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Changing by asking the patient

A qualitative study on introduction of Value-based healthcare at a Swedish hospital

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Abstract

Value-based healthcare (VBHC) is a concept which describes a new way to manage hospitals and puts focus on the patient value. The goal is to achieve as much of this patient value as possible for the cost of healthcare. Recently several hospitals in Sweden have started working with the concept, but little is known about the effects on Swedish healthcare practices and patients caused by the implementation and how the concept translates to practice for healthcare professionals. In this qualitative study, the data has been collected by conducting interviews with 20 respondents, including hospital employees of varying professions and two consultants involved in the pilot stages of implementation, along with two observations. Using the grounded theory approach, the data has been coded systematically in order to conduct our analysis. By analyzing the data through the lens of translation and identity creation we found that there are some differences among the respondents regarding the understanding of the VBHC concept and what it means within the context of the hospital. The local contexts' of the patient group, and their different circumstances lead patient groups into translating VBHC differently and this caused practices themselves to vary. However, by changing practices and listening to the patient perspective, there was a change of mindset among the professionals, an effect on the role of the patient, as well as the relationships between professionals and patients. This study has contributed to the lack of research on the process of introducing Value-based healthcare and given some new insight on important factors to consider when introducing VBHC.

Keywords: Value-based healthcare, translation, medical professionals, patient involvement

Introduction

The question of how to manage the healthcare sector appears to be a difficult one to answer for anyone, and Sweden is no exception. Over the last couple of decades, the Swedish healthcare sector has tried numerous organizational strategies and management models to overcome existing challenges in the healthcare sector, but without success (Berlin & Kastberg, 2011; Hallin & Siverbo, 2003; Porter & Lee, 2013). The Swedish healthcare sector still struggles with rising costs, long queue times, and uneven treatment quality (Berlin & Kastberg, 2011; Hallin & Siverbo, 2003). The healthcare sector contains particularly difficult organizations to control and introducing new management models have close to no impact in practice. The explanations for these problems include the organizational complexity and the competing professional and managerial logics within healthcare organizations (Berlin & Kastberg, 2011; Llewellyn, 2001). Furthermore, the healthcare sector consists of many interdependencies, such as politics, which complicates change efforts together with the fact most medical professionals in the healthcare sector work in accordance with their professional logics rather than following the intentions of management models (Berlin & Kastberg, 2011; Bejerot & Hasselbladh, 2013). Contrary to this, Brante (2014) believes that today's new economic and political administrative management make it difficult to maintain the classical profession. As the professionals in the field of healthcare today are characterized with a history of a strong profession, this also forces a change in the typical role of the professionals (ibid).

Entering this field of complex organizations is a concept visualized by Porter and Teisberg (2004) called Value-Based Healthcare (VBHC), which seeks to make competition in healthcare more focused around the customer value creation. Previously, Swedish healthcare management has been characterized by using supply-driven strategies, focusing on costs and processes (Porter & Lee, 2013). Porter and Teisberg (2004) envisions a different way to run healthcare facilities which incorporates the patient perspective in a tangible way. By shifting focus and involving the patient in their healthcare process, tracking outcomes for specific patient groups and costs per patient, the tools are set in place for an efficient hospital with more satisfied patients. Compared to the supply-driven strategies, VBHC claims that patient value is defined as the health outcomes achieved per dollar spent, a definition of value that also encompasses efficiency (Porter & Teisberg, 2006; Porter 2010).

Currently, VBHC has gained popularity constitutes a frequently occurring management model, which has been introduced at several major hospitals in Sweden, and hospitals' management put great faith into the management concept (Svens, 2015). However, in order for VBHC to be successful in practice, it is important to adjust it into the local context, since the local healthcare professionals are the ones creating value for patients (Porter & Lee, 2013). Despite this importance of local contexts, studies around VBHC have been focused on the understanding of the concept, therefore there is a lack of research on other factors that may affect how VBHC affects the Swedish healthcare. Andersson et al. (2015) concludes that more studies about the process of introducing VBHC are needed. If factors affecting the

VBHC process can be mapped, similar projects and the processes could be adjusted to avoid possible pitfalls. Following up on a project in retrospect can provide clearer and more accurate results about what has actually affected the change process (Magnusson & Nilsson, 2014).

Based on the complexity of achieving changes within the healthcare industry, we wanted to explore the VBHC concept further in order to find out if it had potential to trigger actual change or if it would be another unsuccessful attempt at doing so. Firstly, this study aims to find out what happens when the VBHC concept meets a Swedish hospital context. This will contribute to the lack of research regarding the process of introducing VBHC and factors that may affect the process of introducing VBHC. The second aim of this study is to explore how the introduction of the VBHC concept affects implicates the roles of the different actors involved, such as medical professionals and patients. With these research aims, we wish to provide managers and professionals in healthcare organizations with an understanding of how introduction of VBHC in a patient group will affect healthcare practices, professional mindset and quality of care. In order to fulfill this purpose, we formed the following questions:

1) How has the process of introducing VBHC unfolded in the different contexts within the hospital?

2) How has the introduction of VBHC affected the medical professionals and patients?

In order to answer these research questions we will look back at the introduction of VBHC at a Swedish hospital. By questioning medical professionals and other actors involved in the introduction process, then applying the theoretical framework of translation we hope to provide some insight on how the process developed. To reach this insight we have structured the paper as such: In the following sections, we first present previous studies on the concept of VBHC and field of healthcare. Next, relevant theoretical framework is outlined, focusing on identity, name and imitation as well as the translation concept, followed by a presentation of the chosen methodology. Followed by our findings and analysis of the main findings. Lastly, a conclusion and practical implications of the study are drawn and suggestions for further studies are presented.

Previous studies on VBHC and healthcare

This study aims to study the concept of VBHC and therefore studies on management in healthcare and how changes in society affects the field of healthcare, as well as how the previous studies on the VBHC concept is used to understand the process of VBHC introduction. We use these studies about change efforts in healthcare organizations and they contain varied theoretical frameworks, some of them are not in line with our chosen framework of translation. Hence, this part may include concepts and terminology, e.g. implementation, that will not be used as part of our analysis.

Over the past few decades, there has been a shift in society due to environmental changes, such as governmental changes and new management systems (Scott, 2000). Healthcare has been subject to an increased pressure of change, as today's healthcare organizations are facing a number of challenges (Terry et al., 2014). In the field of healthcare, organizations have been characterized by the influence of the profession for a long time (Brante, 2014). Professions, such as physicians and nurses are today characterized with a history of a strong profession with own autonomy and authority (ibid). Sehested (2002) stated that the concept New Public Management came with reforms that challenged the roles of professionals in public organizations. Professionals are faced with different strategies at the same time, e.g. combining decentralization, democratization and managerialism, and these strategies will affect the roles of the professionals in different ways (ibid). The hospital being part of the public sector has turned it into a melting pot for a number of different organizational interventions connected to politics, regulation and inspection, in addition to managerial and professional interventions (Bejerot & Hasselblad, 2013). Llewellyn (2001) argues that healthcare professionals view management as 'the other', a separate entity from themselves with different ambitions and a different logic. This is further supported by Arman et al. (2014), who found that even when management logic dominates the professional logic in a healthcare setting, the professional logic persists and professionals continue to challenge management even from a subordinate role. Additionally, healthcare and health information is one of the most searched topics on the Internet. Due to the Internet and change in society, there has been a shift in the role of the patient, shifting from a passive recipient to active consumer of health information (McMullan, 2006). Healthcare professionals may not be aware of their patients' needs or preferences, and patients could be reluctant to raise their concerns. Therefore, to ensure the quality of care and know what care the patient want, the first step is to ask the patient (Zucca et al., 2016).

VBHC aims to increase the value for the patient by offering better healthcare at lower costs (Porter & Teisberg, 2006). The founders of the concept argue that VBHC is the solution to the future challenges in healthcare. This idea of reforming the healthcare system came to Porter and Teisberg (2004) as they perceived the healthcare market in the USA as deeply dysfunctional with constantly increasing prices without corresponding quality to match it. Porter and Teisberg (2004) identified a market where competition existed, but was zero-sum and focused around which actor among hospitals, patients, health plans or companies would foot the bill. The alternative would be referred to as a positive-sum competition based around who could provide the best care to the patients and Porter and Teisberg (2004) suggested a number of necessary reforms in order for a system such as this to be able to form. Initially, the individual providers should reshift their strategies and allow themselves to specialize in order to distinguish themselves from each other. Not by withdrawing services to patients but by attracting more patients within their specialties, and most importantly be willing to redirect other patients to specialized hospitals within other fields. This step closely connects to the ideas presented by Normann (2001) about how to view customer value through a network of different suppliers and focus on maximizing this value by adapting this network.

Höglund et al. (2012) believes that Swedish healthcare is good for VBHC as Sweden is at the forefront of measuring health outcomes. Due to being a relatively new field of study, the number of previous studies is limited and the many theorized benefits of VBHC have yet to be confirmed in practice (Eldridge & Korda, 2011). Fredriksson et al. (2015) conducted a study in Sweden about the concept of VBHC and suggested that the understanding is very small, even for researchers working in the field. A similar study, conducted at a major university hospital, addressed a follow-up of the first start-up projects that implement VBHC (Andersson et al., 2015). The study examined the understanding of the concept of VBHC within the project groups, concluding that the term is interpreted differently and differs from the theory of origin (Porter & Teisberg, 2004). Andersson et al. (2015) concludes that more studies about the process of implementing value-based healthcare are needed to avoid possible pitfalls. Following up on a project after a long time can provide better and more accurate results about what has actually affected the implementation of VBHC (Magnusson & Nilsson, 2014). Previous implementation research explain the importance of understanding the characteristics of the innovation implemented, who is implementing the innovation, the target population for the innovation and the implementation strategies and activities, as well as internal and external organizational factors. (Wallin et al., 2006; Grol et al., 2003) It is hard to keep management innovations the same in the long run, and thus necessary to see implementation as a process and understand innovations in healthcare as an evolutionary process, with the innovations being adapted and adjusted over time (Barnett et al., 2011; Øvretveit et al., 2012). To have a successful implementation of an innovation, the implementors are very important (Wallin et al., 2006; Grol et al., 2005; Porter & Teisberg, 2007). Øvretveit et al. (2012) state that, when implementing an innovation, clinical leaders are important and were considered more important than managers to the success of an innovation. Lindgren et al. (2013) explain that it is important and for the physicians to understand the innovation if they are expected to be part of the implementation process. It is important for physicians to understand how the innovation is connected to their professional fulfillment. What our study hopes to accomplish is to build on these studies and increase the understanding of VBHC, as well as how professionals can use the concept to improve healthcare.

Theoretical framework

Imitation, names and identity

In order for us to be able to make sense of how the VBHC concept travels and is interpreted at the hospital we need to gain an understanding about how concepts spread and are made sense of by different actors. DiMaggio and Powell (1983) made the observation that organizations within the same field appear to become more similar over time, and suggested that organizations imitate each other by adopting innovations of other organizations within their fields to be considered legitimate and be able to retain their positions within these fields, a concept referred to as isomorphism. With hospitals having the pressure of providing the best

care possible, this adoption of new practices and ideas is consistently prevalent in the field of healthcare (Ruef & Scott, 1998). This imitation of ideas in turn has an effect on the organizational identities of the imitators (Sahlin & Wedlin, 2008). However, when it comes to the spreading of innovations in healthcare, there is a distinction to be made between the Isomorphism presented by DiMaggio and Powell (1983), in which innovations are copied across organizational fields, and what happens in practice. Erlingsdóttir and Lindberg (2005) found that sometimes the name of an innovation would spread within a field, but be associated with widely differing practices within different organizations. This spreading of name alone is referred to as isonymism, and it is contrasted against actual practices being adopted across an organizational field, known as isopraxism (ibid).

A reason for the spreading of the name alone is that when an idea gets a name, the name becomes associated with an identity which can either be desired or rejected by another organization (Solli et al., 2005). This desire births an impulse to imitate others, which is spawned within imitators as they make sense of their own environment as well as the identity of themselves and others (Sevón, 1996). By adopting the name of an innovation it is possible to identify with said reform despite not practicing it the same way as the innovator, and the opposite case of adopting practices of the innovation while rejecting the name, and the identity it represents, is another possible outcome (Solli et al. 2005). These differing outcomes adds another layer to the act of imitating another, it is not merely an art of observing and copying but it also involves innovation and adaption within the context of the imitator (Sahlin & Wedlin, 2008). Separating innovations from imitations is problematic, and no one can coherently separate them, due to the fact that any attempt at either innovating or copying is affected by one's own experience (Sevón, 1996). Thus, we will refrain from making any judgments about what constitutes innovation.

The process of translation

As we wish to be able to explain how this spreading of ideas happens in practice and how professionals and patients are affected we need to get a grasp of the theoretical concept of translation. One of the founders of the translation concept argues that when an idea is dependent on human actors, the actions of these actors will affect the idea as it travels, changing the idea as it spreads (Latour, 1986). Translation is contrasted against the concept of diffusion of ideas, which argues they can spread unaltered through time and space without much resistance if there is enough power behind the initial push. Rejection of this diffusion concept is based on the idea that any actor can interact with an idea in many different ways, such as modifying or adding to it and the acts of doing so is referred to as the process of translation (Latour, 1986; Callon, 1986). Moreover, the concept of translation challenges the concept of inherent power and argues that no actor holds power over another unless given power by others acting as followers (Latour, 1986). Thus, the ability to produce change is reliant on actors following and enacting change rather than a concept of a strong leader ordering change.

How different actor relationships form is explored by Callon (1986), who identified four different moments of translation when attempting to spread a concept: problematization, interessement, enrolment, and mobilization. The initial moment of problematization is a process to establish the actors involved, including non-human, and their interests, the moment of interessement attempts to ascertain the identities and interests of these actors, while the moment of enrolment consists of negotiations of roles and establishes alliances. Finally, the moment of mobilization is a process to find representative spokesmen for all the actor interests in order to avoid betrayal (ibid). As an idea goes through these moments of translation and becomes taken for granted within the context of the organization and the different actors it is referred to as black-boxed (Latour, 1986), but any changes in actors or new ideas can open up the black-box again and cause new translation processes (Law, 1992).

While the translation concept has remained mostly the same since its inception, the focus of contemporary translation literature is transformation, how a fashionable idea or practice evokes the desire to imitate and how this transforms the imitator as well as the idea. As other organizations translate a concept into their own contexts, for their own use, and this translation process takes place, not only is the idea translated but the act of translating affects the actors involved in the process (Czarniawska & Sevón, 2005). The circumstances for the translation process are important to the results of the translation, no idea can spread through diffusion in a vacuum, but travels in different contexts and is affected by different actors with existing ideas and traditions (Sahlin & Wedlin, 2008).

> In an organization where a new managerial technique is being introduced, the senior employees claim that they have seen it ten, even twenty years before. Organizations of the same type produce identical innovations but, when queried by researchers, claim to have invented them themselves. Or the other way around: they claim to have imitated some solution or device, but the external observer fails to find similarities between the "original" and the "copy". (Czarniawska & Sevon, 1996, p.2)

This quote exemplifies the complexity of translation processes and how ideas are always perceived in different ways by different actors with various experiences. This means that there is a problem of coherency when discussing new ideas, as some may perceive them as old ideas that are commonly known. This can lead to a process of translating something perceived as known, into something entirely different (Czarniawska & Joerges, 1996). Part of the reason for these erratic and continuous processes of translation is the nature of ideas and practices, a spreading idea materializes in the heads of various actors who make sense of it in different ways based on their respective experiences, reflections and current knowledge, and a practice inherently cannot travel unless it becomes visualized to an idea and spread as such (Czarniawska & Sevón, 2005). However, if we embrace this complexity, the translation framework provides us with a lens to analyze and attempt to understand the change processes and travel of ideas within the organization. We will attempt to use this lense to understand the

introduction of VBHC at the hospital and how the roles of of medical professionals and patients have changed.

Methodology

Since the aim of the study is to provide a deeper understanding of a specific phenomenon or practice, to understand how the VBHC concept was introduced and how it had been adapted at each patient group and affected the roles of professionals and patients, a qualitative research method was chosen (Czarniawska, 2014). According to Silverman (2011), a qualitative study should include more than just interviews, therefore different data collection methods were used, which resulted in a wider and more diverse basis for the analysis.

The setting

In order to maintain anonymity, the healthcare organization hosting the study will simply be referred to as 'the hospital'. As the hospital decided to attempt introducing VBHC they received help from consultants to construct pilot projects and create their own model for how to introduce VBHC in different parts of the hospital. The respondents explained how pre-requisites included that clinics themselves would be in charge of nominating patient groups that they deemed could benefit from changing to VBHC, thus the senior management of the hospital would not be forcing any unwanted changes on the different healthcare units. These aforementioned 'patient groups' are defined in this study as the group of professionals in charge of providing healthcare to patients with a certain diagnosis, not to be confused with a group of patients.

The hospital's model for VBHC introduction required forming a set of teams with different roles in the process, each project group needed one small project team with a mix of medical professionals and administrative staff, which was in charge of the introduction process and lead by someone with medical expertise. The second team was a larger reference team containing stakeholders to the patient group such as other healthcare units a typical patient could visit during treatment, as well as patient representatives and others learning the process for introducing VBHC at the hospital. The role of the reference team was to give feedback to the project team. Finally, there was a third small advisory team consisting of different hospital managers to oversee the introduction, but take no active role. With the support from the hospital's VBHC project office, these teams would work out how to introduce the necessary tools to meet patient needs, including scorecards to measure patient outcomes, patient experience, as well as costs related to different treatments of patients. Furthermore, the model was structured in such a way as to focus the introduction of VBHC into a 12-week program, during which the ultimate goal was to create the scorecard and gain the ability to measure and track progress on all the measurements deemed to provide value to patients. These 12 weeks would be preceded by a several months long preparation phase where the different team members would be determined and the necessary meetings planned. Due to problems with gathering data from the hospital's IT systems for scorecards, which we will go into further in

our findings and discussion, a special unit at the hospital has recently been tasked with supporting some patient groups with retrieving data. This unit will be referred to as 'IT support' within this study. All findings presented in this study are related the process of introducing the hospital's model of VBHC.

Data collection

To understand how the VBHC was translated at a Swedish hospital, both primary data and secondary data was collected. The primary data was collected through semi-structured interviews and observations. The secondary data consists of data gathered from news articles and internal documents from the hospital. Since the VBHC concept is a fairly new concept, the number of previous studies is limited. We chose to focus on articles and papers that were considered most relevant for our topic and research questions. The primary data was collected through interviews and observations with individuals that were part of the introduction process of VBHC in different ways and stages.

The choice of who to interview was based on access. It was difficult getting access, the professionals are very busy and therefore it was very hard to get in contact with them. In order to have different perspectives the goal was to conduct interviews with respondents from different patient groups as well as having a differentiation in roles. We got the names of the respondents from people we knew or respondents we had previously interviewed. This may have affected the differentiation in respondents and the collected data, however a mixture of respondents in different patient groups and different roles participated in the study, reducing the concerns of not representing the whole picture. Interviews were conducted with a total of 20 respondents, 13 medical professionals and seven project supporting professionals participated in the study, to see the distribution of the respondent different roles see Table 1. The professionals we interviewed had a range of different professions and worked within different patient groups. Interviews were conducted with professionals with both medical and administrative roles, e.g. doctors, nurses and operational developers, as well as individuals from the VBHC project office, the IT support at the hospital and individuals from the consultancy firm that helped the hospital introduce the concept. The professionals' were all part of different teams during the introduction of VBHC, with the roles varying between being the project leader to being part of a reference group.

Having a mix of different types of patient groups was considered important as the study aimed to understand how the VBHC concept was introduced and how it had been adapted and understood at each patient group and see potential similarities and differences between them. To ensure this, a total of ten different patient groups with different types of care were part of the study, including both emergent diseases and chronic diseases. The majority of the patient groups were represented by one respondent, with the expectation of three patient groups. For the patient groups that are presented by more than one respondent, the respondent's role during the introduction process varied. A decision we made to receive variation of roles during the introduction process. Also, the patient groups were in different stages of the

introduction of VBHC, some had been part of the pilot project in 2013, some had just started in during the kick-off we observed, and others in between. We found that including patient groups in different stages of their gave us different perspectives regarding the whole process of introducing the VBHC. Hence, with different reflections coming from professionals concerning the method during the early stages of VBHC work, as well as reflections regarding noticeable outcomes from professionals further along with their VBHC process. We had the opportunity to attend two observations, attending these observations helped us get a understanding of how the concept was received and used in the organization, see Table 2 for how these observation were relevant the aim of this study (Meyer & Rowan, 1977). Giving us a broader perspective and not limit our understanding to the interviews (Czarniawska, 2014). Meeting with different types of respondents helped to understand how the VBHC concept had been interpreted from different professionals with different responsibilities (Silverman, 2011).

Since the aim of the study was to understand how the VBHC concept was introduced and how it had been adapted and understood at each patient group, semi-structured interviews were conducted. Semi-structured interviews gives the possibility to better understand the use of the VBHC concept and allowed for a comparison of data between different patient groups (Eisenhardt, 1989). This method gave us the opportunity to keep an open-mind for unexpected information. This method enables the interviewee to talk more freely about their experience and not steer the respondents during the interview. This approach keeps the structure of the interview but also gives space for the interviewee's own interpretation of the question and provides him or her with the possibility of talking from their own perspective as well as sharing personal experiences (Czarniawska, 2014). The length of the interviews varied between 39 and over 90 minutes, which was enough to get an understanding of the respondents thoughts of VBHC and the introduction process. To keep the focus on listening to the respondents and subsequently transcribe and analyze the data at a later time, the interviews were recorded (Czarniawska, 2014; Kvale, 2008). Notes were taken to remember interesting statements as well as to remember statements that needed further explanation, but the focus was on listening to the respondent (Czarniawska, 2014).

The decision to anonymize the organization, the patient groups and the respondents was made to keep the respondents feeling comfortable during the interview, making them able to talk more freely and without any fear of repercussion. In order for the study to remain ethical and objective (Kvale, 2008), all of the respondents signed a consent form before the interview. The consent form stated that respondents would be anonymous, that their participation was voluntary, that they could withdraw their participation at any time, and that they would be asked to approve quotes before publication. All of the affected respondents have been contacted and given the opportunity to withdraw their quotations. In order to keep the respondents' and their profession anonymous, all attributes associated with the respondents and their professions have been hidden, and we have made slight adjustments to quotes, without damaging the message, including the removal of names, places or any other

identificatory terms. As mentioned before, the organization will therefore be referred to as "the hospital" in this study.

Table 1. Participating respondents

Respondents	**Unit/Role**	**Role during the introduction of VBHC**
3	The VBHC project office (Project office)	Main project support
2	Consultancy firm	Consultants (Initial project support)
2	IT support	Project support in IT-related issues
4	Administrative role & Medical role	Project leaders or part of the project teams
6	Administrative role	Project team members
3	Medical role	Part of the project teams, advisory teams, or reference teams

Table 2. Observations

Observation	**About the observation**	**Relevancy to the study**
Scorecard meeting	Had the opportunity to observe how the meetings went and how they discussed each outcome measurement, with a patient perspective.	We had the opportunity to observe if they actually practiced having the patient in mind when discussing healthcare.
Kick-off with four different patient groups	Kick-off for the patient groups starting their VBHC projects during the Spring 2017 including an inspirational lecture from two representatives of a patient group that already completed the introduction process VBHC.	Got to learn more about the VBHC introduction process

Data analysis

Since the aim of the study is to describe and analyze how the VBHC concept was introduced and how it has been translated inside a number of patient groups at a Swedish hospital, also how the role of professionals and patients has changed. We designed the study around continuous comparative analysis and most of the data collected is qualitative data, primarily

from semi-structured interviews, a grounded theory approach was appropriate (Glaser & Strauss, 1967).

To start analyzing the collected data, the interviews were first transcribed and coded, a process suggested by Martin and Turner (1986) that helps create concept cards of different themes that emerged. This process can lead too many codes in the initial stage, which happened to be the case for us with many different respondents with different roles and active in different patient groups (Martin and Turner, 1986). To handle the large amount of different codes, the codes were categorized into different themes that were found most relevant for the study. The themes were: (1) The desire for VBHC, (2) The process of introducing VBHC, (3) Challenges when introducing VBHC, and (4) Accomplished changes through VBHC. From the empirical data presented in the four themes, three main findings from translating the concept of VBHC was categorized into new themes, closer to the chosen theoretical framework: (5) Introducing VBHC, (6) Results of translating VBHC, and (7) The changing role of the professionals and patients. During analysis the first two themes are mainly connected to the first question regarding how the concept of VBHC has been translated into the contexts of different patient groups. Thus, the analysis of last theme will allow us to answer how the role of the medical professionals and patients has changed with the introduction of VBHC.

Limitations

A limitation in this study is the limited time available for the study and the busy nature of clinicians and hospital staff, we have a mixture of respondents with different roles within the hospital that tend to numerous patient groups. Thus, due to the desire of including different patient groups to be able to compare contextual related data, the majority of the patient groups were represented by one respondent with the exception of three patient groups. This was taken into consideration when analyzing the data. Furthermore, we were only able to acquire access to respondents currently or previously involved in the VBHC transformation, meaning no comparison to other non-VBHC patient groups within the hospital was possible. While small, the study builds on the lack of previous studies regarding how VBHC is used in practice and is a first step to a greater understanding of the complexity of VBHC introductions in organizations and can provide some insight for further studies.

Empirical data

The desire for VBHC

To understand why VBHC was introduced at the hospital we need to explain how the idea first arrived and gained support within the organization. The initial idea of introducing VBHC came from a former hospital director, according to respondents. This director continuously argued that these changes would be beneficial, if not necessary, in order for the hospital to increase the quality of care and the value for patients. Thus, the respondents at the hospital reminisce about how the entire healthcare staff were called in to meetings in groups, in order

to define the core values of the hospital. These meetings and the resulting core values laid the groundwork for the future VBHC introduction process. According to a majority of respondents these meetings and the resulting core values generated interest in the VBHC projects as they were expected to involve patients more in healthcare processes. This also meant several groups would have to wait months or years after nominating themselves to the project before they would be allowed to start, due to the resources to support projects at the VBHC project office being limited. The director maintained a position as a public supporter for the VBHC concept and took a big role in generating interest within different parts of the organization, or as one hospital employee puts it:

> The hospital director was a visionary, and skilled at communicating the message to the entire organization, which gained many supporters and started something that continues to live on. - Respondent

The quote exemplifies how the director managed to drum up support for the change project. Many respondents expressed the desire for VBHC for different reasons, some wanted to increase their understanding of their patients' needs, while others simply wanted to try out a new model for structuring healthcare. However, while there was a success in generating interest in changing to understand patients' needs, there was also differing opinions as to what was supposed to be included in the VBHC concept. This included criticism towards measuring costs for different patients' treatments. As such, many respondents explain that rather than taking the hospital model of VBHC to heart, they would pick out the parts they considered useful and attempt to integrate those in their daily work, as exemplified by the following quote from one respondent:

> To be honest we do not work a lot with this today, but the important part is capturing the benefits for the patient and measuring them. We do this but in other ways, this is one tool among others, but there is a spin-off effect in that, when we talk, we start with what's best for the patient. - Respondent

The respondent explains how the VBHC process has affected their way of discussing patient value, and that while they have abandoned practices related to VBHC at the hospital they continue to track patient value using other means.

The process of introducing VBHC

In order to understand how VBHC unfolded at the hospital we have to dig deeper into the introduction process, as well as respondents thoughts about the process. Initially, the pilot groups started their preparations for the project, with supervision and support from consultants, who worked together with the hospital to create the model for introduction that would be used moving forward. The preparations consisted mostly of forming the teams mentioned earlier, project team, reference team and advisory team. The consultants explain that a lot of emphasis was put on who should be included, such as different healthcare

professionals that patients may encounter during their hospital visits, administrative support staff, patients or patient representatives as well as any other members deemed valuable to the process. In addition to forming these teams, the preparation consisted of mapping out the patient group in terms of volume, costs, as well as the different clinics visited and treatments undergone by a typical patient. With these preparations complete, the teams would have to work together to complete four steps decided upon by hospital management:

- Defining relevant measurements, and how to track them in order to create a scorecard
- Gathering of necessary data for the measurements tracked in the scorecard
- Analyzing the data and creating improvement initiatives
- Implement initiatives and ensure continuous improvement moving forward

While the initial pilot groups were heavily supported by the consultants in the beginning of the introduction process, the hospital simultaneously used their expertise to educate employees and form their own project office for introducing VBHC. Which would take over the supportive role the consultants had provided during the initial trials for VBHC. As this project office took over the supporting role for all introduction processes of VBHC at the hospital, they used what they learned from the pilots and consultants and through adaptation they ended up creating their own manual for introducing of VBHC. While this manual consists of essentially the same steps as the consultant model, respondents from the office explained how the approach to completing the steps changed over time as more patient groups joined the VBHC work, each with their own unique problems that they could learn from e.g. patients refusing to or not being able to participate. The resulting model consist of an intensive 12 week project schedule, with pre-planned meetings and accomplishments to achieve before each meeting. These 12 weeks were preceded by preparations suggested by consultants and many respondents explained that the 12 weeks were usually followed by a few weeks of downtime, where no work was done towards VBHC as everyone involved thought it necessary to “catch their breath” and let the intensive work sink in before incorporating it into their daily routines.

During the introduction process for VBHC most patient groups have had active support from the VBHC project office, but the emphasis was always on the different teams to make the project their own. Thus, medical professionals were exclusively considered as the leader of every project, as they maintain the greatest insight on the daily activities that seek to create value for the patient. Many interviews concluded that the original model could not apply adequately to their patients and was thus adapted in part and adjusted to fit the circumstances of the patient group involved e.g. some groups needing several more months to produce a usable scorecard. Additionally, one respondent who was part of two VBHC projects highlighted the difference between being a part of the consultant supported pilots, comparing it to the support given by the project office:

> When the consultants were involved there was order, there was control, while this time we received a kit and were expected to do it ourselves. The physicians

> were supposed to lead, and they did not have the time, meetings were not called, rooms were not booked. It also took a lot of time to answer these questions, it was not possible to get the data on how we work, and thus it took a very long time to reach any kind of scorecard for us to follow. - Respondent

This view of differing levels of support being available to patient groups was reflected by the consultants as well, who admit that the pilots had access to a lot of support from their end, as they dedicated all of their time to supporting pilots and creating the model for how to introduce VBHC at the hospital. The reason presented by the consultants was that they had to build up knowledge within the organization. This accumulated knowledge of the process within the organization should then be able to compensate for the comparatively smaller time investment from the project support office. In contrast, others had no expectations of support to meet and one group decided not to rely on the project office at all. Because, while the VBHC project office supported all the nominated groups, some groups who had not yet been nominated were eager to start. Respondents from one of these groups explained that they decided to simply follow the hospital's model created for VBHC introduction. These groups requested only occasional visits from the VBHC project office, to review and approve the changes they had accomplished. The respondents claimed that the lack of support was covered by their enthusiasm, and that there was a sense of pride in accomplishing the project work by themselves.

Furthermore, respondents from different patient groups expressed confusion about the hospital's interpretation of VBHC, we were told this was due to a lack of information about the interpretations and adaptations the hospital had done to apply VBHC to the organization. As a result, some respondents heavily criticized the Porter conceptualization of VBHC when talking about the change process at the hospital, making the name a reason for questioning or rejecting the attempted changes. When talking about the hospital method for introducing VBHC some respondents described it as a well structured tool to accomplish change and claimed to apply the model in other change projects as well thanks to its adaptability. Others criticized the model for being demanding in terms of time investment and expectations of what should be accomplished in addition to the normal workload during the 12 weeks. Additionally, claims were made that the model was too rigid and failed to reflect the reality of working with patients. The respondents that were more comfortable with using the model pointed out their previous experience as a key part of why they found the model easy to apply and adapt to different contexts.

Challenges when introducing VBHC

As the VBHC processes continued within the organization, patient groups faced different challenges with introducing the concept, some of which will be discussed in this section. We distinguished a common pattern among the respondents when explaining the introduction process of VBHC and problems that arise during the process, IT systems problems was

mentioned by numerous respondents. Although the explanation of the IT problems differ slightly between the respondents, the majority have had problems with receiving the correct data directly to their scorecards. Some of the different patient groups had previous experience using the Swedish National Quality Registries to analyze and compare their patient data and how well they were doing. How useful their quality registries were varied between different patient groups and a common pattern was that the patient groups that considered their quality registers good, in terms of data on outcomes for the patients, had an easier time collecting useful data for their scorecards. Other groups struggled, attempting to withdraw patient data from several different IT systems, which were not interconnected. Three of the patient groups solved the problem by having someone going through the medical records and picking out the important data manually and then calculating and analyzing the data. Respondents explained this interim solution as doable in the context of small groups of patient, but not sustainable when applying VBHC on a larger scale. One patient group had particular difficulty with their data, because it was not permitted by Swedish law to collect any data about the patients included in their patient group. Therefore, their medical records were not designed for quality control or tracking outcomes, and no previous data existed to use for their scorecard. They had to start anew and gather information in ways they were allowed by Swedish law. Another patient group decided to abandon the VBHC scorecard altogether due to problems with data collection. The argument was that their quality registers was a stronger tool for them to track all the relevant data, removing the need for the scorecard.

The majority of the respondents explained that hiring more people to help with the IT systems to support the different patient groups' introduction process would have solved many problems that they had to go through, and to some extent are still experiencing. One respondent argued that IT support is the most important factor to secure to get anywhere in the process of introducing VBHC. However, solving these problems is complicated, as the hospital is a publicly owned property and politicians are ultimately in charge of any future IT investments. This is a major problem as most respondents claim that they are dependent on their patient reported data to improve further. The lack of easy access to this data forces them to turn to their manual medical records, which were described as terribly inefficient tools to use for quality improvements. Another respondent blamed the hospital's own systems and argued that if the systems were better, no ward would have to buy systems from consulting companies to help them to retrieve data, which some wards have to do today. The VBHC project office were aware that most patient groups are in need of more support regarding IT and that they do not having the ability to help every patient group with their IT needs. Hence, the inclusion of the IT support unit to help the VBHC patient groups. The respondents from the IT support unit explain that they are currently in the state of a pilot project to help the patient groups with scorecards, so the patient groups do not have to struggle as much with the collection of data from IT systems in the future.

> All groups were very committed, but found it hard to continue just because it is difficult to get data on all the stuff, you have done a solid job to get these

> different measures and for it to create value for the patients ... then it's hard to follow these up in the next step and it will be hard to continue when you can not see how this works, if it's an improvement, you want to see that it gives a little better result.” - Respondent from the IT support

The reason respondents emphasized IT system problems is because most of them rely on theses systems, as their main method for keeping the patient involved in the change process is tracking data reported by patients in the scorecard. Asking the patient what they think about provided healthcare was a big part of VBHC by all respondent, perhaps the biggest. However, this was something several patient groups encountered problems with. For the majority of these patient groups these problems occurred due to circumstances with patients not being able to represent themselves. Different patient groups solved this problem in different ways, solutions included e.g., other types of representatives or patient associations, as well as surveys. In a struggling patient group, one respondent explained that for their patients, the visit is something they do not want to remember or think about when it is done and therefore they do not want to participate in any subsequent meetings. Another respondent explained the problem as such: “For this group of patients this is a short episode in their life, once they've met us then they would rather not meet us again”. To solve this problem, they started using anonymous surveys which the patient could fill in during their visit.

Another challenge was the subject of having the first line boss included in the process, which was brought up by several respondents. Furthermore, they explained that without support from the first line boss it is perceived as difficult to get the necessary time to work with the VBHC project, as any work linked to VBHC needs to be prioritized in order for employees to be able to dedicate enough time.

> It's probably the hardest thing, and it's hardest to get it rooted in an activity that has no room for it. We are too few for it and we have not had anyone ... our boss has not been in the management team, which makes it hard when you have to talk ... because if the boss is part of it, it will be easier for the boss to motivate. - Respondent

Another respondent explained that the having the first line bosses included is a lesson they learned during the process, and that it was one of the most important learning outcomes from their introduction process. It becomes very difficult to get the first line boss on board when they are not part of the process from the beginning, or even worse, not at all. To get the VBHC project prioritized, the boss with the decision-making power needs to understand the importance of the project and allow time commitment to the project.

> And as a manager, when you have resources and when you have mandate. If you try to get through changes, if you do not have the bosses with you then you will have a lot of work. If you can make it easier, so you do not have to work

> with all those pieces, to have the bosses from the beginning, understand the scorecard and understand the thoughts behind the whole theory. Rather than have done it, packed it up nicely and say this is how it looks and we need to work with this. - Respondent

The VBHC project office explained that the goal with VBHC at the hospital, is to have the approach that the patient groups themselves should want to apply the model. In order to achieve this, the project leaders or managers in charge of patient groups are the ones asking to introduce VBHC to their patient group. However, other professionals, e.g. nurses argue the VBHC project feels forced unto them by management. One respondent was included in one of the processes by email, telling her when and where the first meeting was. This created a sense of being disrespected when having many years of experience and actually being the one that takes care of patients on a day-to-day basis. The respondent continued explaining that there are many new projects that have come and gone through the years, and it is not that the concept of VBHC is inherently bad, but rather a case where all the previous projects never stuck and therefore there is a lack of belief that VBHC is going to last. Some respondents explained that they are very affected by the changing trends in the industry, with new concepts often coming and going. This was express as follows by one respondent:

> ... there's been a lot of things that have come and gone, and that's the way it is I believe, in any business, regardless if you are a technology company or whatever. - Respondent

These past experiences of change initiatives are lifted by respondents as reasons for professionals trying to resist change. Furthermore, respondents express that with every new hospital director, there appears to be a new concept to implement. One respondent state that a problem with a concept becoming fashionable, is that they try to incorporate a concept that does not work for all patient groups. This respondent argued that the concept of VBHC is more suitable for emergent diseases such as surgery, rather than chronic diseases from which a patient is never being declared healthy. One respondent from a patient group argued that talking too much about change project may lead to resistance, due to the many different changes and new concepts over the recent years. In order to overcome this, the consultants, the project support team at the VBHC project office, and several respondents argued that it is not that important for the professionals working in the different patient groups to know that VBHC has been introduced or have a relation to the VBHC concept. One respondent at the VBHC project office stated that it is more important for the professionals to simply understand that there is a shift of focus towards quality rather than budgeting resources. In line with the VBHC project office, the consultants stated that it is more important that they understand the new routines and the changed practices after implementing VBHC, than being able to theoretically define the concept. However, because the VBHC concept and its meaning is being downplayed, there was expressions of confusion regarding what the change means for the medical professionals.

The hospital have their own interpretation of what VBHC is, which differs to the originators modeling, and according to the consultants all other hospitals practicing VBHC in Sweden, all create their own interpretations. Respondents explained there was confusion among the patient groups, as it was difficult to know which version of VBHC they are asked to implement. The reasoning is that if you read Porter's works, and then what the media writes, it becomes confusing to understand what the hospital's version is and why it is different to other interpretations of VBHC, when it is not being properly explained. One respondent suggested that a solution would be have an introductory course to what VBHC at the hospital is before starting the project, and that this should include the whole project team. Other respondents explained that they found the hospital's model for introducing VBHC fine, but they also acknowledged the fact that they had worked with similar types of models before. One respondent calling it "typical systematic classical development work", another calling it "classical process work, process management".

> Maybe it was a bit of luck that we completed this education, two years about quality improvement in business development. Because that's what it's about, so it can be difficult sometimes to get started with this if you have not worked that way before. We had some use of it, then it was just fun that we finally got to work in a systematic way, as we know is good. Some have had a hard time getting started in their systematic work. - Respondent

One respondent had difficulty to understand why the project leader needed to have medical expertise, explaining that it created difficulties for the project due to medical professionals often lacking previous knowledge in leading projects. Also, medical professionals do not have the proper knowledge of how to lead a project, as well as not having the time for administrative work such as leading a project.

Accomplished changes through VBHC

Patient involvement is a large part of VBHC, to include the patient in the process and ask them for their opinion in order to improve practices. The majority of the respondents explained that they always had the patient in mind when thinking about healthcare. However, the main difference is that they now proceed to ask the patients about their healthcare experience, instead of making assumptions about what the patient wants and needs. Several respondents further argue for the benefit they have had by including the patient in the process, the professionals have gotten a better understanding and a very different understanding of what the patient wants and prioritizes. Several respondent explained that they were surprised to find that what they thought the patient wanted was very different from what they actually wanted, after asking them. Furthermore, one respondent explained that there has been a history of professionals being somewhat arrogant in terms of their assessing their performance. Thinking that the only important outcome is medical, e.g. a successful surgery, and not the patient's feelings during the experience nor the patient's recovery at home. When

asking the patient, one respondent explained that the patients were more worried about the pain than the surgery from a technical aspect.

> The patient is not that interested in the technical aspect of the practices, what they are interested in is more regarding their pain. When and how long will I be on sick-leave? When can I go back to work? That is what the patient wants to know, it's about their own lives and it was a bit of an Aha-experience for us when we stop being so active, as well as allowing the patient in a little bit more in this. - Respondent

During an observation of a scorecard meeting, the members of the scorecard group discussed each outcome for every quarter and how to perform better with the perspective of the patient's best interest. During the meeting they discussed different solutions to a problem of how to handle different medical students being part of a patient's examination, where one member firmly stated "No, the patient will be uncomfortable in that situation".

One respondent explained that the scorecard gives them a goal to work towards. The outcome at the end of each quarter makes the professions want to analyze their work and improve it. The staff of some patient groups embraced the VBHC project to the extent that they through own initiatives found new practices to improve or found ways to make them remember the changes in their practice. For example, one respondent explained that the nurses now use a toad, which is slang for tablet in Swedish, on their board to remember to give the patient the tablet to complete the survey. Another respondent described an environmental change between the different professions, how they through own initiatives wanted to change how they met with the patient. In order to make the patient's experience of the appointment better and save time spent waiting in between visits for the patient they collaborated in joint meetings within different medical fields. This was put forward as a victory for VBHC for one of the patient groups, because while it could be slightly easier for the different professions to do their job separately, the patient was deemed more important, causing them to put differences aside and work together.

> I do not think that when you have experienced this concept that it is ethically defensible anymore not to have the patient perspective, even though I've been working without it so many years before. - Respondent

This respondent claimed that, after introducing and working with the VBHC concept, it is unethical to not include the patient perspective. Another respondents stated the same thing, that after introducing the patient in the process, it is strange to think that they have not included the patient before and that they thought that it was okay to make assumptions about the patient experience. But the respondent continued to explain that everything changes, the industry changes and that this does not mean they were bad doctors previously, it just meant that they did not know better. The respondent connected the progress by remembering the

years when the professionals did not think babies needed anesthesia, because it was believed they did not feel pain. A common statement from the respondents was that no one can argues against creating value for the patient. One respondent, whose patient group abandoned the hospital's VBHC practices stated that they still have a similar view on value and creating value for the patient, but chose to do so in a different way. We were told that they chose to let go of the hospital's version of VBHC and focused on assembling around the patient in new ways, which the respondent explained as more reminiscent of Porter's modeling of VBHC.

Discussion

As previous studies mostly focus on how the concept of VBHC is understood rather than on studying factors that affect how the VBHC concept turns out in Swedish healthcare (Andersson et al., 2015). We aim in this study to understand how the VBHC concept was introduced and how it had been adapted and understood at each patient group, as well as understand how the roles of the medical professionals and the patients have evolves. In this part of the study we discuss the result from the empirical data with our chosen framework of translation theory. From the empirical data presented in the four themes above, we have identified three main findings from translating the concept of VBHC, providing us with three new themes: (1) Introducing VBHC, (2) Results of translating VBHC (3) The changing role of the professionals and patients. These themes will be further elaborated in the discussion.

Introducing VBHC

The Swedish healthcare have tried numerous organizational strategies and management models over the last couple of decades in order to overcome existing challenges in the healthcare sector, but without any major successes (Berlin & Kastberg, 2011; Hallin & Siverbo, 2003; Porter & Lee, 2013). As such, the hospital director had a challenge ahead in terms of accomplishing change within the hospital, and being able to translate the VBHC concept to an attractive identity that hospital wards would want to pick up (Latour, 1986; Solli et al., 2005), despite their previous experiences of change projects (Sahlin & Wedlin, 2008).

Looking at the process of introducing VBHC through the lens of translation we found some interesting moments. Considering a starting point with the appointment of a new hospital director, there was a period before work with VBHC began, a phase when the new director was attracting allies and pushing to increase interest for VBHC (Callon, 1986). Many respondents found the meetings to decide hospital core values to be an important first part, despite not being a part of the formal VBHC introduction. The new core values put focus on the patient and with this, personnel within the hospital could identify with the new VBHC concept and consider it a valuable part of a patient focused healthcare (Solli et al., 2005). The initial allies included staff and management at the hospital as well as a consulting firm to support VBHC introduction at the hospital. Gathering from our interviews a tool used to unite allies was the patient, and discussions on how value was generated for the patient, and this

was adapted into using a scorecard as a tool to track patient outcomes and experiences. Provided patient opinion on the healthcare became a focal point of the change project, something which acted to mobilize actors involved and made change acceptable to the healthcare professionals (Callon, 1986).

With the construction of reference teams consisting of actors spread across different hospital functions, the idea spreads to other wards not currently working with VBHC and gives them some insight into the practices of each other, which can spawn the desire to imitate and start their own VBHC change processes (Solli et al., 2005). As the project progressed in stages with VBHC projects starting in new patient groups every year, numerous new allies had to be enroled in order to continue to spread the VBHC concept throughout the organization, while others were disenrolled (Callon, 1986). The consultants are an example of allies that had an important role in the early stages of the VBHC introduction. Partway into the process they made way for the local project office in order for the hospital to maintain their own knowledge of the concept and be able to sustain the lengthy and complicated process of spreading VBHC throughout the organization. With more professionals in the organization interested in VBHC, and a limited amount of support available to those looking to introduce the concept. Some desired the VBHC enough to introduce it themselves without the help of consultants or the project office but using the hospital model for the process, thus finding alternate ways of achieving change but still committing to the VBHC identity of the hospital (Solli et al., 2005). To this patient group their translation of VBHC meant that transforming themselves was urgent enough to not await further resources but rather start enrolling their own allies (Czarniawska & Sevón, 2005; Callon, 1986).

This was one of several examples of patient value and VBHC becoming associated with changes in process, and when it started to affect how the patient is being treated, the gathered allies started having differing opinions about how to go about things. Some wholeheartedly accepted the model constructed by management and consultants, others spoke out against it, finding flaws or even abandoning the practices tied to the VBHC model. These differing opinions can be attributed to the previous experiences of change projects within the hospital (Sahlin & Wedlin, 2008). Some professionals felt uncomfortable when having to question their existing practices for treating patients and were not ready give power to patients and become followers of the VBHC concept and the identity it represented to them (Latour, 1986; Solli et al. 2005). Furthermore, becoming followers of the VBHC concept and involving the patient, created a sense of losing their authority, being the one with the upper-hand (Brante, 2014).

In the case of introducing a new concept and for the concept to be accepted, the actors involved in the introduction of VBHC are very important (Porter & Teisberg, 2007; Wallin et al., 2006; Grol et al., 2005). The majority of the respondents were positive to the structuring of the process for introducing VBHC at the patient group, however a few clinicians found the model to be rigid and lacking applicability within their group of patients. It is of great

importance to include medical professionals when attempting to innovate within healthcare organizations (Øvretveit et al., 2012), but our respondents expressed problems when physicians attempted to make sense of the hospital's VBHC model. On the other hand, those with administrative experience in working with change projects were consistently more excited to be working with the model and expressed no problems related to adapting the model to the contexts of the different patient groups (Sahlin & Wedlin, 2008). As such, the hospital's rule of having medical professionals as project leaders is in line with previous research (Øvretveit et al., 2012) in the field. However, our study shows it is paradoxical in terms of achieving change as they showed the most difficulty with applying the model within their context, and became reliant on other actors with the experience to be able to translate the VBHC idea to a transformation of identity and practices (Erlingsdóttir & Lindberg, 2005; Solli et al. 2005). As stated by one of the respondents, having the first line boss being part of the introduction process from the beginning is one of the most important lessons their project team learned from their VBHC process. This is because the first-line boss is perceived as an important ally to get the concept accepted and prioritized with resources within the larger context of the organization (Callon, 1986). Additionally, a respondent expressed the importance for the first line boss to understand the concept in order to be part of the change process. Thus, there is no reason for a first line boss to support VBHC if the first line boss does not understand their role in the process or why it is important, which is in line with Lindgren et al. (2013).

Furthermore, as veteran professionals have experienced many failures of numerous introduced management models, it is important for management not to offend medical professionals by stepping on anyone's toes. When stepping on someone's toes, there is a feeling of disrespect and which could lead to actors rejecting the VBHC concept (Solli et al., 2005). Hence, it is very important for all actors to work towards the same goal together, in contrast to feeling that the medical professionals work towards one goal and management towards another, similar to Llewellyn (2011) and Arman et al. (2014). As presented above, one respondent would have liked to been included properly in the introduction process, instead of just being told what to do from management when having 30 years experience of taking care of patients on day-to-day basis. If a professional feels disrespected, that could affect the VBHC introduction process. Therefore, it is important to remember that medical professionals might have a different insight and ideas when contextualizing the concept to the patient group. On the other hand, other respondents had no problem being included in the process without giving their feedback. These problems highlight the importance of mobilizing actors with differing experiences in the change process in order to achieve change (Callon, 1986; Sahlin & Wedlin, 2008), in line with previous studies about including medical professionals (Øvretveit et al., 2012).

Results of translating VBHC

There are many different meanings and understandings of VBHC. Including the hospital's own modeling of VBHC, and then of course different interpretations in every hospital

claiming to practice VBHC, as well as different interpretations within the different patient group contexts at the hospital (Erlingsdóttir & Lindberg, 2005; Sahlin & Wedlin, 2008). There is not just one way of working with VBHC, and Porter and Teisberg's (2004) idea has travelled the world and taken different shapes. The medical professionals are the people who understand their working situation, and can use the ideas from VBHC to change and improve healthcare in the ways they deem necessary to accomplish the basic goal of VBHC as described by the consultants: providing the maximum value for the patient with the available resources. At the hospital however, both the project office and the consultancy firm agreed that the name of the concept is not an essential part. Instead, it is more important that the followers understand the goals of the changes rather than being able to define VBHC. However, VBHC was something everyone could relate to (Solli, et al., 2005), and yet depending on the type of patients and the role of the respondent the concept was connected to different kinds of practices (Erlingsdóttir & Lindberg, 2005). Even though all the patient groups go through the same introduction process the concept travels within different contexts, different patients and different pre-conditions, and thus concept is designed a little differently at each patient group (Sahlin & Wedlin, 2008). All of the patient groups share the practice of using, or at least designing, a scorecard and every patient group measure and track what they think is important for them, and this can differ a lot between groups. Despite downplaying its importance for the change effort, the hospital has kept the name VBHC, and continuously evolved its own interpretation and model of VBHC. In line with the study by Andersson et al. (2015), the hospital has chosen to interpret the meaning of VBHC differently from the theory originated from Porter and Teisberg (2004). This has been the source of confusion among employees as some of them turned to the source Porter and Teisberg to understand the VBHC concept, while the project office has distanced their model from the source by adapting the concept to fit the hospital context (Solli et al., 2005; Porter & Lee, 2013). One respondent highlighted the issue by wishing for a short education of the hospital's VBHC concept before the introduction process, as the respondent found that the VBHC concept presented by Porter did not match up with the practical changes happening as part of the hospital framework. Theses issues can occur when adapting the model while still keeping the name. As any actor exposed to the model, without thorough knowledge of the adaptation will have a hard time separating the name from the new identity the concept has taken in context the hospital (ibid). Thus, some respondents expressed scepticism towards the name VBHC even if they enjoyed the new way of working.

All respondents reflected on one shared problem, often described as the main problem, the patient groups have all struggled with IT and their systems in terms of being able to retrieve the necessary data to measure the desired outcomes. Their systems were not working with the hospital's conceptualization of VBHC, using data and scorecard to measure and analyze patient outcomes. The IT actor needs to work together with other actors in order for the VBHC practices to be taken for granted and successfully black-boxed (Law, 1992). In this situation the actor referred to as IT is not being able to fulfill its role within the network which cause the need for additional actors to be enrolled to make up the flaws in the network

(Callon, 1986). In order to make up for the problems of retrieving relevant data, a number of different administrative personnel had to put in extra work to make up for the lack of usable data that is not being automatically retrieved from the different IT systems to the scorecards. This amount of extra work caused friction within a few of the groups after starting the VBHC process, which in turn led to one group abandoning the scorecard as a tool for tracking patient value altogether. Other groups continued to struggle with their scorecards and in order to support them, enrollment of IT support staff to deal with the recurring problems related to the hospital IT systems was necessary (Callon, 1986). As such, when IT systems stop the scorecard from being made in the desired form, by not having access to the relevant data or not being able to gather it in the first place, it loses value as a tool for tracking patient value. This was demonstrated by the patient group that completely abandoned the scorecard and the hospital's model of VBHC and instead focused on using other forms of data-tracking, which still focused on patient feedback and working towards an improved patient experience. This is an interesting example of when a patient group reject the VBHC name and the associated identity (Solli et al., 2005) while still taking to heart some practices of VBHC such as patient inclusion and continuous improvement and even comparing themselves to Porter's model of VBHC (Erlingsdóttir & Lindberg, 2005). The overarching change accomplished across all groups, which every professional embraced, was the very nature of how they discuss healthcare. Which has changed to focus almost entirely on the patient's opinions and how to maximize patient value. This was lifted by respondents as the very core of VBHC and the one thing every respondent agreed upon being of great importance and is the core of change that survived through all the different circumstances of different patient groups, something which transformed all actors as they translated VBHC (Czarniawska & Sevon, 2005). This outcome is interesting as the hospital model focused on defining patient value measurements based on outcomes and patient experience. When the IT actor betrays the others by not fulfilling its intended role, the professionals shift focus toward the patient in other ways. This patient focus, expressed by consultants and the project support office as the important VBHC core continues to spread despite being translated into different contexts (Latour, 1986; Czarniawska & Sevón, 2005). These practices of involving the patient of VBHC is the closest thing to having been taken for granted as a natural part of work and potentially become black-boxed (Latour, 1986).

The changing role of the professionals and patients

In order to be able to answer our second questions, we need to understand the history of healthcare professionals as a group and how these roles are affected by the introduction of VBHC. By looking at the previous studies within the field and connect them to our findings at the hospital, we attempt to present a picture of how this relationship has been transformed by the introduction of VBHC (Czarniawska & Sevón, 2005). Healthcare has been going through a lot of changes over the past few decades (Terry et al., 2014). Just as the role of professionals have been affected by a shift in society and other types of management concepts (Scott, 2000). Introducing VBHC at the hospital has changed the role of the medical professionals (Brante, 2014; Sehested, 2002). Furthermore, as the role of the patient has changed

(McMullan, 2006) the relationship between the medical professionals and the patient, as well as the relationship between the professionals has been affected. As presented, the professionals have been used to only being responsible for their own field of expertise. With the introduction of VBHC, and the identity it represents, this has transformed practices and professional collaboration in order to make the experience better and more efficient for the patient (Solli et al., 2005; Czarniawska & Sevón, 2005). For a couple of patient groups, the medical professionals have embraced the VBHC identity and continued to find other improvements for the patient group. The goal with VBHC at the hospital, as expressed by some respondents, is to have continuous improvement projects based on patient feedback, and use these for processes to let the concept evolve within the organization, which is in line with the study by Øvretveit et al. (2012) and Barnett et al. (2011). As presented in the findings, the professionals always had value for the patient in mind. However, the medical professionals received a new perspective on the importance of including the patient and appreciation of how a small change as asking the patient completely changed their thoughts on VBHC and their everyday practices. Additionally, if professionals continue to assume what the patient wants and prioritizes the quality of healthcare will not get better, hence the importance of asking the patient, in line with Zucca et al. (2016). As expressed by respondents, medical professionals have had a history of only perceiving medical factors as important, e.g that the operation went as planned, not including factors as such e.g. feeling safe and recovery time. Though, after introducing the involvement of the patient and the scorecard, the medical professionals explain that they have become more humble to new perspectives of what factors affect the quality of healthcare from a patient's perspective (Czarniawska & Sevon, 2005). Thus, with the present awareness regarding the importance of including the patient it would be strange, and also unethical, to not ask patients for their feedback. With the adoption of VBHC professionals have undergone a transformation of mindset and changed their practices, it becomes hard to relate to a previous identity and old practices, which one respondent explains as a natural part of the healthcare industry evolving (Czarniawska & Sevon, 2005; Solli, 2005).

With professionals translating VBHC to their contexts, they have transformed their way of working and mobilizing around the patient in new ways, such as doing meetings together to save the patient's time (Callon, 1986; Czarniawska & Sevón, 2005). This adaptation by the medical professionals to meet patient needs reflects a change in the power dynamic where the professionals transform to become followers of the patient (Latour, 1986; Czarniawska & Sevón, 2005). However, this new level of involvement puts pressure on the patient as well. Rather than merely receiving treatment, the patient now has expectations from other actors to take an active role in analyzing and sharing their own healthcare experience. When patients did share their thoughts, respondents expressed surprise at how much it deviated from the assumptions professionals had made previously, and many rejoiced in learning more about how to improve patient care from patients. The respondents explained how the patient's interests have always been important in healthcare, but how their perception of how to have the patient involved had changed when starting to ask the patient, in line with Zucca et al.

(2016). Because, while the idea of doing what is best for the patient was obvious, the practice of listening to what truly mattered to patients transformed this perceived obvious knowledge into entirely new ways of thinking among the professionals (Czarniawska & Joerges, 1996).

With the patient involvement becoming part of standard practices within the patient groups, several respondents reflected on previous practices. On how they had transformed with the introduction of VBHC and how they no longer could relate to older practices (Czarniawska & Sevón, 2005). In a sense, by participating in the VBHC process they start to reject their old identity (Solli et al., 2005). However, not every patient wished to take on the role of sharing experiences and working to improve healthcare practices. This meant some patient groups struggled for patient involvement in reference teams and had to adapt to the situation which translated to solutions such as patient surveys or enrolling other actors to represent patients (Callon, 1986). Interestingly, despite respondents highlighting the importance of patient inclusion and opinion, two groups struggled greatly with special patient circumstances. These issues stopped them from gaining patient involvement with their change process, yet they still claim being part of VBHC at the hospital, despite being abandoned by patients in their change process and thus not being able to include them (Erlingsdóttir & Lindberg, 2005).

As a result of all these processes, patients have gained a larger role in affecting healthcare practices within these different patient groups at the hospital. As a consequence, the introduction of VBHC appears to have been an important part of uniting medical professionals and inviting the pat(Callon, 1986; Czarniawska & Sevón, 2005)ient to join in the process of improving healthcare. However, as one respondent state, due constant changes in healthcare and introduction of patient involvement would have happen either way, meaning with the introduction of VBHC or not. The concept of VBHC have contributed to patients for the first time getting asked for feedback (Zucca et al., 2016) and patients being more involved in healthcare. A change such as this one could be part of a bigger shift happening in society (Scott, 2000). Due to changes in society, such as new management concepts becoming fashionable or Internet leading to patient becoming more of an active patient, as the patient is able to search online and to some extent diagnose themselves(Czarniawska & Sevón, 2005; McMullan, 2006). That leads to pressure on the patient to ensure the quality of their own healthcare (McMullan, 2006). Hence, bigger changes in healthcare and society leads to organizations translating concepts to fit their own organization, in line with Czarniawska and Sevón (2005).

Conclusion and implications

In order to explain how the VBHC introduction process has unfolded within the hospital, we have looked at how the very concept of VBHC has been translated into new practices within the different patient groups. With the hospital deciding to create its own model for how to conduct the VBHC process they acquired help by recruiting allies in the form of consultants which helped create a method for how to track patient value through a scorecard. This method

for tracking value was adopted by the hospital and translated to fit different patient group contexts by the VBHC project support office and the various professionals of the patient groups. Despite the hospital's transformation of the concept, the name VBHC was kept which did cause confusion among the professionals, as the name was associated with an identity which some wanted to reject regardless of feelings toward the new practices associated with the hospital's VBHC model. The local contexts of the patient groups, and these different circumstances caused patient groups to translate VBHC differently and this caused the VBHC practices themselves to vary. This was partly due to problems with IT systems, which caused patient groups to make different adaptations to the concept, ranging from manually filling in scorecards to abandoning them altogether. Another reason for different practices was related to the ability of enrolling patients in the change process. Different patient groups had different circumstances and in order to fulfill the goal of patient involvement, some had to innovate ways to involve patients such as surveys or alternate representatives. The core of VBHC that remained through all translations was the focus on patient value. This affected the mindset and discussions among all the patient groups, and was highlighted as the important part of VBHC by all respondents.

With the patient becoming the focal point of change at the hospital, our study has looked at how the roles of the medical professionals and patients have evolved through the introduction of VBHC. A hospital has numerous of different professionals involved when treating patients and as shown in previous studies, these different professionals tend to desire autonomy and thus challenge initiatives from management within healthcare organizations. These circumstances adds a layer of complexity to the translation process of VBHC at the hospital. However, by asking the patient to be more involved in their healthcare and share their experiences and opinions, VBHC changed the role of the patient from a passive actor receiving healthcare, to an actor which has some power to change healthcare practices. Using the patient in this way appears to have been an effective way of unifying professionals, as they shared an interest in what the patient had to say in regards to their work. The information provided by patients triggered new mobilizations of professionals from different fields such as medical doctors and surgeons meeting the patient together, both to save time and make sure there would be less communication errors between the units. In this sense the professionals translating VBHC caused them to transform their practices to change the patient experience, meanwhile reflecting on how they did not consider listening to the patient earlier. Additionally, by changing practices and listening to the patient perspective, there was a change of mindset among the professionals and which made them more alert to medical and non-medical factors affecting the quality of care, both from a medical point of view as well as from the patient's point of view. Thus, we can conclude that the introduction of VBHC at the hospital has had an effect on professional practices and the relationships between professionals and patients as well as the relationships between professionals as they mobilize themselves around the patient.

This study, while limited to one hospital and a smaller number of respondents, has started to fill in the gap of research regarding VBHC change processes expressed by Andersson et al. (2015), but further research is necessary in order to improve our understanding of the VBHC concept in practice. Larger studies are necessary in order to be able to do international comparative studies which can show VBHC transformation in different contexts, including political influences, payment models, as well as types of diseases. Furthermore, our study indicates that VBHC has been able to affect the practices of healthcare professionals, but comparisons of practices between healthcare organizations that have adopted VBHC and health organizations that have not could provide further insights as to how much the concept manages to affect change of healthcare practices. In more general terms of change efforts in healthcare organizations it is interesting how this study indicates an uncommon willingness for professionals, compared to previous studies (Hallin & Siverbo, 2003; Berlin & Kastberg, 2011; Arman et al., 2014), to embrace change initiatives that put emphasis on the patient and this could be valuable to explore further, both for managers in healthcare organizations and future research.

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