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VALUE-BASED APPROACH TO ROAD MAP OF MODERNIZATION OF THE ONCOLOGICAL CARE

© *Yuliia A. Zuenkova*

Peoples Friendship University of Russia. Miklukho-Maklaya str., 6. Moscow, Russian Federation, 117198

Contact information: Yuliia A. Zuenkova — Doctor of Business Administration, Senior Lecturer of the Department of Public Health, Health and Hygiene. E-mail: zuenkova@bk.ru ORCID ID: 0000-0002-3660-0476

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ABSTRACT. The value-based concept in healthcare was introduced by M. Porter in 2004 as an approach for improving the quality of medical care. The existing practice of implementing this approach in Russia and abroad by the present time has been limited by single projects and tools, while comprehensive methodology adapted to Russian oncological care isn't created. The article presents a roadmap for implementation of value-based projects in oncology developed and based on the author's experience. The analysis of Russian and foreign literature, standards, methods on the research topic was carried out. Project management tools and road mapping techniques are used. Processes decomposition, scenario and intermediate results were determined to achieve the goal — a value-oriented oncological care. The roadmap includes seven consecutive steps — setting up the integrated practice units in the form of centers of excellence, the multidisciplinary teams education, mapping the patient's pathways, implementation into routine practice the patient-reported outcome measures (PROMs) and patient-relevant experience measures (PREMs), shared decision-making, and development of patient support programs. The necessary measures to support stakeholders for each stage of implementation are formulated. The present study is theoretical, representing the result of the analysis of the author's previous experience and the synthesis of existing approaches. Since the roadmap has a long life cycle, the content of the stages may change during operation. The implementation of the approach requires reforming the healthcare system with a change in financing methods, approaches to cancer care, and the creation of rational incentives for all stakeholders. For replication a benchmarking platform and a flexible digital infrastructure with the ability to monitor the costs and results of medical care at the individual patient's level must be formed.

KEY WORDS: value-based healthcare; patient-oriented approach; patient adherence; quality of life; shared decision making; patient pathway; oncology care.

ДОРОЖНАЯ КАРТА МОДЕРНИЗАЦИИ ОНКОЛОГИЧЕСКОЙ СЛУЖБЫ НА ОСНОВЕ ЦЕННОСТНО-ОРИЕНТИРОВАННОГО ПОДХОДА

© *Юлия Александровна Зуенкова*

Российский университет дружбы народов. 117198, Россия, Москва, ул. Миклухо-Маклая, 6

Контактная информация: Юлия Александровна Зуенкова — доктор делового администрирования, член КС НСБ РФ, старший преподаватель кафедры общественного здоровья, здравоохранения и гигиены.
E-mail: zuenkova@bk.ru ORCID ID: 0000-0002-3660-0476

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РЕЗЮМЕ. Идея ценностно-ориентированного подхода в здравоохранении была предложена M. Porter в 2004 г. в качестве средства повышения качества медицинской помощи. Существующая практика реализации подхода в России и за рубежом до настоящего времени ограничена внедрением лишь отдельных инструментов, тогда как всеобъемлющая методология, адаптированная к российской онкологической практике, отсутствует. В статье представлена разработанная на основании опыта автора дорожная карта реализации проектов ценностно-ориентированного подхода в онкологии. Был проведен анализ российской и зарубежной литературы, стандартов, методик по теме исследования. С помощью методов проектного менеджмента и дорожного картирования была произведена декомпозиция работ, определены промежуточные результаты, разработан сценарий достижения цели — ценностно-ориентированной онкологической службы. Дорожная карта включает семь последовательных этапов — создание центров компетенций интегрированного оказания медицинской помощи, формирование и обучение мультидисциплинарных команд, картирование пути пациента, внедрение оценок пациентских показателей исхода (PROMs) и опыта пациента (PREMs), совместное принятие решения о лечении, разработка программ поддержки пациентов. Сформулированы необходимые меры поддержки стейкхолдеров для каждого этапа внедрения. Настоящее исследование является теоретическим, представляя собой результат анализа предыдущего опыта автора и синтеза имеющихся подходов. Поскольку дорожная карта имеет длительный жизненный цикл, в процессе работы содержание этапов может меняться и корректироваться. Реализация подхода требует переформатирования системы здравоохранения со сменой методов финансирования, подходов к оказанию онкологической помощи, создания рациональных стимулов для ее участников. Для тиражирования необходимо наличие платформы для бенчмаркинга и гибкой цифровой инфраструктуры с возможностью мониторинга затрат и результатов оказания медицинской помощи на индивидуальном уровне.

КЛЮЧЕВЫЕ СЛОВА: ценностно-ориентированное здравоохранение; пациентоориентированность; приверженность пациента; качество жизни; совместное принятие решения о лечении; путь пациента; онкологическая служба.

A distinctive feature of modern healthcare is its high technology and innovation. However, with the advent of innovative, expensive technologies, healthcare costs are increasing. The aging population and the growing proportion of chronic diseases also lead to increased costs, which may hinder the achievement of target indicators. The issues of increasing the efficiency of the healthcare system are extremely acute throughout the world, and Russia is no exception [32].

Changes in methods of payment for medical services partially solve this problem. Thus, in recent years, the Russian Federation has undertaken considerable work to shift from the "payment per service" and "per capita financing" models to clinical and statistical groups (CRGs). It is obvious that payment should be linked not to the quantity, but to the quality of medical care — namelly to the value received as a result of treatment. At the same time, a patient himself should formulate the value of treatment since he is the object of therapeutic manipulations. These approaches are the basis of a relatively new concept for Russian medicine — value-based health care.

The basis of the value-based approach in healthcare (VBA) is the transformation of medical care "from measuring the volume and processes of medical care to controlling the final results that are important for patients" [26, 27]. The goal of a value-based approach is to maximize "value," defined as the ratio of outcomes "important to patients" to the cost of achieving them [3, 10].

Despite the fact that the idea of VBA was first mentioned by M. Porter in 2004 [26] after 10 years of research devoted to analyzing the health care industry from the perspective of competition, there is no algorithm for its practical implementation. The term "value" often refers to "humanistic principles" or to a concept for "cost reduction" [22].

Separate attempts to create a methodology for VBA were implemented within the framework of the EIT Health project [22]. In addition, a wide variety of organizations develop and apply standardized toolkits (sets, checklists) in order to accomplish individual VBA tools. One

such organization involved in standardizing Patient-reported outcome measures (PROMs) is the non-profit organization International Consortium of Health Outcomes (ICHOMB) [28]. Nevertheless, a comprehensive methodology for the implementation of PROMs, especially adapted to Russian oncologic practice, is currently lacking, which determines the importance of the present research [10].

In June 2022, the Agency for Strategic Initiatives (ASI) established the Coordination Council for the Development of the Healthcare System of the Russian Federation (CC NSSS (non-state security sphere) of the RF). The main focus of the CC NSSS RF is to search for opportunities to cooperate between civil society, non-profit organizations and entrepreneurs with legislative and executive authorities at different levels and in various formats. As part of the work of the CC NSSS RF, the project "Modernization of Oncology Service on the Principles of Value-Based Approach" was selected as a backbone project. It was recommended for further support by the authorities. To support the implementation of the Project, the website www.VBHC.ru is functioning.

AIM

To develop a roadmap for the implementation of value-based approach projects in oncology.

MATERIALS AND METHODS

Russian and foreign literature, standards, and methods of the value-based approach were analyzed. Based on the synthesis of information, foreign practices of the value-oriented approach, and the author's previous experience of implementation, the main parameters and provisions were formulated [2–8]. The structure of the roadmap is based on the methodologies of project management and road mapping. The work was decomposed, intermediate results were defined, and a scenario was developed to achieve the goal of implementing the full cycle of value-based approach projects.

RESULTS

Based on the results of the pilot projects of the value-based approach, a roadmap with seven consecutive stages of implementation was drawn up.

1. Implementation of an integrated system of specialized oncological care through the designation of centers of competence

At the first stage, it is necessary to reform the existing approach to the provision of medical care by creating centers of competence (CCs) (Integrated practice units (IPUs) for the most common or socially important nosologies. Separation of CCs into divided structural units allows not only to focus efforts on achieving target indicators, but also to visualize processes and facilitate comparison between different organizations and regions [22].

According to the data of the P.A. Herzen Moscow Research Institute of Oncology, in 2020 there were following leading localizations in the overall (both sexes) structure of cancer morbidity in the Russian Federation: Breast (11.8%), skin (except melanoma) (10.9%), trachea, bronchus, lung (9.8%), colon (7.2%), prostate (6.9%), stomach (5.8%), rectum, rectosigmoid junction, anus (5.1%), lymphatic and hematopoietic tissue (5.0%), uterine body (4.3%), kidney (3.8%), pancreas (3.4%), cervix (2.8%), bladder (2.8%), and ovary (2.4%) [9]. Priority nosologies were identified to form eight CCs with subsequent replication to other nosologies, in accordance with the frequency of oncologic morbidity, as well as with expert assessments. Such CCs are multidisciplinary teams, which are ideally physically located in one medical organization. The main task of multidisciplinary teams is to "fully and comprehensively meet the needs of well-defined groups of patients throughout the entire cycle of medical care" [22]. The creation of CCs implies profound organizational changes in order to provide better, patient-centered and efficient medical care with a shorter cycle.

An integrated approach to patient care also implies the use of multimodal methods of diagnosis and treatment. Multidisciplinarity is "an opportunity to improve the quality of medical care for patients on the basis of multilevel and integrated use of the potential of doctors of different profiles and specialists, whose successful cooperation leads to the introduction of organizational, informational, therapeutic innovations" [20].

Previous results of the implementation of multidisciplinary approach in oncodermatologic practice indicate an increase in the detection of skin cancer, increased patient adherence to treatment and dispensary follow-up, and increased patient satisfaction with the quality of services [4].

Implementation of this stage is difficult since the structure of such multidisciplinary teams disrupts the traditional practice of clinical work at the specialty level: it changes approaches to the distribution of authority and cash flow, requires serious changes in staffing and remuneration system [10].

2. Formation of multidisciplinary teams on the basis of centers of competence

In Russia, the multidisciplinary approach to treatment is enshrined in the procedures for the provision of medical care in the relevant profile. Thus, the multidisciplinary approach to the treatment of oncological diseases is defined by the Order of the Ministry of Health of the Russian Federation No. 116n dated February 19, 2021 "On Approval of the Procedure for the Provision of Medical Care to Adults with Oncological Diseases" [11]. Nevertheless, the creation of multidisciplinary teams (MDTs) as a separate organizational structure differs from the multidisciplinary approach since it eliminates formalism, and also provides an opportunity to monitor their effectiveness and motivation by including indicators (key performance indicators, KPI) in the effective contract [12].

In 2009, The National Cancer Action Team (NCAT) studied and standardized the rules of functioning of multidisciplinary teams [24]. To date, these standards are the most widely recognized and accessible guidelines for multidisciplinary practice. Later on, these standards were supplemented and adapted, and special checklists were created. Most of the listed tools include assessment of such basic characteristics as team requirements, infrastructure, organization of the discussion process, patient-centeredness of the clinical decision and team management.

The implementation of an integrated system of specialized cancer care is becoming more common as it is a logical consequence of advances in medicine. The implementation of an integrated approach to the provision of medical care can prevent duplication of medical functions and increase the efficiency of health care resources [15, 20, 25]. Thus, the previously implemented project on the organization of a multidisciplinary team confirmed its effectiveness: doctors began to base their clinical decisions more often on evidence, to comply with clinical recommendations, to focus in their practice not only on clinical results, but also on the psycho-emotional and social needs of the patient [5].

3. Mapping the "patient pathway" on the basis of simulation modeling

The transformation of modern healthcare towards patients' values dictates new requirements to the quality and availability of medical care. Mapping of the "cancer patient's path" based on patients' values allows to identify "bottlenecks" of routing and to predict possible risks of low patient adherence to treatment related to the availability of medical care. For instance, the external and internal routing of skin cancer patients was restructured as a result of patient pathway mapping, which allowed to reduce the time from the beginning of the first treatment to discharge by 9 days in the case of surgical treatment and by 6 days in the case of radiotherapy treatment [3, 4].

The problem of treatment adherence is one of the most significant for modern medicine and society [31]. The research of the types of patients' behavior during the process of choosing a medical institution, attending physician, and treatment method has been called "patient pathway research" [16]. The "patient pathway" map allows describing and predicting the possible risks of "losing" patients at each stage of seeking medical help. Transparency of the patient's journey at all stages of the treatment and diagnostic process, as well as understanding the reasons for his/her refusal of treatment at any stages allows health care authorities to improve the process of providing medical services. The world's leading agencies are developing methodologies for analyzing the "patient pathway" to better understand the relationship between seeking medical care and the availability of medical services [22, 31]. Cancer patient monitoring systems designed for comprehensive informatization of oncological service are already successfully functioning in a number of Russian

regions [1]. They allow comprehensive monitoring of the oncologic situation in the region, manage patient flows by creating an operational digital picture of the oncologic situation.

Patient routing is a key organizational technology in ensuring the quality and availability of medical care. The use of simulation modeling methods allows describing and predicting the possible risks of routing [3].

New models of medical care organization should be built on the basis of a prototype [31]. Simulation modeling is an innovative paradigm. It has become a widespread tool in logistics, management and strategic planning, allowing to solve multicriteria optimization problems of large dimensionality.

4. Evaluation of patient-reported outcomes (PROMs)

A key aspect of value-based approach is the identification of patient-relevant outcomes. Data received from patients refer to patient-reported outcome measures (PROMs). The most commonly used PROM questionnaires assess:

- symptoms (impairment) and other aspects of well-being;
- functioning (disability);
- health status and the patient's perception of health;
- quality of life (QoL);
- health-related quality of life (HRQoL).

Health-related quality of life assessment tools are typically multidimensional questionnaires that assess a combination of impairment and/or disability dimensions and reflect a patient's health status. In contrast, QoL questionnaires go beyond impairments and disabilities, exploring the patient's ability to meet their needs as well as the patient's emotional response to their limitations. Questionnaires can be universal for all diseases (e.g., EQ-5D, SF-36, HUI) or specific, i.e., designed to assess treatment for specific cancers [10, 22].

Evaluation of patient-reported outcome measures, as experience has shown [4, 7], allows a physician to identify the patient's individual values and needs in relation to the conducted therapy and to take them into account when a physician makes corresponding treatment decisions. This approach ultimately improves patient satisfaction with the quality of medical care in general and with the chosen method of treatment in particular. Thus, considering patient-associated factors improved individual patient experience (50–100 Rush scores) [4].

Digitized questionnaires — ePROMs — are becoming increasingly common [22]. As part of the strategy of implementing a single digital circuit in healthcare, ePROMs can be implemented in the form of an additional SEMD (structured electronic medical document) containing specific ePROMs for selected oncologic nosologies. The questionnaires are filled out by medical staff using the patient's words, and the data are entered into the MIS (medical information system) with subsequent uploading to the regional VIMIS (vertically integrated medical information system) and the possibility of integration with federal VIMIS services for data verification and interregional sub-sectoral benchmarking. The use of questionnaires and their validated translations, strictly validated for a specific nosology became an important element of data unification for further comparison.

5. Shared treatment decision making

Patient-reported outcome data (PROMs) should be used as a guide to make joint treatment choices with a patient [4]. The formalization of shared treatment decision making as an approach occurred in the late 1990s as a result of the work of family medicine theorists Alvin and Edwards [17–19, 23]. They developed and proposed criteria that were subsequently included in the UK in a mandatory list of indicators of a treatment quality.

Currently, there are different models of communication with the patient — the OPTION model [17], the ecological model [30], the Treetalk Model [18], IP-SDM [22], VALS and laddering techniques are also used [7].

Several researchers in this field have developed scales to measure the extent to which the patient is involved in the decision-making process. The purpose of these scales is to examine what happens in shared decision making and to what extent a physician can encourage a patient to become an active participant in the choice of treatment. Based on these scales, tools are being developed to help physicians better understand patient needs. SURE rapid questionnaire is one of such validated tools [21].

An earlier research [4] showed the applicability of this concept in Russian industry prac-

tice. Thus, the research showed that younger age (r=–=0.398, p=0.009) and female gender (r=–0.475, p=0.001) are factors associated with higher emotional distress about appearance, which needs to be taken into account when choosing therapy [4]. Older patients were less involved in treatment choice (r=–0.633, p=0.001) [4]. The use of a patient-centered communication algorithm achieves satisfactory engagement (≥3 points out of 4) in 67% of patients [4].

6. Measuring patient experience

Patient-relevant experience measures (PREMs) also include data on patient perceptions of the treatment process. Unlike PROMs, PREMs are of non-medical nature, they aim to assess the quality of service delivery. Patient-relevant experience measures do not require strict validation of questionnaires and can be adapted to the aim of the research. According to the Federal Law No. 256-FZ of July 21, 2014 "On Amendments to Certain Legislative Acts of the Russian Federation on the Issues of Independent Assessment of the Quality of Service Delivery by Organizations in the Sphere of Culture, Social Services, Health Care and Education", all medical institutions "participating in the implementation of the program of state guarantees of free medical care for citizens are obliged to conduct an independent assessment of the quality of service delivery" [14]. In accordance with the Order of the Ministry of Health of the Russian Federation of July 13, 2018, No. 442 "On the organization of work to provide a technical possibility for patients to express their opinions about the quality of conditions of service provision by medical organizations on the official website of the Ministry of Health of the Russian Federation in the Internet», such an assessment is possible in the electronic form as well [13]. The main criteria for such an assessment include "openness and accessibility of information about the medical organization, comfort of service conditions and their availability, waiting time, friendliness, politeness, and competence of employees". There are also various numerical options for evaluating patient experience [2].

7. Development of patient support programs

The final stage of a value-based approach is development of patient support programs (PSP) to increase patient adherence to treatment and follow-up. PSP is a system of patient support throughout the patient's path from diagnosis and prescription of therapy to its completion or certain outcome in order to improve and preserve the patient's quality of life [29, 31].

The main goals of PSP implementation include: increasing patients' awareness of the disease; increasing adherence to treatment; and building disease management skills. The results of researches demonstrate the positive impact of PSP on the adherence of patients with chronic diseases, clinical outcome indicators in such patients, as well as their psychological state [29]. The aggregated Russian experience of program implementation has shown its direct impact on reducing healthcare costs, improving the quality of medical care, and patient adherence [8]. Patient support programs, implemented with the support of commercial stakeholders (pharmaceutical companies), take over a part of the functions of the health care institution such as drug supply, diagnostics, training medical personnel and patients, as well as infrastructural support [8].

IMPLEMENTATION OF ENCHMARKING SYSTEM AT THE NATIONAL LEVEL

Benchmarking is a systematic research, comparison and analysis of key indicators, processes, functional features and trends of the company with similar indicators among both competitors, and leaders from other areas. It helps to identify gaps in the company functioning and ways to eliminate them by introducing the best practices. Benchmarking provides a systematic approach to the issue of identifying reference points for development and efficiency improvement. In public health care, benchmarking is used for the rating system of medical organizations [10]. Benchmarking is an obligatory tool for the implementation of value-based healthcare projects, since it makes it possible to compare the work of both medical organizations and private services and medical specialists [10, 22, 26]. Owing to dynamic comparison, the principle of competition and improvement of the quality of medical care can be implemented [10, 22, 26].

Benchmarking provides a sufficiently high degree of reliability of the results in case the methodology of benchmarking research is followed. Using the tool is complicated as it requires a good knowledge of benchmarking methodology, experience in conducting such studies, time and in some cases resources to obtain data. The introduction of benchmarking (rating system) is possible if the approaches to assessing the results of medical care are standardized. Various foreign organizations develop and implement standardized sets (checklists) of outcomes assessment [28]. Thus, according to ICHOM methodology, data on the results of medical care can be divided into three categories: "Achieved health status", "Recovery process", "Sustainable result" [28].

DISCUSSION

Implementation of value-based approach programs in oncology requires active participation and coordination of support measures with all stakeholders: adaptation of the staff schedule and effective contract provisions, organization of team training, implementation of developed SOPs (standard operating procedures), adaptation of routing, exchange of cancer patient monitoring data, integration with federal and regional services.

Limitations of the research. Despite the fact that individual tools of the value-based approach were previously successfully implemented in Russian oncological service, these projects have not been implemented as a comprehensive program, which may require clarification in the future.

CONCLUSION

The implementation of value-based principles requires reformatting of the entire healthcare system with a change in financing methods, approaches to oncological care, revision of key performance indicators for medical personnel, and creation of rational stimulation for participants. Taking into account the complexity in implementing such projects, it is recommended to start with individual elements — oncologic nosologies that contribute most to morbidity and mortality.

The expected results of the implementation of value-based healthcare projects according to the stated roadmap include:

1) increased efficiency of oncology services at the scale of individual regions and the whole country through operational efficiency and concentration of resources which are important for patients;
2) increasing patient adherence to treatment through patient-centered external (at the regional level) and internal (within the medical organization and structural subdivisions) routing;
3) increasing patient satisfaction through the introduction of patient-centered principles of work, taking into account the patient's opinions and his individual psycho-emotional and social needs when choosing a method of treatment;
4) improvement of interdisciplinary interaction, compliance with clinical recommendations, which ultimately improves the quality of medical care.

To replicate centers of competence and create a platform for benchmarking, it is necessary to have a flexible digital infrastructure with the ability to monitor costs and results of medical care at the individual level (at the level of a particular patient). The software should enable transparent and objective monitoring of both clinical and patient data. When co-creating software, it is necessary to take into account the existing digital infrastructure of the region and the medical organization.

ADDITIONAL INFORMATION

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REFERENCES

1. Efremov S.A., Gruzdeva E.A., Petkau V.V. Informatizacija onkologicheskoj sluzhby v regione: sistema podderzhki raboty onkologicheskoj sluzhb [Informatization of oncology care in the region: a system to support the

work of oncological services]. Zhurnal telemediciny i jelektronnogo zdravoohranenija. 2020; 6(3): 31–5. (in Russian).
2. Zuenkova Ju.A. Vozmozhnosti i perspektivy tehnologii raspredelennogo reestra v upravlenii «opytom pacienta [Distributed ledger technology in patient experience management]. Menedzher zdravoohranenija. 2020; 9: 47–54. DOI: 10.37690/1811-0185-2020-9-47-54. EDN XABBRP. (in Russian).
3. Zuenkova Ju. A. Opyt realizacii cennostno-orientirovannogo podhoda v luchevoj terapii v ramkah metodiki EIT health [Experience of implementing a value-based approach in radiation therapy: EIT health methodology]. Zdravoohranenie Rossijskoj Federacii. 2022; 66(3): 201–7. DOI: 10.47470/0044-197X-2022-66-3-201-207. EDN NROUSY. (in Russian).
4. Zuenkova Yu.A. Opyt realizacii cennostno-orientirovannogo podhoda v onkodermatologicheskoj praktike [Experience of implementing a value-based approach in oncodermatology]. Farmakoekonomika. Sovremennaya farmakoekonomika i farmakoepidemiologiya. 2022; 15(2): 250–8. DOI 10.17749/2070-4909/farmakoekonomika.2022.125. EDN YNYDYA. (in Russian).
5. Zuenkova Yu.A. Organizacionnye aspekty formirovaniya mul'tidisciplinarnyh komand: standarty kachestva, effektivnost' i vnedrenie v praktiku [Organizational aspects of multidisciplinary teams: quality standards, efficiency and implementation in practice]. Medicinskoe obrazovanie i professional'noe razvitie. 2022; 3(47): 32–42. DOI 10.33029/2220-8453-2022-13-3-32-41. EDN YQFRBQ. (in Russian).
6. Zuenkova Ju.A., Kicha D.I., Abramov A.Ju. et al. Pacientorientirovannyj algoritm raboty rentgenoterapevticheskogo kabineta onkologicheskogo dispansera [Patientoriented algorithm for the X-ray therapy cabinet of oncology dispensary]. Medicinskaja radiologija i radiacionnaja bezopasnost. 2021; 66(5): 45–9. DOI: 10.12737/1024-6177-2021-66-5-45-49. (in Russian).
7. Zuenkova Ju.A. Primenenie metodiki VALS i tehniki ledderinga pri sovmestnom prinjatii reshenija o lechenii [Application of the VALS and the laddering techniques at shared decision-making]. Menedzher zdravoohranenija. 2022; 5: 13–9. DOI: 10.37690/1811-0185-2022-5-13-19. EDN TSNFAH. (in Russian).
8. Zuenkova Yu.A. Rol' programm podderzhki pacientov v realizacii cennostno-orientirovannogo zdravoohraneniya [Patient support program as a part of value-based healthcare implementation]. Menedzher zdravoohranenija. 2022; 4: 4–9. DOI 10.21045/1811-0185-2022-4-4-9. EDN LNFMUN. (in Russian).
9. Kaprin A.D., Starinskij V.V., Shahzadova A.O., red. Zlokachestvennye novoobrazovanija v Rossii v 2020 godu (zabolevaemost' i smertnost') [Malignant neoplasms in Russia in 2020 (morbidity and mortality)]. Moskva: MNIOI im. P.A. Gercena — filial FGBU "NMIC radiologii" Minzdrava Rossii; 2021. (in Russian).
10. Omel'janovskij V.V., Musina N.Z., Gostishhev R.V. i dr. Koncepcija cennostno-orientirovannogo zdravoohranenija [Concept of value-based healthcare]. FARMAKOJEKONOMIKA. Sovremennaja Farmakojekonomika i Farmakojepidemiologija. 2020; 13(4): 438–51. Available at: https://doi.org/10.17749/2070-4909/farmakoekonomika.2020.042._(accessed: 07.11.2022). (in Russian).
11. Prikaz Ministerstva zdravoohranenija RF ot 19.02.2021 g. № 116n "Ob utverzhdenii Porjadka okazanija medicinskoj pomoshhi vzroslomu naseleniju pri onkologicheskih zabolevanijah" [On approval of the Procedure for providing medical care to adults with oncological diseases]. Available at: https://base.garant.ru/400533605/?ysclid=lage68g5gl915468794. (accessed: 07.11.2022). (in Russian).
12. Prikaz Ministerstva zdravoohranenija RF ot 28.07.2013 g. № 421 "Ob utverzhdenii Metodicheskih rekomendacij po razrabotke organami gosudarstvennoj vlasti sub''ektov Rossijskoj Federacii i organami mestnogo samoupravlenija pokazatelej jeffektivnosti dejatel'nosti podvedomstvennyh gosudarstvennyh (municipal'nyh) uchrezhdenij, ih rukovoditelej i rabotnikov po vidam uchrezhdenij i osnovnym kategorijam rabotnikov" [On approval of Methodological recommendations on the development by state authorities of the subjects of the Russian Federation and local self-government bodies of performance indicators of subordinate state (municipal) institutions, their managers and employees by types of institutions and main categories of employees]. Available at: https://base.garant.ru/70417648/?ysclid=lage5pm02r706541119. (accessed: 07.11.2022). (in Russian).
13. Prikaz Ministerstva zdravoohranenija RF ot 13.07.2018 g. № 442 "Ob organizacii raboty po obespecheniju tehnicheskoj vozmozhnosti vyrazhenija mnenij pacientami o kachestve uslovij okazanija uslug medicinskimi organizacijami na oficial'nom sajte Ministerstva zdravoohranenija Rossijskoj Federacii v seti «Internet»" [About the organization of work to ensure the technical possibility of expressing opinions by patients about the quality of conditions for the provision of services by medical organizations on the official website of the Ministry of Health of the Russian Federation on the Internet]. Available at: https://www.garant.ru/products/ipo/prime/doc/71889420/?ysclid=lagedbxpqo658587461. (accessed: 07.11.2022). (in Russian).
14. Federal'nyj zakon ot 21.07.2014 g. № 256-FZ "O vnesenii izmenenij v otdel'nye zakonodatel'nye akty Rossijskoj Federacii po voprosam provedenija nezavisimoj

ocenki kachestva okazanija uslug organizacijami v sfere kul'tury, social'nogo obsluzhivanija, ohrany zdorov'ja i obrazovanija" [On amendments to certain legislative acts of the Russian Federation on the issues of conducting an independent assessment of the quality of services provided by organizations in the field of culture, social services, health and education]. Available at: https://base.garant.ru/70701066/?ysclid=lageb6qkqs42145076. (accessed: 07.11.2022). (in Russian).

15. Berwick D., Nolan T., Whittington J. The Triple Aim: Care, Health and Cost. Health Affairs. 2008; 27(3): 759–69.
16. Cherif E., Martin-Verdier E., Rochette C. Investigating the healthcare pathway through patients' experience and profiles: implications for breast cancer healthcare providers. BMC Health Serv Res. 2020; 20(1): 735. DOI: 10.1186/s12913-020-05569-9. PMID: 32781993; PMCID: PMC7422593.
17. Elwyn G., Edwards A., Wensing M., et al. Shared decision making: developing the OPTION scale for measuring patient involvement. BMJ. Quality & Safety. 2003; 12: 93–9.
18. Elwyn G., Durand M.A., Song J. et al. A three-talk model for shared decision making: multistage consultation process. BMJ. 2017; 6(359): j4891. DOI: 10.1136/bmj.j4891. PMID: 29109079; PMCID: PMC5683042.
19. Elwyn G., Edwards A., Kinnersley P., Grol R. Shared decision making and the concept of equipoise: the competences of involving patients in healthcare choices. Br J Gen Pract. 2000; 50(460): 892–9. PMID: 11141876; PMCID: PMC1313854.
20. Enthoven A. Integrated Delivery Systems: The Cure for Fragmentation. American Journal of Managed Care. 2009; 12 (15): 284–90.
21. Ferron Parayre A., Labrecque M., Rousseau M. et al. Validation of SURE, a four-item clinical checklist for detecting decisional conflict in patients. Med Decis Making. 2014; 34(1): 54–62. DOI: 10.1177/0272989X13491463. Epub 2013 Jun 17. PMID: 23776141.
22. Implementing Value-Based Health Care in Europe: Handbook for Pioneers. EIT Health; 2020. Available at: https://eithealth.eu/wp-content/uploads/2020/06/Implementing-Value-Based-Healthcare-In-Europe.pdf (07.11.2022: 28.08.2022).
23. Lewis K.B., Stacey D., Squires J.E., Carroll S. Shared Decision-Making Models Acknowledging an Interprofessional Approach: A Theory Analysis to Inform Nursing Practice. Res Theory Nurs Pract. 2016; 30(1): 26–43. DOI: 10.1891/1541-6577.30.1.26. PMID: 27024998.
24. National Cancer Action Team. The Characteristics of an Effective Multidisciplinary Team (MDT). Available at: http://www.ncin.org.uk/cancer_type_and_topic_specific_work/multi disciplinary_teams/mdt_development. (accessed: 07.11.2022).
25. Porter M.E., Guth C., Dannemiller E.M. The West German headache center: integrated migraine care. Harvard Business School Case. 2007; 707–59.
26. Porter M.E., Teisberg E.O. Redefining competition in health care. Harvard Business Review. 2004; 82(6): 64–136.
27. Porter M.E., Tiesberg E.O. Redefining health care. Boston. MA: Harvard Business School Press; 2006.
28. Robert L. et al. Standardized Outcome Measurement for Patients with Coronary Artery Disease: Consensus from the International Consortium for Health Outcomes Measurement (ICHOM). J Am Heart Assoc. 2015; 4: e001767. Available at: https://doi.org/10.1161/JAHA.115.001767. (accessed: 07.11.2022).
29. Shao J., Rodrigues M., Corter A.L., Baxter N.N. Multidisciplinary care of breast cancer patients: a scoping review of multidisciplinary styles, processes, and outcomes. Curr Oncol. 2019; 26(3): e385–97. DOI: 10.3747/co.26.4713. PMID: 31285683; PMCID: PMC6588064.
30. Street R.L. Communication in medical encounters: An ecological perspective. In: Thompson T.L., Dorsey A., Parrott R., Miller K., eds. The Routledge Handbook of Health Communication. Routledge Communication Series. Routledge; 2003: 63–89.
31. Subbaraman R., Nathavitharana R.R., Satyanarayana S. et al. The Tuberculosis Cascade of Care in India's Public Sector: A Systematic Review and Meta-analysis. PLoS Med. 2016; 13(10): e1002149. DOI: 10.1371/journal.pmed.1002149. PMID: 27780217; PMCID: PMC5079571.
32. World Health Organization. Global Report on Global Spending on Health: a World in Transition. 2019. Available at: https://www.who.int/health_financing/documents/health-expenditure-report2019.pdf?ua=1. (accessed: 07.11.2022).

ЛИТЕРАТУРА

1. Ефремов С.А., Груздева Е.А., Петкау В.В. Информатизация онкологической службы в регионе: система поддержки работы онкологической служб. Журнал телемедицины и электронного здравоохранения. 2020; 6(3): 31–5. Доступен по: https://cyberleninka.ru/article/n/informatizatsiya-onkologicheskoy-sluzhby-v-regione-sistema-podderzhki-raboty-onkologicheskoy-sluzhb. (дата обращения: 11.07.2022).
2. Зуенкова Ю.А. Возможности и перспективы технологии распределенного реестра в управлении опытом пациента. Менеджер здравоохранения. 2020; 9: 47–54. DOI: 10.37690/1811-0185-2020-9-47-54. EDN XABBRP.
3. Зуенкова Ю.А. Опыт реализации ценностно-ориентированного подхода в лучевой терапии в рамках

методики EIT health. Здравоохранение Российской Федерации. 2022; 66(3): 201–7. DOI: 10.47470/0044-197X-2022-66-3-201-207. EDN NROUSY.

4. Зуенкова Ю.А. Опыт реализации ценностно-ориентированного подхода в онкодерматологической практике. Фармакоэкономика. Современная фармакоэкономика и фармакоэпидемиология. 2022. 15(2): 250–8. DOI 10.17749/2070-4909/farmakoekonomika.2022.125. EDN YNYDYA
5. Зуенкова Ю.А. Организационные аспекты формирования мультидисциплинарных команд: стандарты качества, эффективность и внедрение в практику. Медицинское образование и профессиональное развитие. 2022; 3(47): 32–42. DOI 10.33029/2220-8453-2022-13-3-32-41. EDN YQFRBQ.
6. Зуенкова Ю.А., Кича Д.И., Абрамов А.Ю. и др. Пациенториентированный алгоритм работы рентгенотерапевтического кабинета онкологического диспансера. Медицинская радиология и радиационная безопасность. 2021; 66(5): 45–9. DOI: 10.12737/1024-6177-2021-66-5-45-49.
7. Зуенкова Ю.А. Применение методики VALS и техники леддеринга при совместном принятии решения о лечении. Менеджер здравоохранения. 2022; 5: 13–9. DOI: 10.37690/1811-0185-2022-5-13-19. EDN TSNFAH.
8. Зуенкова Ю.А. Роль программ поддержки пациентов в реализации ценностно-ориентированного здравоохранения. Менеджер здравоохранения. 2022; 4: 4–9. DOI 10.21045/1811-0185-2022-4-4-9. EDN LNFMUN.
9. Каприн А.Д., Старинский В.В., Шахзадова А.О., ред. Злокачественные новообразования в России в 2020 году (заболеваемость и смертность). М.: МНИОИ им. П.А. Герцена — филиал ФГБУ «НМИЦ радиологии» Минздрава России; 2021.
10. Омельяновский В.В., Мусина Н.З., Гостищев Р.В. и др. Концепция ценностно-ориентированного здравоохранения. ФАРМАКОЭКОНОМИКА. Современная Фармакоэкономика и Фармакоэпидемиология. 2020; 13(4): 438–51. Доступен по: https://doi.org/10.17749/2070-4909/farmakoekonomika.2020.042. (дата обращения: 11.07.2022).
11. Приказ Министерства здравоохранения РФ от 19.02.2021 г. № 116н «Об утверждении Порядка оказания медицинской помощи взрослому населению при онкологических заболеваниях». Доступен по: https://base.garant.ru/400533605/?ysclid=lage68g5gl915468794. (дата обращения 07.11.2022).
12. Приказ Министерства здравоохранения РФ от 28.06.2013 г. № 421 «Об утверждении Методических рекомендаций по разработке органами государственной власти субъектов Российской Федерации и органами местного самоуправления показателей эффективности деятельности подведомственных государственных (муниципальных) учреждений, их руководителей и работников по видам учреждений и основным категориям работников». Доступен по: https://base.garant.ru/70417648/?ysclid=lage5pm02r706541119. (дата обращения 07.11.2022).
13. Приказ Министерства здравоохранения РФ от 13.07.2018 г. № 442 «Об организации работы по обеспечению технической возможности выражения мнений пациентами о качестве условий оказания услуг медицинскими организациями на официальном сайте Министерства здравоохранения Российской Федерации в сети “Интернет”». Доступен по: https://www.garant.ru/products/ipo/prime/doc/71889420/?ysclid=lagedbxpqo658587461. (дата обращения 07.11.2022).
14. Федеральный закон от 21.07.2014 г. № 256-ФЗ «О внесении изменений в отдельные законодательные акты Российской Федерации по вопросам проведения независимой оценки качества оказания услуг организациями в сфере культуры, социального обслуживания, охраны здоровья и образования». Доступен по: https://base.garant.ru/70701066/?ysclid=lageb6qkqs42145076. (дата обращения 07.11.2022).
15. Berwick D., Nolan T., Whittington J. The Triple Aim: Care, Health and Cost. Health Affairs. 2008; 27(3): 759–69.
16. Cherif E., Martin-Verdier E., Rochette C. Investigating the healthcare pathway through patients' experience and profiles: implications for breast cancer healthcare providers. BMC Health Serv Res. 2020; 20(1): 735. DOI: 10.1186/s12913-020-05569-9. PMID: 32781993; PMCID: PMC7422593.
17. Elwyn G., Edwards A., Wensing M., et al. Shared decision making: developing the OPTION scale for measuring patient involvement. BMJ. Quality & Safety. 2003; 12: 93–9.
18. Elwyn G., Durand M.A., Song J. et al. A three-talk model for shared decision making: multistage consultation process. BMJ. 2017; 6(359): j4891. DOI: 10.1136/bmj.j4891. PMID: 29109079; PMCID: PMC5683042.
19. Elwyn G., Edwards A., Kinnersley P., Grol R. Shared decision making and the concept of equipoise: the competences of involving patients in healthcare choices. Br J Gen Pract. 2000; 50(460): 892–9. PMID: 11141876; PMCID: PMC1313854.
20. Enthoven A. Integrated Delivery Systems: The Cure for Fragmentation. American Journal of Managed Care. 2009; 12 (15): 284–90.
21. Ferron Parayre A., Labrecque M., Rousseau M. et al. Validation of SURE, a four-item clinical checklist for detecting decisional conflict in patients. Med Decis Making.

2014; 34(1): 54–62. DOI: 10.1177/0272989X13491463. Epub 2013 Jun 17. PMID: 23776141.
22. Implementing Value-Based Health Care in Europe: Handbook for Pioneers. EIT Health; 2020. Available at: https://eithealth.eu/wp-content/uploads/2020/06/Implementing-Value-Based-Healthcare-In-Europe.pdf (07.11.2022: 28.08.2022).
23. Lewis K.B., Stacey D., Squires J.E., Carroll S. Shared Decision-Making Models Acknowledging an Interprofessional Approach: A Theory Analysis to Inform Nursing Practice. Res Theory Nurs Pract. 2016; 30(1): 26–43. DOI: 10.1891/1541-6577.30.1.26. PMID: 27024998.
24. National Cancer Action Team. The Characteristics of an Effective Multidisciplinary Team (MDT). Available at: http://www.ncin.org.uk/cancer_type_and_topic_specific_work/multi disciplinary_teams/mdt_development. (accessed: 07.11.2022).
25. Porter M.E., Guth C., Dannemiller E.M. The West German headache center: integrated migraine care. Harvard Business School Case. 2007; 707–59.
26. Porter M.E., Teisberg E.O. Redefining competition in health care. Harvard Business Review. 2004; 82(6): 64–136.
27. Porter M.E., Tiesberg E.O. Redefining health care. Boston. MA: Harvard Business School Press; 2006.
28. Robert L. et al. Standardized Outcome Measurement for Patients with Coronary Artery Disease: Consensus from the International Consortium for Health Outcomes Measurement (ICHOM). J Am Heart Assoc. 2015; 4: e001767. Available at: https://doi.org/10.1161/JAHA.115.001767. (accessed: 07.11.2022).
29. Shao J., Rodrigues M., Corter A.L., Baxter N.N. Multidisciplinary care of breast cancer patients: a scoping review of multidisciplinary styles, processes, and outcomes. Curr Oncol. 2019; 26(3): e385–97. DOI: 10.3747/co.26.4713. PMID: 31285683; PMCID: PMC6588064.
30. Street R.L. Communication in medical encounters: An ecological perspective. In: Thompson T.L., Dorsey A., Parrott R., Miller K., eds. The Routledge Handbook of Health Communication. Routledge Communication Series. Routledge; 2003: 63–89.
31. Subbaraman R., Nathavitharana R.R., Satyanarayana S. et al. The Tuberculosis Cascade of Care in India's Public Sector: A Systematic Review and Meta-analysis. PLoS Med. 2016; 13(10): e1002149. DOI: 10.1371/journal.pmed.1002149. PMID: 27780217; PMCID: PMC5079571.
32. World Health Organization. Global Report on Global Spending on Health: a World in Transition. 2019. Available at: https://www.who.int/health_financing/documents/health-expenditure-report2019.pdf?ua=1. (accessed: 07.11.2022).