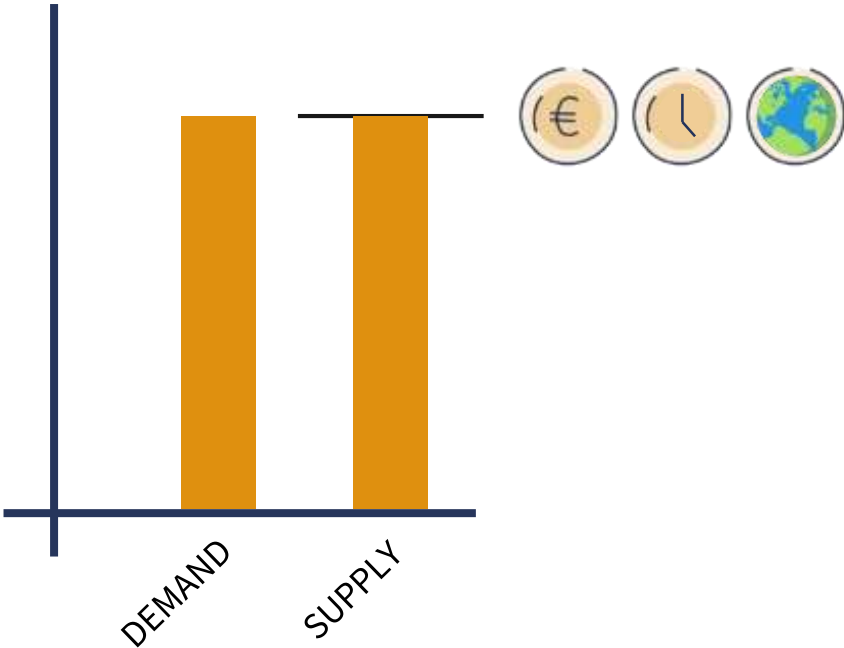
**We don't implement...**

# Different approach necessary

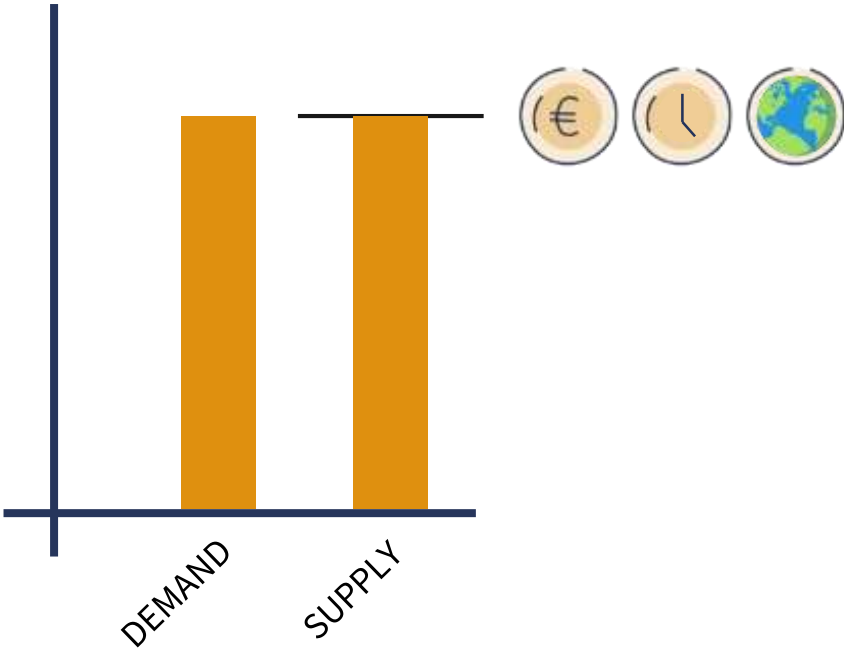




# Different approach necessary



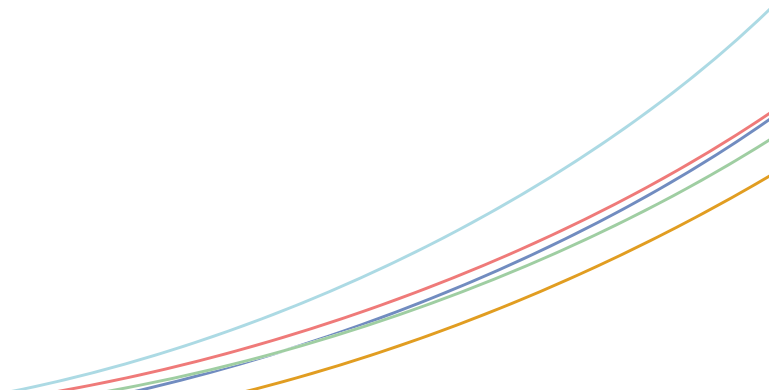
# Different approach necessary



# Choices....



Which care is really of benefit for our patients and which care is not?



# Choices.... | Option grids



	testoortdeel	n netwerk mobiel bellen	n mobiel bellen (%)	ontvangen en n SMS	n SMS'en (%)	n netwerk mobiel internet	n mobiel internet (%)	verleende service	prijs-kwaliteit	duidelijkheid tarieven/orden	tratieve problemen (%)
Intervention Diagnostic Test	Effectiveness	Costs	Personnel	Sustainability							
Nothing	?										
A	?										
B	?										
Hollandsnieuwe	6,9	7,4	6	7,8	3	7,0	12	7,0	7,7	7,6	4
Ben	6,8	7,3	7	7,6	3	7,3	6	6,5	7,3	7,1	10

# Less is more...?



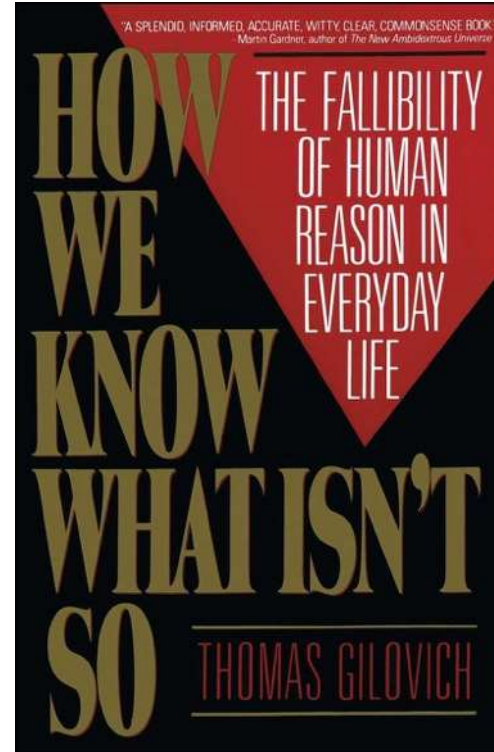
EMA Approvals 1995-2020: Of the acquired 458 added benefit ratings, 59 (13%) were classified as major benefit, 107 (23%) as substantial benefit, 103 (23%) as minor benefit, and 189 (**41%**) as **negative or non-quantifiable benefit**.

SMAs: 36% negative | CMAs 57% negative | AECs 47% negative

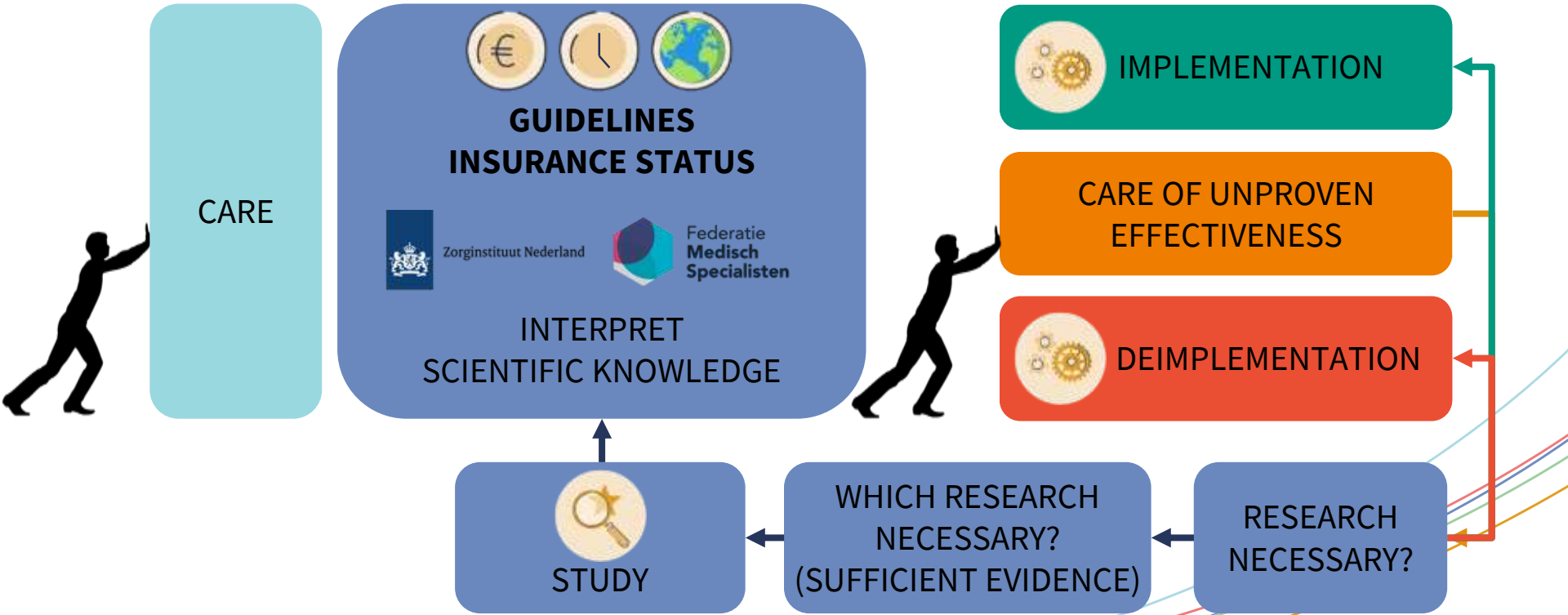
**Start** something new  
**Stop** something old

THE  
PARADIGM  
SHIFT

# Change is difficult...



# Structural process



# Which research is necessary?



1. Continuous discussion afterwards → Slow inclusion, limited adoption
2. Determine collectively beforehand which research is necessary
3. Which elements?
  - a. (primary) outcomes
  - b. Minimal clinically important difference
  - c. Design
  - d. Statistical power
4. Who determines?
  - a. Professional societies, insurers, patients, health care institute
  - b. All parties collectively
  - c. Signed agreements beforehand



**A study supported by all parties which is rapidly conducted and implemented**



# Collective machinery



## 1. Agenda

- a. Determine which questions to address
- b. Co-creation of study design (including decision on insurance status)



## 2. Evaluation

- a. Public insight into who participates and with how many inclusions
- b. Collective benchmark for inclusions



## 3. Implementation

- a. Collective 'implementation agenda'
- b. Integrated in all contracts between hospitals and insurers
- c. Audit and Feedback insights
- d. Learning platforms



## Example – implement | MRI knees –

Choosing wisely example from orthopedics (NOV): no MRI and no arthroscopy in patients >50 years without lock complaints (initial X-ray)

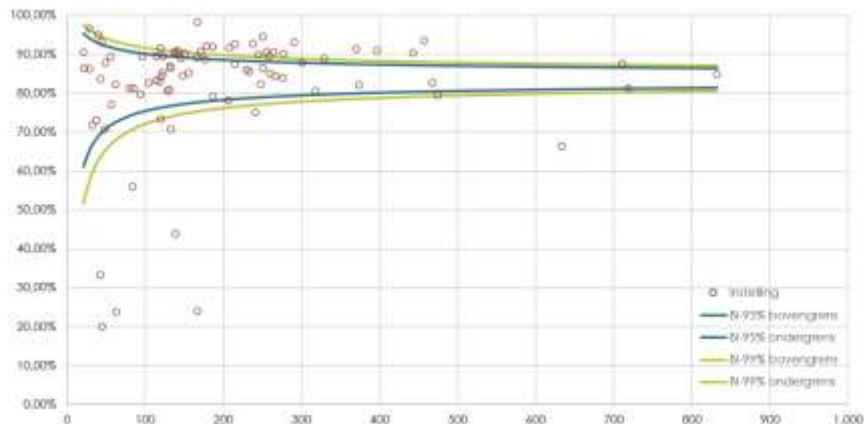
3

**Geen artroscopie en geen MRI bij degeneratieve knieën  
zonder slotklachten**

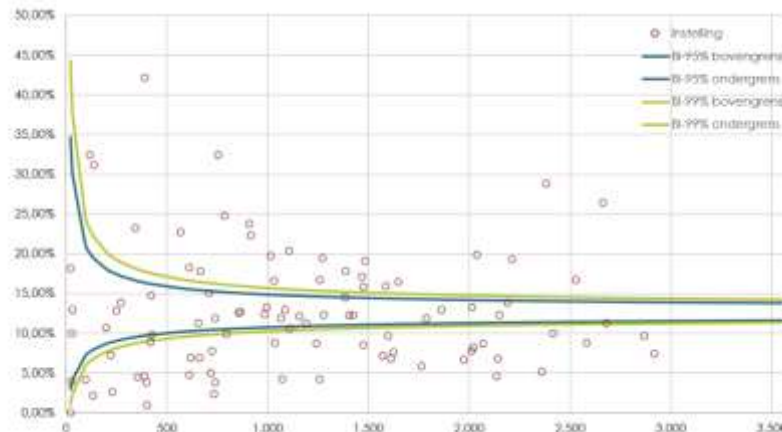


**Choosing  
Wisely<sup>®</sup>**

# Example – implement | MRI knees –



X-ray before MRI



MRI

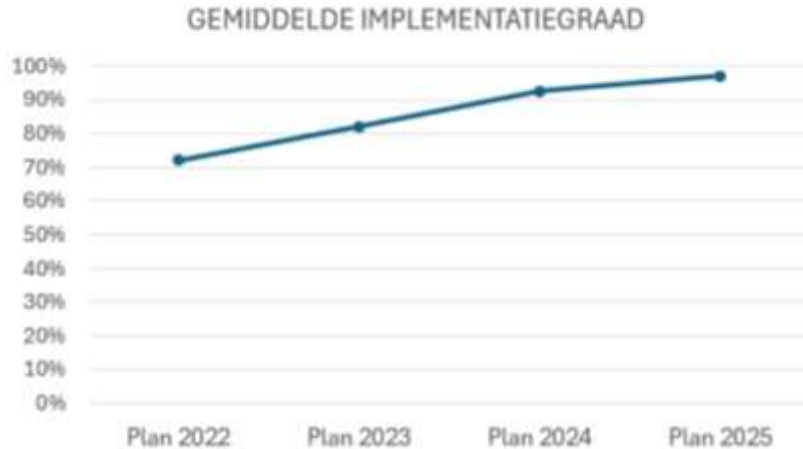
1. Funnel plots based on claims data
2. Available for all hospitals and insurers

# Implementation approach works!



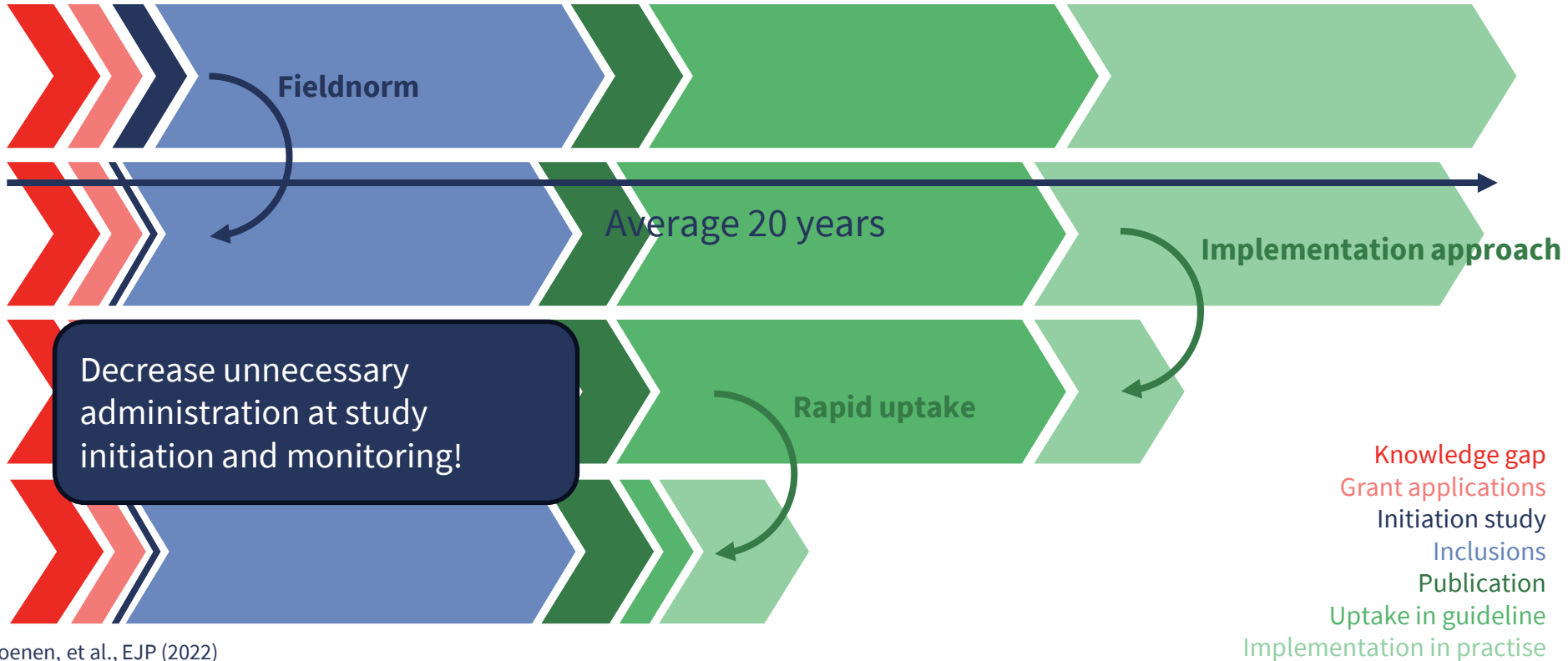
## Infrastructure for implementation

- Contact person in every hospital, internal PDCA cycli, part of contract agreement
- Audit & Feedback hospitals and insurers (DHD/Vektis), national monitoring

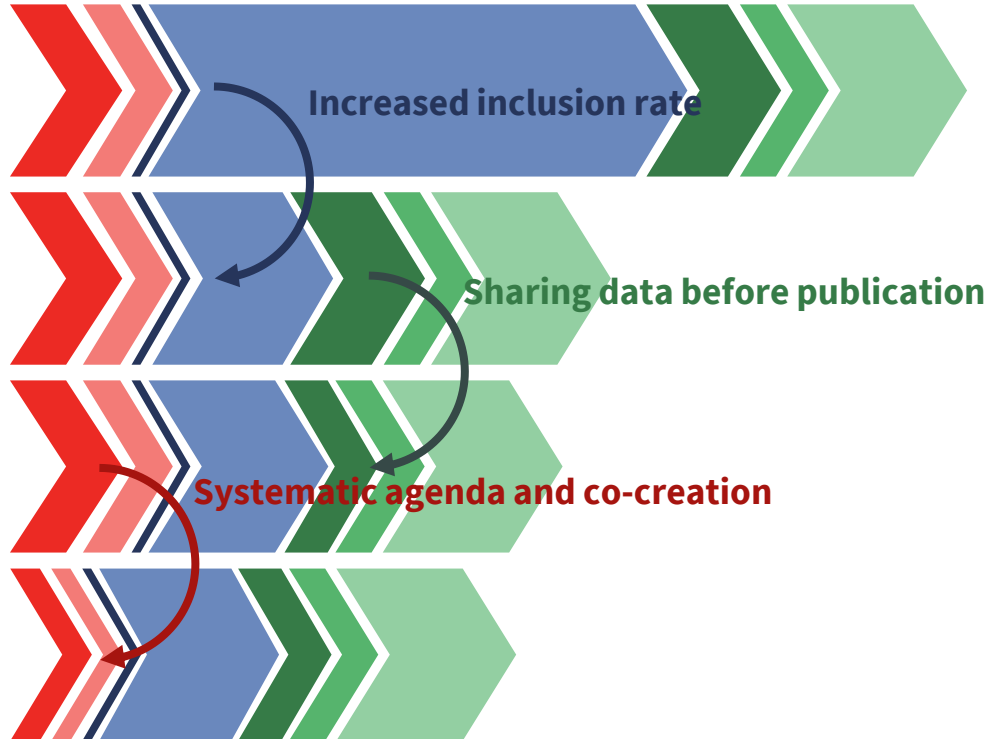


Figuur 1. Pambrolizumab: Aandeel verstrekkingen onder registratieplicht naar jaar (2020 t/m 2023)

# ZE&GG ambition: faster, better and more



# ZE&GG ambition: faster, better and more



Maximal effort on inclusion of patients



Knowledge gap  
Grant applications  
Initiation study  
Inclusions  
Publication  
Uptake in guideline  
Implementation in practise

# ZE&GG ambition: faster, better and more



Average 7 years

Average 20 years

- Knowledge gap
- Grant applications
- Initiation study
- Inclusions
- Publication
- Uptake in guideline
- Implementation in practise

# ZE&GG ambition: less is more



< 2 years

Average 20 years

- Knowledge gap
- Grant applications
- Initiation study
- Inclusions
- Publication
- Uptake in guideline
- Implementation in practise



Thoughts or interested?

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