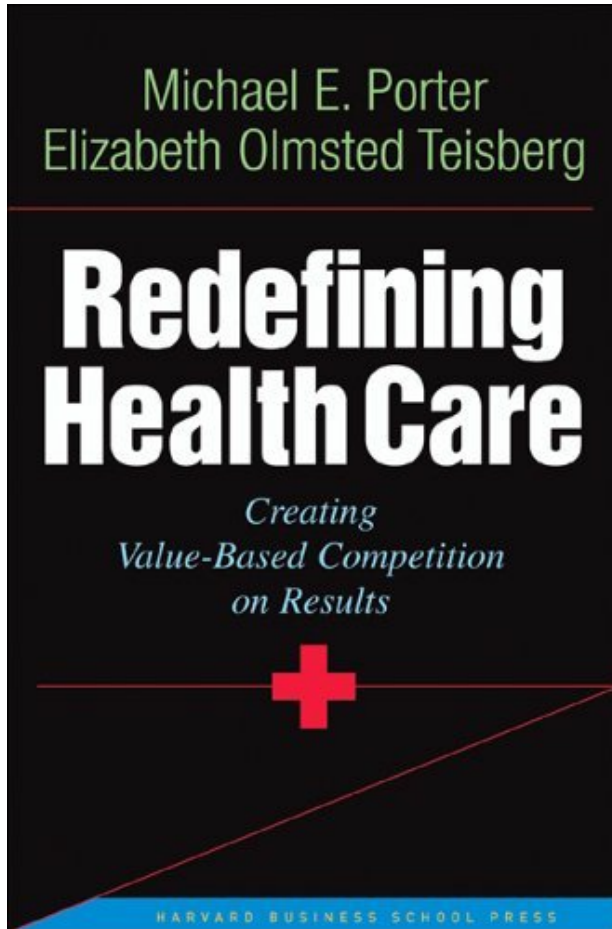


Redefining Health Care: Creating Value-Based Competition on Results

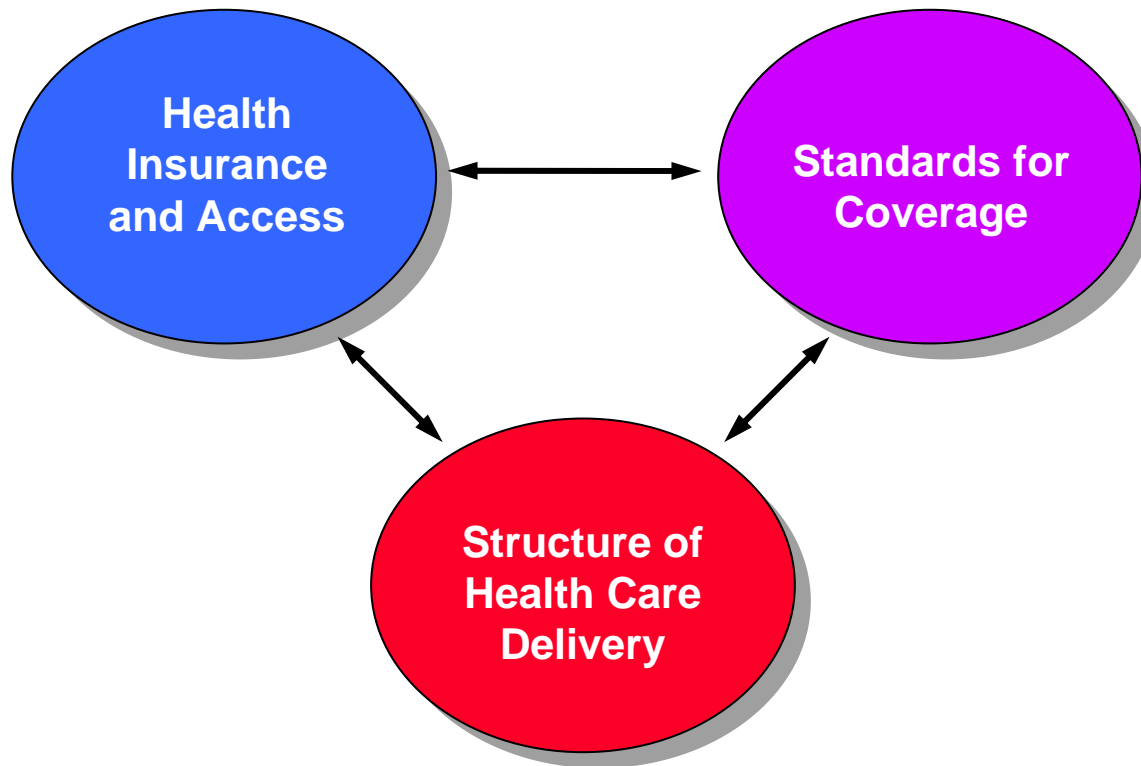


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This presentation draws on [Redefining Health Care: Creating Value-Based Competition on Results](#), Harvard Business School Press, 2006, co-authored with Michael E. Porter, and "How Physicians Can Change the Future of Health Care," JAMA, March 2007. Earlier publications about the work include the *Harvard Business Review* article "Redefining Competition in Health Care" and the associated *Harvard Business Review* Research Report "Fixing Competition in U.S. Health Care" (June 2004). 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.



**The key to success is improving the heart of the system:
delivery of care and enabling of health.**

When value increases significantly, it is possible to deliver far better health outcomes per dollar spent. This enables more access and more coverage. No matter who pays for health care, **increasing value is the critical issue.**

The focus should be on
value for patients,
not just lowering costs.

The health care system must be about improving health and care.

If cost reduction were the goal,

pain killers and compassion would be all we need.

Dysfunctional, Zero-Sum Competition in Health Care is about *Dividing Value*, rather than *Creating Value*

- Competition to **shift costs**
- Competition to **increase bargaining power**
- Competition to reduce costs by **restricting choice**
- Competition to reduce costs by **restricting services**



None of these forms of competition **increase value for patients.**

Gains of one participant come **at the expense of others.**

Cost shifting efforts increase administrative costs.

These forms of dysfunctional competition exist in many countries.

What does it mean to COMPETE?

There must be
unrestricted competition
based on **results**.

Competition to improve results for patients aligns interests.

When a patient's health is improved, he or she wins...and so do physicians, suppliers, payers, employers, family and society. Win-win!

Value-based competition is results driven and patient centric, not consumer driven.

- Sweden
- Cystic Fibrosis

Framing the choices as government run v. consumer driven misses the opportunity to lead change that drives simultaneous improvement in quality and efficiency.

Competition should
center on medical conditions
over the **full cycle of care.**

A medical condition is a set of interrelated medical circumstances that are best treated in an integrated way.

So, from the patient's perspective, having diabetes with hypertension IS the medical condition.

Is it realistic to think about innovation in the organization of care delivery?

Yes. Someone is already doing each of the steps we recommend. Some examples:

- The Cleveland Clinic – institutes, disease systems, organ systems
- ThedaCare – only services above 95th percentile
- M.D.Anderson – organized by type of cancer
- Independent breast cancer specialist
- Preferred Global Health in Europe and Middle East

Notice, we are not talking about each service or procedure delivered at a separate facility. We are talking about multi-specialty practices. We are talking about reorganization, improvement, and making choices to increase value for patients.

Information on results

needed for value-based competition
must be widely available.

**Physicians need results measures to know what to improve
and when they are improving outcomes for patients.**

RESULTS are what really matter.

Patient HbA1c levels measure results.

Blindness or amputation are also results, but not good results.

Competition to Improve Results will be much more effective than efforts to specify care delivery processes.

Pay for performance has become pay for compliance with process specifications.

- Administrative specification of care won't *drive* improvement in value.
- You can't specify everything... and trying to drives costs up.
- Even with process compliance, results differ. (Consider diabetes.)
- Process compliance requirements may limit what the best can achieve. (Consider cystic fibrosis.)
- Process specifications are difficult to keep current.
- P4P builds in cost escalation that may be unnecessary.

Risk adjusted outcomes need to be measured and reported.

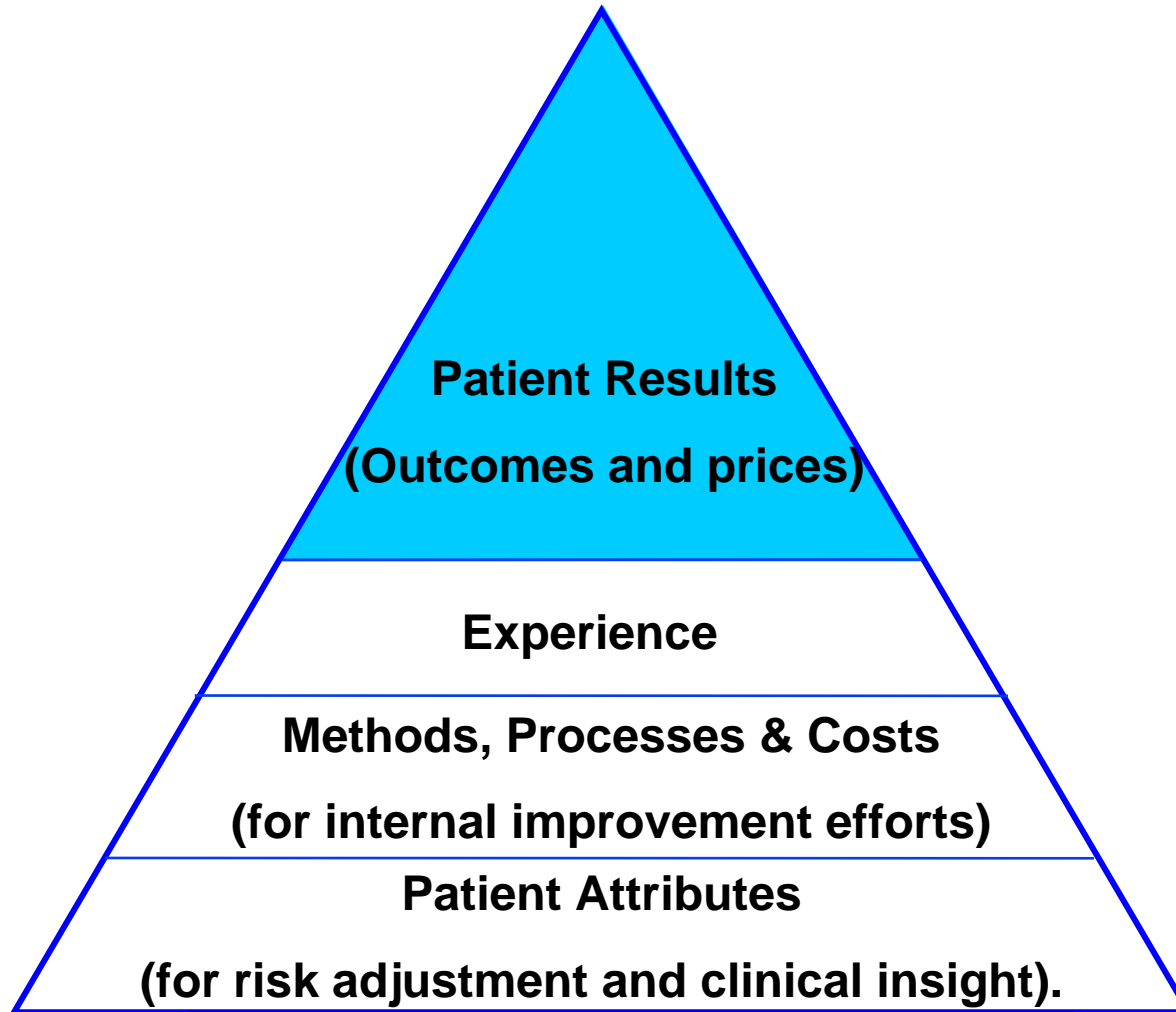
“But, patients don’t use information when it IS available!”

- The point is... **doctors DO.**
(Recall Cystic Fibrosis in the U.S. and public reporting in Sweden.)
- In New York, CABG surgery had a **41% reduction in mortality** in the first four years of outcome reporting.
- The Society of Thoracic Surgeons has developed state-of-the-art outcome measures (for internal use) since public reporting began.
- Minnesota began publishing **diabetes outcome data** in 2004, by physician. Statewide, in the first two years of public reporting, **the percent of patients passing all 5 of the outcome thresholds doubled (from 4% to 9%).**

Think about using outcome measures to enable improvement.

- Places that do this really well use outcome data as an enabler for physicians and teams, not as a report card.
- This isn't about just throwing information on the web. Support – for physicians as well as for patients-- is necessary. (Consider PGH.)
- Studies show that informed, involved patients choose less invasive treatments, comply better with physician advice and have better outcomes.
- Information needs to be coupled with ways for people to understand and use it, especially when lifestyle changes are involved.

The Information Hierarchy



Boston Spine Group -- Multidimensional Measures

Clinical and Outcome Information Collected and Analyzed

OUTCOMES

Patient Outcomes

(before and after treatment, multiple times)

Visual Analog Scale (pain)

Owestry Disability Index, 10 questions
(functional ability)

SF-36 Questionnaire, 36 questions
(burden of disease)

Length of hospital stay

Time to return to work or normal activity

Service Satisfaction

(periodic)

Office visit satisfaction metrics (10 questions)

Overall medical satisfaction

("Would you have surgery again for the same problem?")

Medical Complications

Cardiac

Myocardial infarction

Arrhythmias

Congestive heart failure

Vascular deep venous thrombosis

Urinary infections

Pneumonia

Post-operative delirium

Drug interactions

Surgery Complications

Patient returns to the operating room

Infection

Nerve injury

Sentinel events (wrong site surgeries)

Hardware failure

METHODS

Surgery Process Metrics

Operative time

Blood loss

Devices or products used

**Quality and efficiency
will often improve
simultaneously.**

Health care IS different.

Good quality is often more efficient, not more expensive.

**More health is better, not more treatment. And more health
is inherently less expensive than poor health.**

Health Care *IS* different

- More than in other sectors, *better quality inherently reduces costs*
 - Fewer mistakes and repeats
 - Faster recovery
 - Less disability
 - Less invasive treatment methods
 - Less long term care
 - Disease management
 - Prevention
 - Right Diagnosis
 - Treatment earlier in causal chain
 - Right treatment to the right patients
 - Better health is inherently less expensive than worse health

The “good” or “product” here is **health**, *not treatment*.

Much delivered health care is behind best practices

→ big opportunity for simultaneous improvement in quality and efficiency.

Value is driven by

**the team's experience, scale,
and learning**

at the **medical condition level.**

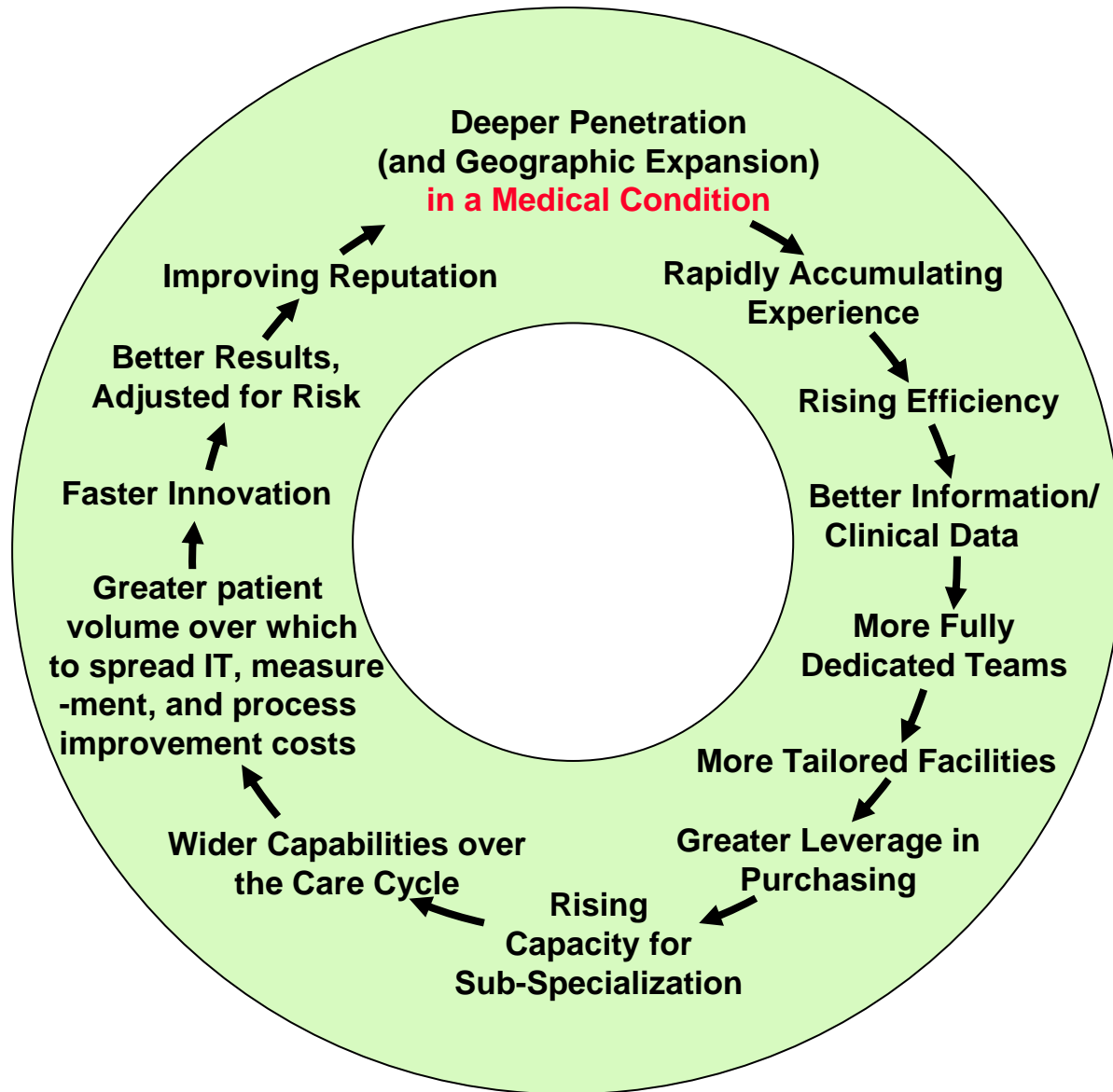
**Experience can drive learning, and
learning drives excellence.**

You and I would like to assume that every physician and every team is learning and up to date, but...

Studies show that today, the care delivered -- and the results -- depend more on **where the patient is diagnosed and treated than on science or the state of the art of medical knowledge.**

That's scary!

The Virtuous Circle in Health Care Delivery



Competition should be
regional and **national**,
not just local.

**The most important competition is the competition of every hospital,
every physician, every supplier, every health plan....
to improve results for patients compared to others with same
condition (whether or not patients travel for services).**

Let's consider some data....

- How many heart transplant centers in the U.S.?
- What percentage of patients survive for one year after a heart transplant at a center with great results?
- What percentage of patients survive for one year after a heart transplant at a center with among the worst outcomes?
- Services that counsel patients about this data find that most are **eager to consider traveling** to a good center.
- The reason people think patients won't travel is because **patients and referring doctors lack data on RESULTS.**

Innovations that increase value
must be actively encouraged
and strongly rewarded.

The biggest need is for *organizational innovation* that improves
the value of health care delivery *to patients*.

Patient value needs to be the beacon of ideas and inspiration
for innovation.

Health Plans have significant opportunities when increasing health and health care value are the goals.

Provide Health Information and Support to Patients and Physicians

1. Organize around **medical conditions**, not geography or administrative functions
2. Develop measures and assemble **results information on providers and treatments**
3. Actively **support provider and treatment choice** with information and unbiased counseling
4. Organize information and patient support around the **full cycle of care**
5. Provide comprehensive **disease management and prevention services** to all members, even healthy ones

Restructure the Health Plan-Provider Relationship

6. Shift the nature of **information sharing** with providers
7. Reward provider **excellence** and value-enhancing **innovation** for patients
8. Move to **single bills** for episodes and cycles of care, and **single prices**
9. Simplify, standardize, and eliminate **paperwork and transactions**

Redefine the Health Plan-Subscriber Relationship

10. Move to **multi-year subscriber contracts** and **enabling health**
11. **End cost shifting practices**, such as re-underwriting, that erode trust in health plans and breed cynicism
12. Assist members to own and manage their **medical records**

Health care teams can innovate to increase the value delivered to patients. Here's how to set your compass and define direction...

- **Define the goal as increasing the value for patients**
 - Patients experience value when their medical conditions are resolved or managed effectively and efficiently.

Reorganize Practice around Care Cycles for Medical Conditions

- Tall order, but huge opportunity to lead positive change
 - This will make success far easier from the patient's perspective.
 - Remember, financial success *follows* creation of value.
- **Measure results**
 - Well constructed outcome information enables physicians and teams to enhance their expertise and improve value for their patients.
 - *Drive your own learning!*

How Will Redefining Health Care Begin?

- It is **already happening!**
- Each system participant can take **voluntary** steps in these directions, and will **benefit** irrespective of other changes. *Altruism is not required!*
- The changes are **mutually reinforcing**.
- Once competition begins working, value improvement will **no longer be discretionary** or **optional**. *Moving early has major benefits.*

***We CAN create
health care systems that drive
improvements in health
and
health care value for patients.***

end

