

„A coherent concept for systematic transfer“

In the double cover interview: Prof Josef Hecken, G-BA, and Prof Wolfgang Hoffmann, DNVF.

"This is the only way we can create the necessary evidence that is urgently needed for any kind of improvement to the system" (Hoffmann). "Transfer must not just depend on the goodwill of those involved" (Hecken). In the MVF double cover interview, Prof Josef Hecken, the impartial chairman of the Federal Joint Committee (G-BA), and Prof Wolfgang Hoffmann, Chairman of the German Network for Health Services Research (DNVF), discuss ideas for the further development of the Innovation Fund. The discussion focuses on a contracting obligation, possible interim analyses and an implementation obligation for the health insurance funds involved in the project in the event of a positive transfer recommendation.

>> Dear Professors, would you agree with the thesis that the Innovation Fund is an outstanding instrument for the further development of healthcare in Germany? Yes or no?

„The decisive point for me is whether the quantity of the funded projects corresponds to the outcome."
Prof. Josef Hecken, G-BA

Hecken: In principle, the Innovation Fund is a good instrument. I personally fought for this fund to exist in the first place. We need an experimental area in order to improve the rather sluggish healthcare system from small to large and from the bottom up. Gradually, more and more good ideas that have been researched or tested can be put into practice. Of course, there is still room for optimisation in the innovation fund, but the political decision to make the fund permanent is the right one - despite, or rather because of, the current pressing financial difficulties. If we want structural changes and, above all, efficiency- and quality-enhancing improvements in the healthcare system, then we urgently need this testing platform.

Hoffmann: The Innovation Fund is a very important instrument for the further development of healthcare in Germany - and currently also the only one with the possibility of developing and evaluating new forms of care across sectors in cooperation with many players in the healthcare system. This is the only way we can create the necessary evidence that is urgently needed for any kind of improvement to the system. There are currently no other significant funding systems for this, neither in terms of cross-sectoral improvement nor for projects of the size required for the new forms of care . There are also other funding pools for healthcare research, but neither at EU nor national level - for example through the DFG - can projects be funded to the extent necessary to develop, implement and evaluate new healthcare models. In this respect, the Innovation Fund has an important unique position. However, the question is - and we will certainly discuss this together - whether the Innovation Fund can fully fulfil these principles and the expectations placed in it in its current form.

Let's start with that: Is the Innovation Fund really outstanding so far in terms of the number of projects applied for and implemented in the meantime? And above all, has it made the leap from quantity to quality?

Hecken: I can emphatically say yes to that. If you analyse the 347 decisions made by the Innovation Committee on completed projects since December 2020, you can see that 97 requests to review the project results in healthcare or recommendations for testing as a new form of care, or NPF for short, were made - that's 27.9%, or almost a third. Of these, 50 projects came from the health services research funding part, 26 from the NVF funding part and a further 21 from the medical guidelines funding package. In addition to the 97 resolutions mentioned above, there were a further 120 resolutions (34.6%) whose results were forwarded for information purposes - 92 came from health services research and 28 from the NVF. And finally, there were 130 decisions - 75 from health services research and 55 from the NVF - for which no recommendation could be made. But the system even learns from these projects. This is because it then becomes clear that a sufficiently well-founded and plausible hypothesis did not stand up to rigorous evidence-based scrutiny after all.

Is there still sufficient interest in the Innovation Fund?

Hecken: There is still a lot of interest. We could now support many more projects, but of course we only have limited funds available. With the legislator's decision to stabilise the Innovation Fund in 2024, it has also reduced the annual funding volume. As a result of this and the increasing number of applications, the probability of applicants receiving a positive funding decision has fallen significantly over the years. We are now seeing a factor of 1 in 5 or even 1 in 10 of the applications that are ultimately funded. This puts the Innovation Fund on a par with the German Research Foundation. The crucial point for me, however, is whether the quantity of funded projects corresponds to the outcome.

The question is whether there is an appropriate relationship between the funds invested and the potential benefit of implementing improved cross-sectoral care structures.

Hecken: I still remember very well that I said at the launch of the Innovation Fund that we would be happy if we succeeded in transferring 30 per cent of the funded projects into large selective contracts or standard care. At the moment, we are very close to this goal: around 27 per cent of the projects we are funding are currently being implemented in one form or another. These are projects in which indications of improvements in care have been evaluated and we have been able to pass on this added value to various addressees with the request to establish it or at least as information. Of these recommendations for implementation, 21 percent went to the Association of Scientific Medical Societies and medical societies, 15 percent to the Federal Ministry of Health and subordinate authorities, 14 percent to the Federal Joint Committee (G-BA) and 13 percent to the G-BA's supporting organisations. If we exclude the guidelines here, as the updates to a guideline are usually implemented, we are still at 22 per cent of projects that have led to good findings and have therefore been forwarded to various stakeholders for implementation. They represent real progress because they enable improvements in care to be implemented.

The only pity is that there has not yet been a single New Forms of Care project that has been adopted one-to-one into standard care.

The only one where this would have been possible had to be terminated because the stated benefits were not as high as originally assumed due to incorrect data analyses.

Hecken: Yes, that was highly regrettable, the project was about sports therapy for mild to moderate depression. But we are not discouraged by this experience, because there are a whole series of funded projects that lead to improvements in care. In the area of new forms of care, for example, we have the CCC-Integrativ project, which has established and investigated evidence-based counselling for cancer patients in the field of complementary medicine and care. The information and training materials developed in the programme are now offered by all health insurance funds throughout Germany. The ZSE-DUO project focused on rare diseases and tested a dual pilot structure - consisting of a somatic and a psychiatric or psychosomatic specialist - at centres. These pilots accompany the patient during the clarification of the illness. In this way, a final diagnosis could be made for significantly more patients after twelve months at the latest. Today, there are already selective contracts, including with the University of Würzburg, which have adopted this structure. A third example: In Berlin, there is a selective contract between the Vivantes clinics and AOK Nordost, which goes back to the Cardiolotse project. The pilot model developed in the funding project helps people with heart disease to find suitable outpatient care after hospitalisation. These are all projects supported by the Innovation Fund, which show us that we are on the right track. And we should not forget that many funded projects initially had to contend with all kinds of difficulties and unforeseen circumstances, triggered above all by the coronavirus pandemic. The consequences of corona completely cancelled out many recruitment plans in the first funding phase, when the larger innovation projects got underway. It took a great deal of spiritual strength on the part of the consortium leaders and partners to persevere.

Hoffmann (laughs): Supply researchers have plenty of spiritual strength, which is a key resilience factor for us. But we also need it, because the healthcare system in which we are active - not only in the context of the Innovation Fund - is not exactly the most willing to change. Nevertheless, I would like to put the above-mentioned percentage figures into a wider context: It is good and right that the project results are scrutinised to see whether the results generated should be transferred to standard care in some form. However, if this subsequently happens only cautiously or not at all, this is not the fault of the Innovation Fund or the Innovation Committee, nor is it the fault of healthcare research. Rather, the reason for the lack of transfer lies in the fact that the Innovation Fund was not politically designed sufficiently for the actual transfer to real care. As a result, many of the projects with a positive transfer recommendation nevertheless end up in nirvana. Our network analysed this in a paper in 2024 (1): The institutions and stakeholders that the Innovation Committee wrote to about a positive transfer recommendation generally did nothing - many did not even respond.

„It is of little use to send out letters with recommendations when the innovation committee makes positive decisions as long as politicians do not introduce a commitment to responsibility.“
Prof. Dr. Wolfgang Hoffmann, DNVF

Why is that?

Hoffmann: In the existing legal framework of our healthcare system, for example, it is not possible for individual key players, such as medical associations or large research institutes, to change healthcare provision on their own. For this reason, all stakeholders - even those who are passionate about their work - and therefore also the Innovation Fund, repeatedly reach a point where they themselves cannot make any progress, but no one else is taking action either. It is of little use to send out letters with recommendations when the Innovation Committee makes positive decisions as long as politicians do not introduce a commitment to responsibility. We need a binding procedure for how successfully evaluated new forms of care that have received a transfer recommendation from the Innovation Committee can be implemented in real care. Such procedures exist for medicines and medical devices, but not yet for new forms of care.

That seems to be the main problem with the lack of transfer.

Hoffmann: In addition, expectations of the innovation fund are somewhat exaggerated. There are research and funding institutions in other areas with annual budgets of many millions or even billions of euros. I would like to analyse what they have achieved in terms of transfer so far. The fact that we are talking so emphatically about transfer and translation in the Innovation Fund is a major step forward in health research with its own value. If you look at the figures just mentioned by Mr Hecken, there is at least the real possibility of transfer with the Innovation Fund. Let's be honest: beyond the Innovation Fund, we don't do any structured transfer in health research in Germany. How much actually ends up in healthcare has so far played no significant role in how much budget university and non-university research institutions receive. For decades, hardly anyone in our country has been interested in the consistent, evidence-based further development of the healthcare system. Simply because the pipeline 'recognised problem in care - scientific development and testing of solutions - testing of solutions in care - binding introduction of the best solutions' simply has no tradition in this country. The Innovation Fund addresses this pipeline and is therefore an absolute pioneer.

What specific lessons have you learnt from this for the further development of the Innovation Fund? What needs to be done to further improve the transfer of both the new forms of healthcare and healthcare research projects?

Hoffmann: We need to think together about which adjustments need to be made and how, in order to get the findings that have been found to be good into widespread care. This is still being discussed far too little. And at the same time, after a new form of care has been tried and tested for a certain period of time, we must abolish the inferior old form of care. Such a mechanism is not even being considered in the German healthcare system. In fact, care innovations are always introduced in addition. This has consequences: Because the inferior form of care remains in operation at the same time, some health insurance companies in particular are extremely sceptical about innovations. In their perception, these almost always lead to addi-

tional costs. This is one reason why health insurance companies often put both feet on the brakes when it comes to transfers. The half-baked mechanism ultimately makes our healthcare system more expensive - that's an argument I can certainly understand. In the end, this wash-me-but-don't-make-me-wet approach hinders important innovations in the healthcare system. However, this is not specific to the Innovation Fund, but can unfortunately be seen everywhere.

Hecken: I wouldn't generalise like that. There are already examples in which forms of care or auxiliary and medicinal products are excluded from the care system. The crucial question, on which we are in absolute agreement, is: How can we make the innovation fund more binding? And in such a way that the results of well-evaluated and positively approved projects are actually implemented in the end for the benefit of as many patients as possible. This also means that transfer must not just depend on the goodwill of those involved. Incidentally, I am involved in a very constructive exchange with various political players in ministries and in parliament, who have of course recognised the weakness for some time. For example, we are discussing how a higher degree of commitment can be implemented with the promise of financial support.

What level of commitment do you have in mind?

Hecken: We are talking here about ideas for an Innovation Fund 2.0 and therefore about a possible and, in my view, desirable further development. Specifically, I see these points: Firstly, if one or more health insurance funds participate as consortium partners in a New Forms of Care project, I expect them to promise that they will continue this project, at least with a large selective contract, if the evaluation and decision are positive. On the one hand, this would prevent health insurance funds from only getting involved in projects because there is money from the innovation fund, and on the other hand, it would lead to an increase in quality and sustainability in terms of transfer. This is the direction we must go in, even if this reduces the total number of applications somewhat. This would also reduce project funding where it is clear to all applicants in advance that they do not want to realise the project later - regardless of the outcome. Such an obligation on the project partners to include demonstrably positive results in contracts is, in my view, a very important step towards ensuring greater motivation for transfer.



Prof. Josef Hecken

has been the impartial Chairman of the Federal Joint Committee since July 2012 and Chairman of the Innovation Committee, which is part of the Federal Joint Committee, since October 2015. He was also awarded the title of professor by the Saarland government in 2015 in recognition of his achievements in science and research. Since 2018, he has held teaching positions at Leibniz University Hanover and the Medical Faculty of Heidelberg and is a lecturer in the Master's degree programme in Pharmaceutical Law at the Faculty of Law at the University of Marburg. Before his appointment as impartial chairman of the G-BA, Hecken was, among other things, President of the Federal Insurance Office (2008-2009), Minister of Justice, Health and Social Affairs of the Saarland (2004-2008) and, from 2008, also Minister of Labour and, at the same time, Chairman of the Health Committee and Deputy Chairman of the Legal Committee of the Bundesrat.

Point 1 points to a second one.

Hecken: Secondly, we need to start thinking about transfer much earlier. That's why another idea that I'm currently discussing with politicians at various levels is to produce an interim report halfway through the project that not only asks about the outflow of funds and the recruitment status, but also analyses whether factors are emerging that indicate that the project is progressing positively. At this point at the latest, an expert must be involved with the project in an institutionalised capacity as a kind of transfer mentor. At this early stage, he or she would have to determine at the important levels of influence what might stand in the way of a later transfer or what needs to be done, for example, to enable an EBM code for standard care or a selective contract following the project. This also requires that in future it is described much more intensively and better - to some extent already in the applications, but especially in the evaluation reports - how the possible project results can ultimately be realised in the reality of care. Irrespective of this, we must of course also check more closely when approving applications whether the statements made there on the usability and transfer of the project results are realistic.

What exactly is a transfer counsellor or pilot supposed to do?

Hecken: I certainly don't want to create a new profession of - to put it provocatively - project counsellor or even project mentor. I envisage a person with an institutionalised function, i.e. a general mandate, who exclusively takes care of transfers across all projects in a highly professional manner. And at a very early stage. Because if this important work only starts when the evaluation and final report is submitted and we make a transfer recommendation, it's too late.

Hoffmann: I absolutely agree with the proposal that it should be stipulated at the beginning of a project involving health insurance funds that positively evaluated results will be continued after the end of the project - for example in the form of a subsequent se-

lective contract. For me, this would be an important change that would lead to more successful transfers. However, I am a little sceptical about the interim analysis you mentioned. Some principles of good scientific practice have long explicitly included a ban on interim analyses. This is not to say that interim analyses are not possible in principle, but that they must be approached with all due caution. We should give further thought to the possible form and design of interim analyses, for which the German Network for Health Services Research is happy to help.

„We need a coherent concept if we really want to systematically anchor transfer."
Prof. Josef Hecken, G-BA

What do you think of the function of a transfer counsellor?

Hoffmann: As long as it is located at a higher level and not assigned to a project itself, this is a tried and tested approach. However, the person who is able to fulfil such an important function must be very well networked and be familiar with legal and selective contract issues as well as cross-sector structures - it's certainly not easy to find them. However, if a group of competent people with legal and health economics qualifications and relevant experience is established, it will be an asset, so that the uncertain transition period after the end of the project, which is dangerous for the transfer, can be shortened

Hecken: I understand the elements I just mentioned to be quite explicitly cumulative. We need a coherent concept if we really want to systematically anchor transfer. This will probably meet with very little approval in our federal system with its distributed competences and responsibilities. But it would be necessary. And we also need to think about legal supervision.

What exactly do you mean?

Hecken: Let's stick to the issue of obliging a health insurance fund to conclude a corresponding selective contract following a positive project decision. In this case, the audit competence of the Federal Social Security Office, which is responsible for the legal supervision of the 63 federally funded health insurance funds, must cease. It is not acceptable for us to oblige a health insurance fund to conclude a selective contract on the basis of certain model components that are then rejected by the supervisory authority because the economic viability of each contract must be proven after two years. This would be throwing out the proverbial baby with the bathwater. However, politicians are still very reluctant to address this issue.

Hoffmann: Such institutional obstacles must be identified and removed. I would like to emphasise that explicitly here: We healthcare researchers don't do our work for the fun or pleasure of pure science, but because we want to use our expertise to improve the healthcare system to a certain extent where it doesn't work so well. That's what sets us apart from some scientists in other disciplines! We could be much further ahead with all our knowledge if we had fewer innovation-inhibiting mechanisms in Germany. Of course, there is a very important body called the G-BA, but in my opinion it is primarily responsible for the negotiation process between the interests of the self-governing partners. The G-BA is not primarily responsible for innovation, even if the one or other innovation sometimes gets through. The reason for this is that each of the benches active in the G-BA can prevent any innovation on its own, and this is usually the case.

Hecken: I have to clearly disagree with that, Mr Hoffmann. Under my leadership, for example, the G-BA has carried out over 1,000 benefit assessments for medicinal products, where it was first checked whether they were really innovative and not just new. And in no way is it about preventing availability on the German market, but about fair prices. What's not innovative about that? And to make this clear as well: A single bank cannot prevent a decision, at least 7 of the 13 votes in the G-BA are required to do so.

Let's come back to the innovation fund. You are proposing interim analyses and greater liability for participating health insurance funds. And then? Everything as before according to the good old principle of hope?

Hoffmann: The principle of hope is not enough, as we have all seen long enough. Let's start with the issue of a higher obligation for participating health insurance funds to conclude selective contracts after a positive project conclusion. The following is conceivable, and we have already discussed this in the BMG: If a certain proportion of patients in a region are insured by the health insurance funds participating in a project for new forms of care, the other health insurance funds operating in this region must also participate. This is where the nasty word 'compulsory contracting' comes into play. It could be formulated in a friendlier way: The collective agreement must always take effect if there is a large enough minority that can benefit from something really demonstrably better.

How big should this minority be?

Hoffmann: In my opinion, the rate should be set at 25 per cent. The percentage can certainly be discussed, but it won't make sense to set it at 75 or even 95 per cent. What is more important is that health insurance funds can no longer use selective contracts primarily as an element of competition on the basis of such a regulation. Withholding proven effective innovations from other patients for competitive reasons is simply an abuse of evidence. We must work together to convince the health insurance funds that the evidence generated by the innovation fund - often with their own active involvement - helps them to provide better and more efficient care to their policyholders and thus ultimately also save costs.

Hecken: In many cases, selective contracts are the only way to implement structural changes in our healthcare system relatively quickly. Let's take the example of sports therapy for mild and moderate depression that you mentioned earlier. This was a new treatment method that the G-BA could have introduced via its guidelines as part of its mandate. Everything else must be laid down in guidelines or agreed in structural contracts between health insurance funds and service providers. This is because the G-BA cannot regulate treatment procedures. That is why this constant criticism that the G-BA should

organise care differently is completely out of place.

Back to the 'obligation to contract'.

Hedges: The moment all health insurance funds have to participate in a contract, you have to create the appropriate EBM numbers. However, this also means that the financial expenses that the health insurance funds initially involved in a contract have shouldered must be socialised in a suitable form. In other words, all health insurance funds that are forced to participate must then contribute to the initial costs according to their patient clientele. However, the basis would first have to be regulated by the legislator.

Hoffmann: We also need to talk about the underdeveloped culture of innovation in Germany. It is very often due to individual interests that something innovative is not implemented, even if it is three times evidence-based and absolutely clinically significant. The G-BA cannot change this either, because this behaviour is inherent in the system for many stakeholders. This can only be changed by the legislator, who should stipulate that such important transfer decisions should no longer require the consensus of all those involved, because such consensus is rare. Each of the stakeholders involved always has a major or minor advantage or disadvantage at some point - and because this is the case, there are so few positive decisions. In order to get out of this decision-making trap, we need an overarching control function that initiates the necessary legislative changes at federal level at an early stage and forces the partners in self-administration to introduce a demonstrably better procedure and abolish the inferior procedure after a certain waiting period.

Hecken: Incidentally, this is precisely why the thirteenth vote of the impartial chairman exists, which ultimately decides in the G-BA in the event of a stalemate whether, for example, new treatment methods are introduced on an outpatient basis or not. In the case of the Innovation Fund, we are in a situation - and I say this now without violating any internal company or business secrets - where 98 per cent of the transfer recommendations were made unanimously. This should not give the impression that the representatives of the health insurance funds are preventing innovation.



Prof. Dr. med. Wolfgang Hoffmann MPH *has been Managing Director of the Institute of Community Medicine since 2007 and has held the W3 professorship for Population-based Healthcare Epidemiology and Community Health at Greifswald University Medicine since December 2011. Since 12/2012, he has been the spokesperson for the Rostock/Greifswald partner centre of the German Centre for Neurodegenerative Diseases (DZNE). Since 04/2017, he has been Head of the Central Office of the Mecklenburg-Vorpommern Cancer Registry. Hoffmann was elected Deputy Chairman of the DNVF in May 2018 and Chairman in October 2022.*

Could we go back for a moment: What are other hurdles that have so far prevented positively approved projects from actually making it into standard care?

Hecken: The main reason is the lack of commitment. The innovation fund is based on the assumption of a 'do-gooder'. However, this only works when it comes to really fundamental improvements, the evidence for which cannot be discussed at all. Unfortunately, these are very rare because life usually takes place in shades of grey. This explains why many decision-makers, who could have taken up our recommendations with great enthusiasm, do not do so for a variety of reasons: either because it costs money or because they shy away from new ideas.

That's a very thick board to drill. How can we make faster progress?

Hoffmann: Nevertheless, that's right! What would work somewhat more easily and very quickly and accelerate the improvement of transfer would be comprehensive analyses of similar innovation fund projects. The German Network for Health Services Research has been proposing this for some time (2). For example, several similar pilot projects, whose results are often statistically significant, could be summarised and it could be determined which components or detailed interventions of the projects found to be good were the key drivers in each case. Then you might only need one combined pilot. Unfortunately, this type of project approach is not yet eligible for funding within the Innovation Fund.

Do you have an example of this?

Hecken: Yes, of course. We had an innovation fund project called Telenotarzt Bayern, the benefits of which were well documented. Ambulances are fitted with great equipment so that an emergency doctor doesn't always have to be on board as a valuable resource at all times. In cases where an emergency doctor is actually needed urgently, he or she can join in digitally and give the well-trained staff on site the right instructions.

Of course, due to the legal framework, the staff in the ambulance must be able to administer intravenous medication, for example, which is unfortunately regulated differently from state to state. To cut a long story short: the system has been trialled in Bavaria and has achieved excellent results. That's why, as Chairman of the Innovation Committee, I sent a recommendation for implementation to all the federal states. If there was any feedback at all, it was: Thank you for the information, but we have set up our

own system with a lot of money and will continue to do so.

Hoffmann: The state of Mecklenburg-Vorpommern has adopted the system!

Hecken: That's right. But there are 14 other federal states. All I'm trying to say is that without a transfer obligation, it's of little use to assume that sufficient evidence will be established by itself. Unfortunately, this only happens in rare cases - see Mecklenburg-Western Pomerania. Our healthcare system is extremely persistent. We therefore need a new commitment to implement a proven better system for the benefit of patients. And not only at the level of the organisations that are subject to the supervision and creative power of the Federal Ministry of Health, but also at the level of the federal states. Of course, federalism comes into play here, with all its advantages, but also with all its limitations. The regional demarcation mentality must be broken through a legislative tightening of the transfer obligations.

You have mentioned good ideas for the further development of the Innovation Fund. How quickly can the necessary transfer take place?

Hecken: Personally, I'm not making any predictions on this because the legislator currently has other important things to regulate. Nevertheless, we can't wait and see, but must prepare what is necessary now and talk to important people in political institutions.

„We have an obligation to the many people who rely on a resilient healthcare system to identify and reform the components that are not functioning well enough."
Prof. Dr. Wolfgang Hoffmann, DNVF

Hoffmann: Time is pressing! Unfortunately, the problem is not getting smaller, but bigger. We are already at risk of a shortage of supplies in some parts of the country. We have an obligation to the many people who depend on a resilient healthcare system to identify and reform the elements that are not functioning well enough. That is why we must work together at all levels to ensure that our healthcare system improves in a structured way and does not gradually deteriorate. Many people are now realising that our care is far from good.

Hecken: My concern in our conversation today is this: We have already achieved good results so far, which would probably be more significant without the obstacles we have just mentioned. In addition, there is a need for optimisation, which we must develop as quickly as possible in joint, trusting work between the Federal Joint Committee, health services research and the Federal Ministry of Health, because this is the only way we can bring structural improvements in care into the system for the benefit of all patients. Let's get on with it!

Professors, thank you for the interview. <<

The interview was conducted by MVF publisher Prof Dr Reinhold Roski and MVF editor-in-chief Peter Stegmaier.

Literature:
1: https://t1p.de/283l9
2: https://t1p.de/i9hlf

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Übersicht Beschlüsse zu Projekten des Innovationsausschusses seit Dezember 2020	
Bisher insgesamt 347 Beschlüsse (217 VSF, 21 med. LL, 109 NVF)	
Anzahl: 347	**in Prozent**
davon 97 Prüfbitten/Erprobung als NVF (50 VSF/ 26 NVF/ 21 med. LL	27,9%
davon 120 informatorische Weiterleitung (92 VSF/ 28 NVF)	34,6%
davon 130 keine Empfehlung (75 VSF/ 55 NVF)	38,5%
Top-Adressaten	
AWMF/med. Fachgesellschaften	21%
BMG und nachgeordnete Behörden	15%
G-BA	14%
Trägerorganisationen G-BA	13%
Projekte in der Umsetzung	
36 VSF-Projekte mit konkreten Informationen zur Umsetzung	
36 NVF-Projekte mit konkreten Informationen zur Umsetzung	
> 22% (inkl. Veröffentlichung aller Med. LL = 26,8%)	

Tab. 1: Übersicht Beschlüsse zu Projekten des Innovationsausschusses seit Dezember 2020. Die Informationen zur Umsetzung sind nicht vollständig. Es gibt jedoch über 100 Projektentwicklungen insgesamt, die für die Öffentlichkeit nutzbar sind. Diese Zahlen können aber immer nur eine Unterschätzung des realen Effekts der Projekte auf die Gesundheitsversorgung darstellen. Legende: LL = Leitlinien; VSF = Versorgungsforschung; NVF = Neue Versorgungsformen.

Beispiele von Projekten, deren Ergebnisse in der Versorgung angekommen sind				
Neue Versorgungsformen				
Fördernr.	**Kürzel**	**Datum**	**Art**	**Erste Transfererfolge**
01NVF18004	CCC-Integrativ	23.05.2025	Beratung von Krebspatient:innen im Bereich Komplementäre Medizin und Pflege	Mehrere Preise, Weiterführung in Baden-Württenberg, entwickelte Schulung wird deutschlandweit angeboten
01NVF17031	ZSE-DUO	17.05.2024	Lotsenstruktur in Zentren für Seltene Erkrankungen	Selektivvertrag Uniklinik Würzburg seit 01.10.2024
01NVF1705	DiaTT	19.04.2024	Dialyse-Trainingstherapie	In 7 von 16 Dialysezentren in Sachsen und Thüringen wurden Vereinbarungen dazu getroffen
01NVF17036	Cardiolotse	15.12.2023	Poststätionäre Weiterbehandlung nach kardiologischer Erkrankung mit Lotsen	Selektivvertrag mit Vivantes Kliniken (alle Berliner Standorte), Open-house-Zulassungsverfahren der AOK Nordost, Erfahrungen aus Projekt fließen in laufendes Projekt LEX LOTSEN ein
Versorgungsforschung				
01VSF18015	VIPER	18.10.2024	Vergleich von Impfstrategien bei RSV	Ergebnisse sind in drei unterschiedliche Empfehlungen der STIKO eingeflossen
01VSF18017	AMSeC	15.05.2024	Auffrischimpfung Meningokokken C	Ergebnisse in die Beratungen der STIKO eingeflossen
01VSF17043	EDCP-BRCA	15.12.2023	Decision Coaching-Programm für Prävention bei BRCA1/2-Trägerinnen	Programm in bestehende Beratungsabläufe der spezialisierten Zentren für familiären Brust- und Eierstockkrebs integriert, Leistung im Versorgungsvertrag ab 2024 der PKV, Verhandlungen mit GKV zum geplanten Selektivvertrag laufen noch

Tab. 2: Beispiele von Projekten, deren Ergebnisse in der Versorgung angekommen sind.

Überblick über Transferempfehlungen mit Prüfbitten (2025–2024) sowie der Adressaten				
Transferempfehlungen mit Prüfbitte 2025				
Fördernr.	**Kürzel**	**Datum**	**Beschlussart**	**Adressat/Empfänger**
01NVF18019	KOMPASS D2	23.05.2025	Empfehlung zur Überführung von Präventionsansätzen in die Regelversorgung	IQTIG sowie Deutsche Krankenhausgesellschaft e.V. (DKG), Deutscher Pflegerat e. V. (DPR), Delir-Netzwerk e. V., DeutschenGesellschaft für Geriatrie e. V. (DGG) und Deutscher Berufsverband für Pflegeberufe – DBfK Bundesverband e. V.
01NVF18028	GBV	11.04.2025	Empfehlung zur Überführung in die Regelversorgung	Bundesministerium für Gesundheit (BMG), Bundesministerium für Arbeit und Soziales (BMAS) und Bundesministerium für Familie, Senioren, Frauen und Jugend (BMFSFJ) sowie Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde e. V. (DGPPN), Bundesverband Psychiatrie-Erfahrener e. V. (BPE) und Deutschen Berufsverband für Soziale Arbeit e. V. (DBSH)
01VSF19016	ISAR-IQ	21.02.2025	Mögliche Weiterentwicklung der Leitlinie	Deutsche Gesellschaft für Gefäßchirurgie und Gefäßmedizin - Gesellschaft für operative, endovaskuläre und präventive Gefäßmedizin e.V. (DGG)
01VSF20025	BARGRU-II	24.01.2025	Überarbeitung der Psychotherapie-Richtlinie	Unterausschuss Psychotherapieund psychiatrische Versorgung des Gemeinsamen Bundesausschusses sowie Bundespsychotherapeutenkammer (BPtK), Bundesärztekammer (BÄK), Kassenärztliche Vereinigungen (KV), Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde e. V. (DGPPN), Deutsche PsychotherapeutenVereinigung e. V. (DPtV), Berufsverband Deutscher Psychologinnen und Psychologen e. V.. (BDP), Deutsche Gesellschaft für Gruppenanalyse und Gruppenpsychotherapiee. V.(D3G) sowie Deutsche Gesellschaft für Allgemeinmedizin und Familienmedizin e. V. (DEGAM)
Transferempfehlungen mit Prüfbitte 2024 (Teil 1)				
Fördernr.	**Kürzel**	**Datum**	**Beschlussart**	**Adressat/Empfänger**
01VSF19017	ILEG	21.11.2024	Etablierung von Gemeindenotfallsanitätern zur Optimierung der Notfallrettung im jeweiligen Bundesland	Für den Rettungsdienst zuständigen Ministerien der Länder sowie Bundesministerium für Gesundheit, Gesundheitsministerkonferenz der Länder (GMK), Deutsche Gesellschaft für Rettungsdienst und präklinische Notfallmedizin e. V.. (DRGN), Deutsche Interdisziplinäre Vereinigung für Intensiv- und Notfallmedizin e. V. (DIVI), Deutsche Gesellschaft für Interdisziplinäre Notfall- und Akutmedizin e. V. (DGINA) sowie Kassenärztliche Bundesvereinigung (KBV)
01VSF20019	DEAL	21.11.2024	Aktualisierung und Weiterentwicklung von Leitlinien- oder Impfempfehlungen	Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften (AWMF) e. V., Geschäftsstelle der Ständigen Impfkommission (STIKO), Zentralinstitut für die kassenärztliche Versorgung (Zi), die Deutsche Krebsgesellschaft e. V. (DKG) sowie Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen (IQWiG)
01VSF20022	AnIm-PaLLO	21.11.2024	Ausgestaltung und Weiterentwicklung entsprechender Leitlinien	Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen (IQWiG) sowie Deutsche Krebsgesellschaft e. V. (DKG) und Deutsche Krebshilfe, welche in Zusammenarbeit mit der AWMF das Leitlinienprogramm Onkologie verantworten. Ebenso an Aktionsbündnis Patientensicherheit (APS), Nationale Kontakt- und Informationsstelle zur Anregung und Unterstützung von Selbsthilfegruppen (NAKOS) und Bundesarbeitsgemeinschaft Selbsthilfe von Menschen mit Behinderung, chronischer Erkrankung und ihren Angehörigen e. V. (BAG SELBSTHILFE)
01NVF18016	PROMoting Quality	18.10.2024	Empfehlung zur Überführung in die Regelversorgung	Unterausschuss Qualitätssicherung des Gemeinsamen Bundesausschusses (G-BA) sowie an Verbände der Kranken- und Pflegekassen auf Bundesebene und Deutsche Krankenhausgesellschaft (DKG). Ebenso an Initiative Qualitätsmedizin (IQM), Deutsche Gesellschaft für Endoprothetik e. V., Deutsche Gesellschaft für Orthopädie und Orthopädische Chirurgie (DGOOC) sowie an Deutsches Endoprothesenregister gGmbH (EPRD) und Deutsches Implantateregister (IRD)
01VSF18015	VIPER	18.10.2024	Weiterentwicklung von künftigen Impfempfehlungen	Geschäftsstelle der Ständigen Impfkommission (STIKO)
01VSF18045	DIPS	18.10.2024	Prävention von dialyseassoziierten Infektionen	Krankenhaushygiene und Infektionsprävention (KRINKO) beim Robert Koch-Institut, die DeutscheGesellschaft für Nephrologie, Kuratorium für Dialyse und Nierentransplantation, Verband Deutscher Nierenzentren, Aktionsbündnis Patientensicherheit und Bundesverband Niere

Tab. 3: Überblick über Transferempfehlungen mit Prüfbitten 2025–2024, Teil 1) – Stand: Mitte August 2025. Die vollständige, vom G-BA zur Verfügung gestellte Liste seit 2020 finden Sie hier: https://t1p.de/f45oj

Überblick über die Transferempfehlungen 2024 mit Prüfbitten (Auszug)				
Transferempfehlungen mit Prüfbitte 2024 (Teil 2)				
Fördernr.	**Kürzel**	**Datum**	**Beschlussart**	**Adressat**
01NVF17043	Familien-SCOUT	16.08.2024	Empfehlung zur Überführung in die Regelversorgung	Gesundheits- und Sozialministerien der Länder, GKV-Spitzenverband, Deutsche Krankenhausgesellschaft und Kassenärztliche Bundesvereinigung sowie Bundesarbeitsgemeinschaft der Freien Wohlfahrtspflege sowie an Bundesministerium für Gesundheit (BMG) und Bundesministerium für Familie, Senioren, Frauen und Jugend (BMFSFJ). Ebenso an Deutsche Krebsgesellschaft e. V., Stiftung Deutsche Krebshilfe, Deutsche Gesellschaft für Allgemeinmedizin und Familienmedizin (DEGAM), Deutsche Arbeitsgemeinschaft für psychosoziale Onkologie (dapo) e. V.., Deutsche Gesellschaft für Care und Case Management(DGCC) e. V., Deutsche Gesellschaft für Palliativmedizin e. V. und Verband wir pflegen – Interessenvertretung und Selbsthilfe pflegender Angehöriger e. V.
01NVF17046	PROMPt	16.08.2024	Empfehlung zur Überführung in die Regelversorgung	GKV-Spitzenverband, Zentrale Prüfstelle Prävention und die Bundeskonferenz für Erziehungsberatung sowie Unterausschuss Methodenbewertung des Gemeinsamen Bundesausschusses. Ebenso an Deutsche Gesellschaft für Allgemeinmedizin und Familienmedizin e. V. (DEGAM), Deutsche Gesellschaft für Kinder- und Jugendmedizin e. V. (DGKJ) Deutsche Gesellschaft für Kinder- und Jugendpsychiatrie, Psychosomatik und Psychotherapie e. V. (DGKJP), Deutsche Gesellschaft für öffentliches Gesundheitswesen (DGÖG), Berufsverband der Kinder- und Jugendärzt:innen e. V. (BVKJ), Bundesverband der Ärztinnen und Ärzte des Öffentlichen Gesundheitsdienstes (BVÖGD, Fachausschuss Kinder- und Jugendgesundheitsdienst) sowie Bundeszentrale für gesundheitliche Aufklärung(BZgA)
01VSF18009	GestDi-Na_basic	16.08.2024	Weiterentwicklung entsprechender S3-Leitlinien	Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften (AWMF) sowie Deutsche Gesellschaft für Gynäkologie und Geburtshilfe e.V. (DGGG), Deutsche Diabetes Gesellschaft e.V. (DDG), Deutsche Gesellschaft für Allgemeinmedizin und Familienmedizin (DEGAM), Deutsche Gesellschaft für Kinder- und Jugendmedizin e.V. (DGKJ), Deutscher Hebammenverband (DHV) und Deutsche Diabetes Föderation e. V.
01VSF18043	OMPRIS	16.08.2024	Prüfung im Rahmen seiner Aufgaben	Unterausschuss Psychotherapie und psychiatrische Versorgung des Gemeinsamen Bundesausschusses sowie Bundeszentrale für gesundheitliche Aufklärung (BZgA), Bundesverband Suchthilfe e. V. und Fachverband Medienabhängigkeit e. V. Ebenso an Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften (AWMF) Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde e. V. (DGPPN), Deutsche Gesellschaft für Kinder- und Jugendpsychiatrie, Psychosomatik und Psychotherapie e. V. (DGKJP) sowie Deutsche Gesellschaft für Allgemeinmedizin und Familienmedizin (DEGAM) e. V.
01VSF18038	VerSI-MS-PV	12.07.2024	Prüfung einer möglichen Verwendung im Rahmen seines gesetzlichen Auftrags	Bundesinstitut für Arzneimittel und Medizinprodukte (BfArM) sowie an Bundesministerium für Gesundheit (BMG), Arzneimittelkommission der deutschen Ärzteschaft (AkdÄ), Arbeitsgemeinschaft der Wissenschaftlichen Fachgesellschaften (AWMF) sowie Deutscher Multiple Sklerose Gesellschaft, Bundesverband e.V.
01NVF18008	EsmAiL	21.06.2024	Empfehlung zur Überführung in die Regelversorgung	Unterausschuss Methodenbewertung des Gemeinsamen Bundesausschusses sowie an Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften (AWMF). Ebenso an Deutsche Dermatologische Gesellschaft (DDG), den Berufsverband der Deutschen Dermatologen (BVDD), die Deutsche Gesellschaft für Allgemeinmedizin (DEGAM) und die Deutsche Gesellschaft für Chirurgie (DGCH)
01NVF17031	ZSE-DUO	17.05.2024	Empfehlung zur Überführung in die Regelversorgung	Verbände der Kranken- und Pflegekassen auf Bundesebene sowie an die Deutsche Krankenhausgesellschaft und den Verband der Universitätsklinika. Ebenso an Bundesministerium für Gesundheit, Nationale Aktionsbündnis für Menschen mit Seltenen Erkrankungen (NAMSE), Deutsche Gesellschaft für Allgemeinmedizin und Familienmedizin e. V., Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde e. V. und Deutsche Gesellschaft für Kinder- und Jugendmedizin e. V., Unterausschuss Bedarfsplanung beim Gemeinsamen Bundesausschuss
01VSF18017	AMSeC	17.05.2024	Weiterentwicklung von Impfempfehlungen	Geschäftsstelle der Ständigen Impfkommission (STIKO)
01VSF18053	REDARES	17.05.2024	Berücksichtigung in Vertragsvereinbarungen und Maßnahmen zur Qualitätsverbesserung	Verbände der Kranken- und Pflegekassen auf Bundesebene sowie Landesverbände und an kassenärztliche Vereinigungen sowie Deutsche Gesellschaft für Allgemeinmedizin und Familienmedizin (DEGAM)
01NVF17052	DiaTT	19.04.2024	Überführung von Ansätzen der neuen Versorgungsform in die Regelversorgung	Verbände der Kranken- und Pflegekassen auf Bundesebene sowie an Deutsche Gesellschaft für Nephrologie e. V. und den Verband Deutscher Nierenzentren e. V.
01VSF17019	DEMAND	19.01.2024	Neuordnung der Notfallversorgung	Bundesministerium für Gesundheit sowie Kassenärztliche Bundesvereinigung (KBV), Unterausschuss Bedarfsplanung des Gemeinsamen Bundesausschusses, Verbände der Kranken- und Pflegekassen auf Bundesebene mit Bitte um Weiterleitung an die Landesverbände, Deutsche Krankenhausgesellschaft e. V. (DKG) sowie die Gesundheitsministerkonferenz der Länder (GMK

Tab. 4: Überblick über Transferempfehlungen mit Prüfbitten 2024 – Teil 2 – Stand: Mitte August 2025. Die vollständige, vom G-BA zur Verfügung gestellte Liste seit 2020 finden Sie hier: https://t1p.de/f45oj