### Value-Based Health Care Delivery

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This presentation draws on Michael E. Porter and Elizabeth Olmsted Teisberg: Redefining Health Care: Creating Value-Based Competition on Results, Harvard Business School Press, May 2006, and "How Physicians Can Change the Future of Health Care," *Journal of the American Medical Association*, 2007; 297:1103:1111. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means — electronic, mechanical, photocopying, recording, or otherwise — without the permission of Michael E. Porter and Elizabeth Olmsted Teisberg. Further information about these ideas, as well as case studies, can be found on the website of the Institute for Strategy & Competitiveness at <a href="http://www.isc.hbs.edu">http://www.isc.hbs.edu</a>.

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#### Redefining Health Care Delivery

- Universal coverage and access to care are essential, but not enough
- The core issue in health care is the value of health care delivered

Value: Patient health outcomes per dollar spent



- How to design a health care delivery system that dramatically improves patient value
  - Ownership of entities is secondary (e.g. non-profit vs. for profit vs. government)
- How to construct a dynamic system that keeps rapidly improving

#### Creating a Value-Based Health Care System

 Significant improvement in value will require fundamental restructuring of health care delivery, not incremental improvements

Today, 21<sup>st</sup> century medical technology is often delivered with 19<sup>th</sup> century organization structures, management practices, measurement, and pricing

- Process improvements, care pathways, lean production, safety initiatives, disease management and other overlays to the current structure are beneficial but **not sufficient**
- "Consumers" cannot fix the dysfunctional structure of the current system

#### **Harnessing Competition on Value**

- Competition for patients/subscribers is a powerful force to encourage restructuring of care and continuous improvement in value
- Today's competition in health care is not aligned with value

Financial success of system participants

Patient success



 Creating positive-sum competition on value is a central challenge in health care reform in every country

#### **Principles of Value-Based Health Care Delivery**

The fundamental issue in health care is value for patients, not access, volume, convenience, or cost containment

Value = Health outcomes

Costs of delivering the outcomes

- Outcomes are the full set of patient health outcomes over the care cycle
- Costs are the total costs of care for the patient's condition, not just the cost of a single provider or a single service



How to design a health care system that dramatically improves patient value

#### **Principles of Value-Based Health Care Delivery**

**Quality improvement** is the key driver of cost containment and higher value, where quality is **health outcomes** 

- Prevention
- Early detection
- Right diagnosis
- Right treatment to the right patient
- Early and timely treatment
- Treatment earlier in the causal chain of disease
- Rapid cycle time of diagnosis and treatment
- Less invasive treatment methods

- Fewer complications
- Fewer mistakes and repeats in treatment
- Faster recovery
- More complete recovery
- Less disability
- Fewer relapses or acute episodes
- Slower disease progression
- Less need for long term care
- Less care induced illness



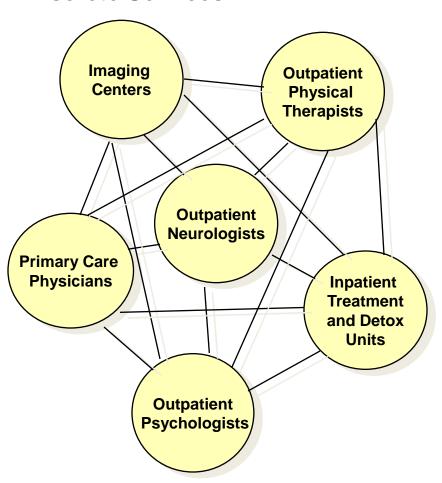
- Better health is the goal, not more treatment
- Better health is inherently less expensive than poor health

## Value-Based Health Care Delivery <u>The Strategic Agenda</u>

- 1. Organize into Integrated Practice Units (IPUs)
  - Including primary and preventive care for distinct patient populations
- 2. Measure Outcomes and Cost for Every Patient
- 3. Utilize Bundled Reimbursement Models for Care Cycles
- 4. Integrate Provider Systems
- 5. Grow by Expanding Excellent IPUs Across Geography
- 6. Create an Enabling Information Technology Platform

### 1. Organize into Integrated Practice Units Migraine Care in Germany

# Existing Model: Organize by Specialty and Discrete Services



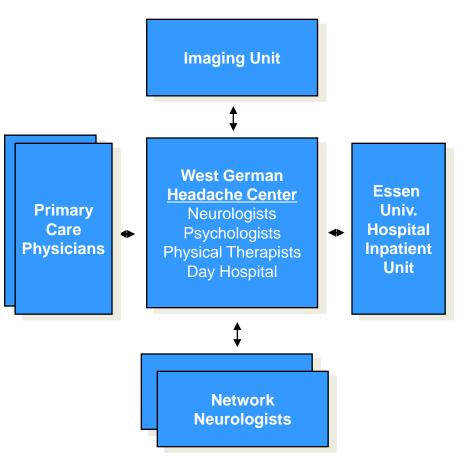
#### 1. Organize into Integrated Practice Units Migraine Care in Germany

# Existing Model: Organize by Specialty and Discrete Services

#### **Imaging Outpatient Centers Physical Therapists Outpatient Neurologists Primary Care Physicians** Inpatient **Treatment** and Detox Units **Outpatient Psychologists**

### New Model: Organize into Integra

Organize into Integrated Practice Units (IPUs)



Source: Porter, Michael E., Clemens Guth, and Elisa Dannemiller, The West German Headache Center: Integrated Migraine Care, Harvard Business School Case 9-707-559, September 13, 2007

## Integrating Across the Cycle of Care <u>Breast Cancer</u>

	• Advice on self screening	•Counceling nations and	Explaining patient	Counseling on the treatment	■Counseling on	■Counseling on long	
INFORMING AND ENGAGING	Consultations on risk factors	Counseling patient and family on the diagnostic process and the diagnosis	treatment options/shared decision making	ent options/shared in making process  - Education on managing side effects and avoiding complications of treatment ological  - Achieving compliance	rehabilitation options, process  •Achieving compliance	term risk management	
			Patient and family psychological counseling		Psychological counseling	Achieving     Compliance	
MEASURING	Self exams     Mammograms	Mammograms     Ultrasound     MRI     Labs (CBC, Blood chems, etc.)      Riopsy	•Labs	Procedure-specific measurements	Range of movement     Side effects     measurement	■MRI, CT ■Recurring mammograms (every six months for the	
		BRACA 1, 2 CT Bone Scans				first 3 years)	
ACCESSING	Office visits     Mammography lab visits	Office visits	Office visits	Hospital stays	Office visits	Office visits	
		•Lab visits	Hospital visits     Lab visits	Visits to outpatient radiation or chemotherapy units	Rehabilitation facility visits	Lab visits     Mammographic labs and	
		High risk clinic visits		■Pharmacy	■Pharmacy	imaging center visits	
	MONITORING/ PREVENTING	DIAGNOSING	PREPARING	INTERVENING	RECOVERING/ REHABING	MONITORING/MANAGING	
		Medical history     Determining the specific nature of the disease (mammograms, pathology, biopsy results)	PREPARING  • Choosing a treatment plan • Surgery prep (anesthetic risk assessment, EKG)	• Surgery (breast preservation or mastectomy, oncoplastic alternative)	REHABING     In-hospital and outpatient wound healing     Treatment of side effects (e.g. skin damage, cardiac complications, nausea, lymphodema	Periodic mammography Other imaging Follow-up clinical exams	
	PREVENTING     Medical history     Control of risk factors (obesity, high fat diet)     Genetic screening     Clinical exams	Medical history     Determining the specific nature of the disease (mammograms, pathology, biopsy	Choosing a treatment plan Surgery prep (anesthetic risk)	Surgery (breast preservation or mastectomy, oncoplastic	REHABING  In-hospital and outpatient wound healing Treatment of side effects (e.g. skin damage, cardiac complications, nausea, lymphodema and chronic fatigue)	Periodic mammography Other imaging Follow-up clinical	
	PREVENTING     Medical history     Control of risk factors (obesity, high fat diet)     Genetic screening     Clinical exams	Medical history     Determining the specific nature of the disease (mammograms, pathology, biopsy results)     Genetic evaluation	Choosing a treatment plan Surgery prep (anesthetic risk assessment, EKG)  Plastic or onco-plastic surgery evaluation Neo-adjuvant	Surgery (breast preservation or mastectomy, oncoplastic alternative)      Adjuvant therapies (hormonal medication, radiation, and/or	REHABING  In-hospital and outpatient wound healing Treatment of side effects (e.g. skin damage, cardiac complications, nausea, lymphodema and chronic fatigue)  Physical therapy	Periodic mammography Other imaging  Follow-up clinical exams Treatment for any continued or later onset side effects or	

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Other Provider Entities

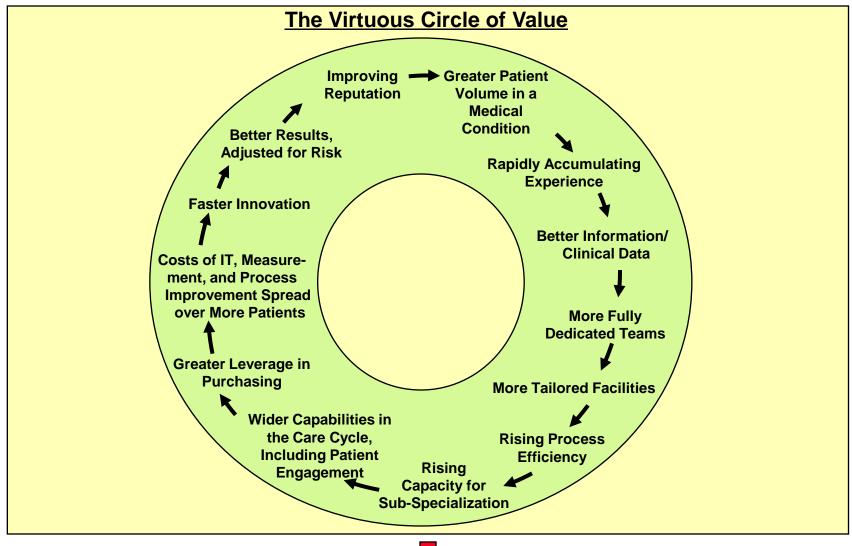
## Integrating Across the Cycle of Care <u>Breast Cancer</u>

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				psychological counseling		Psychological of		Admissing Compilation
MEASURING	Self exams Mammograms		Mammograms Ultrasound MRI Babs/CBC, Blood chems, BCACA 1, 2	Labs	Procedure-specific measurements	Range of move Side effects me		MRI, CT Recurring mammograms (every months for the first 3 years)
ACCESSING	Office visits Mammography lab visits		Office visits Bone Scans	Office visits	Hospital stays	Office visits		Office visits
		,	Lab visits High risk clinic visits	Hospital visits Lab visits	Visits to outpatient radiation or chemotherapy units	Rehabilitation f Pharmacy	facility visits	Lab visits  Mammographic labs and imaging cent visits
			ring.		Pharmacy			\
	MONITORING PREVENTING		DIAGNOSING	PREPARING	INTERVENING	RECOVERING REHABING	6/	MONITORING/MANAGING
		ry k factors fat diet) ening	Medical history Determining the specific nature of the disease (mammograms, pathology, biopsy results) Genetic evaluation	PREPARING  Choosing a treatment plan  Surgery prep (anesthetic risk assessment, EKG)	INTERVENING  Surgery (breast preservation or mastectomy, oncoplastic alternative)	REHABING  In-hospital and wound healing Treatment of si (e.g. skin dam cardiac complied nausea, lymphotographic street in the second st	d outpatient ide effects nage, cations,	Periodic mammography Other imaging  Follow-up clinical exams Treatment for any continued or la
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Other Provider Entities

### The Role of Volume and Experience in Patient Value





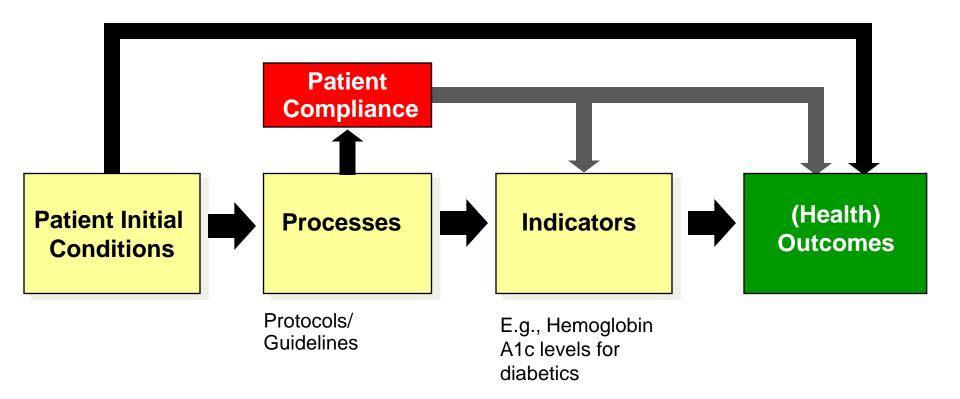
 Volume and experience have an even greater impact on value in an IPU structure than in the current system

## Fragmentation of Hospital Services <u>Sweden</u>

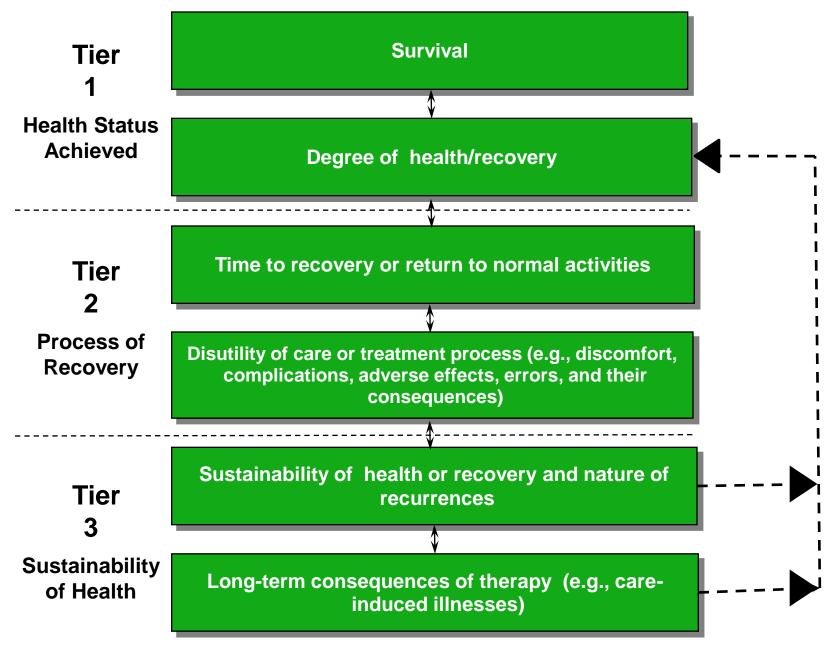
DRG	Number of admitting providers	Average percent of total national admissions	Average admissions/ provider/ year	Average admissions/ provider/ week
Knee Procedure	68	1.5%	55	1
Diabetes age > 35	80	1.3%	96	2
Kidney failure	80	1.3%	97	2
Multiple sclerosis and cerebellar ataxia	78	1.3%	28	1
Inflammatory bowel disease	73	1.4%	66	1
Implantation of cardiac pacemaker	51	2.0%	124	2
Splenectomy age > 17	37	2.6%	3	<1
Cleft lip & palate repair	7	14.2%	83	2
Heart transplant	6	16.6%	12	<1

Source: Compiled from The National Board of Health and Welfare Statistical Databases – DRG Statistics, Accessed April 2, 2009.

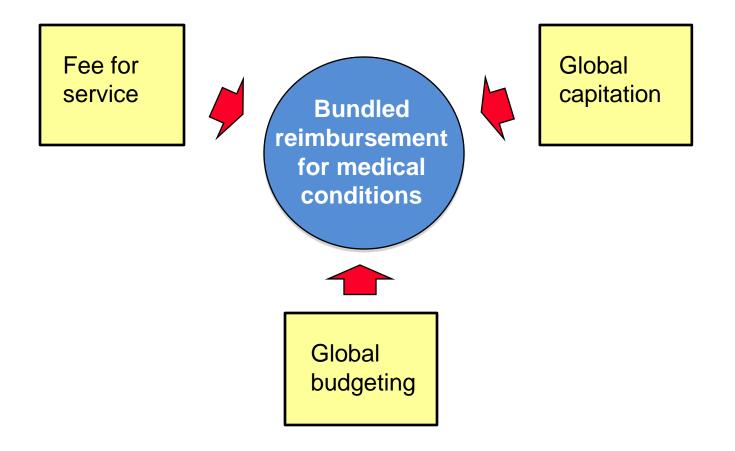
#### 2. Measure Outcomes and Cost For Every Patient



### The Outcome Measures Hierarchy



#### 3. Utilize Bundled Reimbursement Models for Care Cycles



#### What is Bundled Payment?

- Total package price for the care cycle for a medical condition
  - Includes responsibility for avoidable complications
  - Medical condition capitation
- The bundled price should be severity adjusted

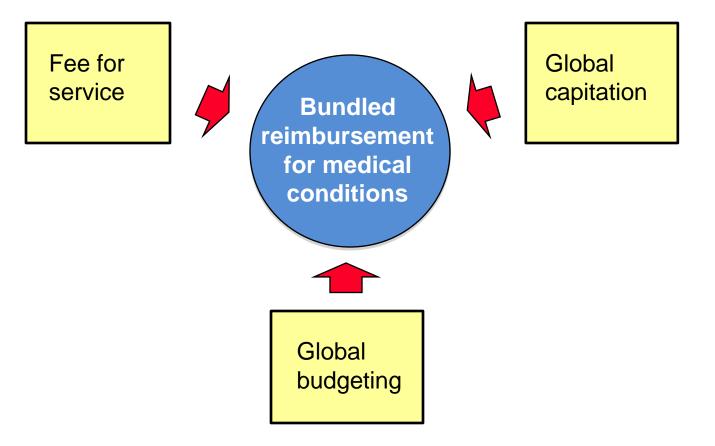
#### What is Not Bundled Payment

- Prices for short episodes (e.g. inpatient only, procedure only)
- Separate payments for physicians and facilities
- Pay-for-performance bonuses
- "Medical Home" payment for add-on services



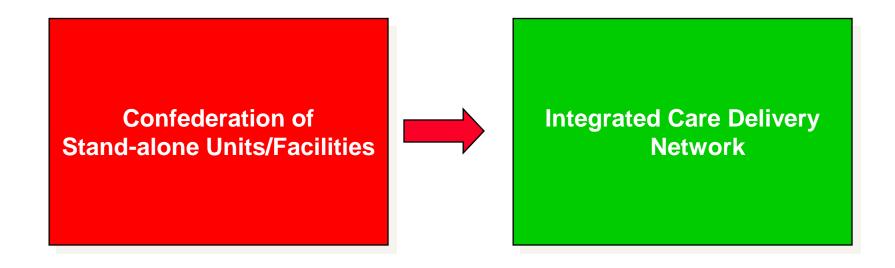
DRGs can be a starting point for bundled models

#### 3. Utilize Bundled Reimbursement Models for Care Cycles



- Bundled reimbursement motivates value improvement, care cycle optimization, and spending to save
  - Let experts decide the value of individual services and products within the bundle, rather than outside parties
- Outcome measurement and reporting at the medical condition level is needed for any reimbursement system to ultimately succeed

#### 4. Integrate Provider Systems



- Fragmented and duplicative services
- Passive referrals

 The provider network is more than the sum of its parts

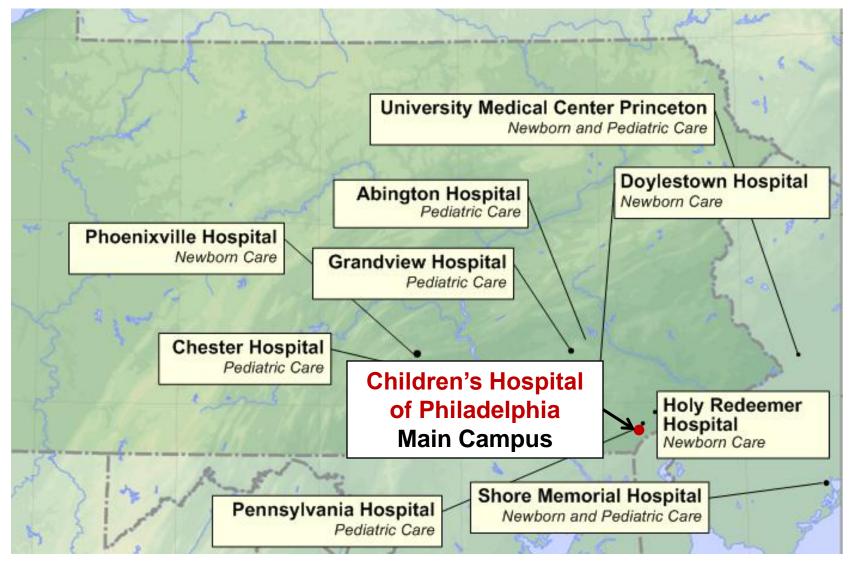
### **Levels of System Integration**

- 1. Rationalize service lines/ IPUs across facilities to improve volume, avoid duplication, play to strength, and concentrate excellence
- 2. Offer specific services at the appropriate facility
  - E.g. acuity level, cost level, need for convenience
  - Refer patients to the appropriate unit
- 3. Clinically integrate care across facilities, within an IPU structure
  - IPUs extend across facilities
    - Consistent protocols, consultations with experts
  - Integrating across the full care cycle
  - Linking preventative/primary care units to specialty IPUs
  - Connecting ancillary service units to IPUs
    - E.g. home care, rehabilitation, behavioral health, social work, addiction treatment

#### 5. Grow Excellent Services Across Geography

Children's Hospital of Philadelphia (CHOP)

Hospital Affiliates



#### **Models of Geographic Expansion**

Diagnostic Centers

Second
Opinions and
Telemedicine

Affiliation
Agreements
with
Independent
Provider
Organizations

Locate
Convenience
Sensitive
Services in the
Community

Expand
Complex IPU
Components
(e.g. surgery)
to Additional
Locations

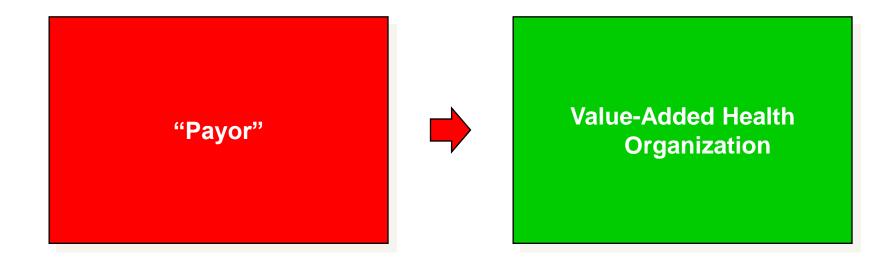
Focused
Hospitals in
Additional
Locations

#### 6. Create an Enabling Information Technology Platform

Utilize information technology to enable **restructuring of care delivery** and **measuring results**, rather than treating it as a solution itself

- Common data definitions
- Combine all types of data (e.g. notes, images) for each patient over time
- Data encompasses the full care cycle, including referring entities
- "Structured" data vs. free text
- Templates for medical conditions to enhance the user interface
- Allowing access and communication among all involved parties, including patients
- Architecture that allows easy extraction of outcome and process measures
- Interoperability standards enabling communication among different provider systems

## Value-Based Healthcare Delivery: <a href="Implications for Health Plans">Implications for Health Plans</a>



#### Value-Based Health Care: The Role of Employers

- Employer interests are more closely aligned with patient interests than any other system player
  - Employers need healthy, high performing employers
  - Employers bear the costs of chronic health problems and poor quality care



- The cost of poor health is 2 to 7 times more than the cost of health benefits
  - Absenteeism
  - o Presenteeism
- Employers are uniquely positioned to improve employee health
  - Daily interactions with employees
  - On-site clinics for quick diagnosis and treatment, prevention, and screening
  - Group culture of wellness

### **Transforming the Roles of Employers**

#### **Old Role**

#### **New Role**

- Set the goal of reducing health premium costs
- Set the goal of employee health

Focus on direct cost of health benefits



 Focus on the overall cost of poor health (e.g., productivity, lost days)

 Use bargaining power to negotiate discounts from health plans and providers



 Work with health plans and providers to improve overall value delivered

 Shift costs to employees via premium payments, co-payments



 Improve access to high-value care (e.g., wellness, prevention, screening, and disease management)

 Evaluate plans and providers based on process compliance (P4P)



 Evaluate plans and providers based on health outcomes

Limit or eliminate the employer role in health insurance



 Take a leadership role in expanding the insurance system to encompass individually purchased plans on favorable terms

#### A Strategy for U.S. Health Care Reform

#### **Shift Insurance Market:**

- Build on the current employer based system
- Shift insurance market competition by ending discrimination based on pre-existing conditions and re-pricing upon illness
- Create large statewide and multistate insurance pools to aggregate volume and buying power and provide a viable insurance option for individuals and small groups, coupled with a reinsurance system for high cost individuals
- Phase in income-based subsidies on a sliding scale for lower income individuals, at a pace that reflects progress of value improvements
- Once viable insurance options are established, mandate the purchase of health insurance for higher income and ultimately all Americans
- Give employers a choice of providing insurance or a payroll tax based on the proportion of employees requiring public assistance

#### A Strategy for U.S. Health Care Reform

#### **Restructure Delivery:**

- Establish a universal and mandatory outcomes measurement and reporting system
  - Experience reporting as an interim step
- Shift reimbursement systems to bundled payment for cycles of care instead of payments for discrete services
  - Including primary/preventive care bundles for patient segments
- Remove obstacles to restructuring of health care delivery around medical conditions
  - E. g. Stark Laws, Corporate Practice of Medicine, Anti-kickback, Malpractice
- Open up value-based competition for patients within and across state boundaries
  - E.g. Harmonize state licensing, insurance rules
  - Minimum volume standards as an interim step
- Mandate EMR adoption that enables integrated care and supports outcome measurement
  - National standards for data definitions, communication, and aggregation
  - Software as a service model for smaller providers
- Set rules that encourage responsibility of individuals for their health and health care through incentives for healthy behavior