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Redefining Health Care

*Creating
Value-Based Competition
on Results*



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Creating a High-Value Health Care System

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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 <http://www.isc.hbs.edu>.

Redefining the goal:

The critical issue is the value of health care delivered.

Improving Value:

Better health outcomes relative to the cost of achieving them.

NOT JUST COST: If cost reduction were the real goal, pain killers and compassion would fit the bill.

NOT JUST ACCESS: Having everyone in the system is essential for efficiency as well as equity, but it is not enough to fix the problems.

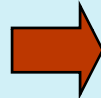
NOT JUST SHORT TERM: Disease progression drives value down with both worse outcomes and higher costs.

Employers need to consider the total costs of health care and health results

- **Two words: Health and Care.**
 - In addition to costs of health benefits, companies spend an additional 200% to 300% on the costs of poor health.
 - Shifting costs of health benefits may raise costs of poor health.
- **Cost shifting to other participants undermines efficiency and quality.**
 - Doesn't reduce costs, just moves them
 - Adds administrative costs
 - May add clinical costs by increasing inappropriate or delayed care
 - May increase costs of lost productivity
 - Distracts from efforts to improve health over the full cycle
 - Distracts from efforts to improve the value of health care.

A high value health system is a new conception of market-based reform.

- Cost-based
- Consumer-driven
- Organized by specialties
- Fragmented
- Poorly Coordinated
- Culture of Control
- More Treatment



- Value-based**
- Results-driven**
- Patient-centered**
- Full Cycle**
- Team Based**
- Culture of Quality**
- More Health**

Today's competition is not aligned with value.

Financial success is not aligned with patient success.

**Framing the choice as between
a government-run system and a consumer-driven system
misses a huge opportunity.**

- Consumers cannot fix the dysfunctional structure of the current system.
 - Most CDHC is cost shifting
- Administrative oversight and process specification will not fix the problems.
 - Managed care
 - Process control
 - Evidence based medicine
 - P4P
 - “transparency”
- IT that automates today’s systems is not enough

To achieve dramatic and ongoing improvements in value for patients, “set the compass” with 3 guideposts:

1. Patient- and Family-Centered Care

- Define the goal as increasing value for patients.

2. Results-Driven Improvement

- Measure results at the level at which value is created for patients.
- *Drive learning!*

3. Value-based Restructuring of Delivery

- Redesign delivery around full care cycles for medical conditions.

A “medical condition” is a set of interrelated medical circumstances that are best cared for in an integrated way.

(So, diabetes with hypertension IS a medical condition; four co-occurring chronic diseases may be “a medical condition.” CABG surgery is a procedure, NOT a condition.)

Improving results for patients increases value rather than dividing value.

- **This is a win-win proposition.**
- Consider anesthesia improvements.
- Notice, the goal is **improving value for patients**, not creating consumer-driven care, which often means *shifting costs*.
- Consider Swedish results improvements.

What should it mean to COMPETE?

Sports and war are the wrong models.

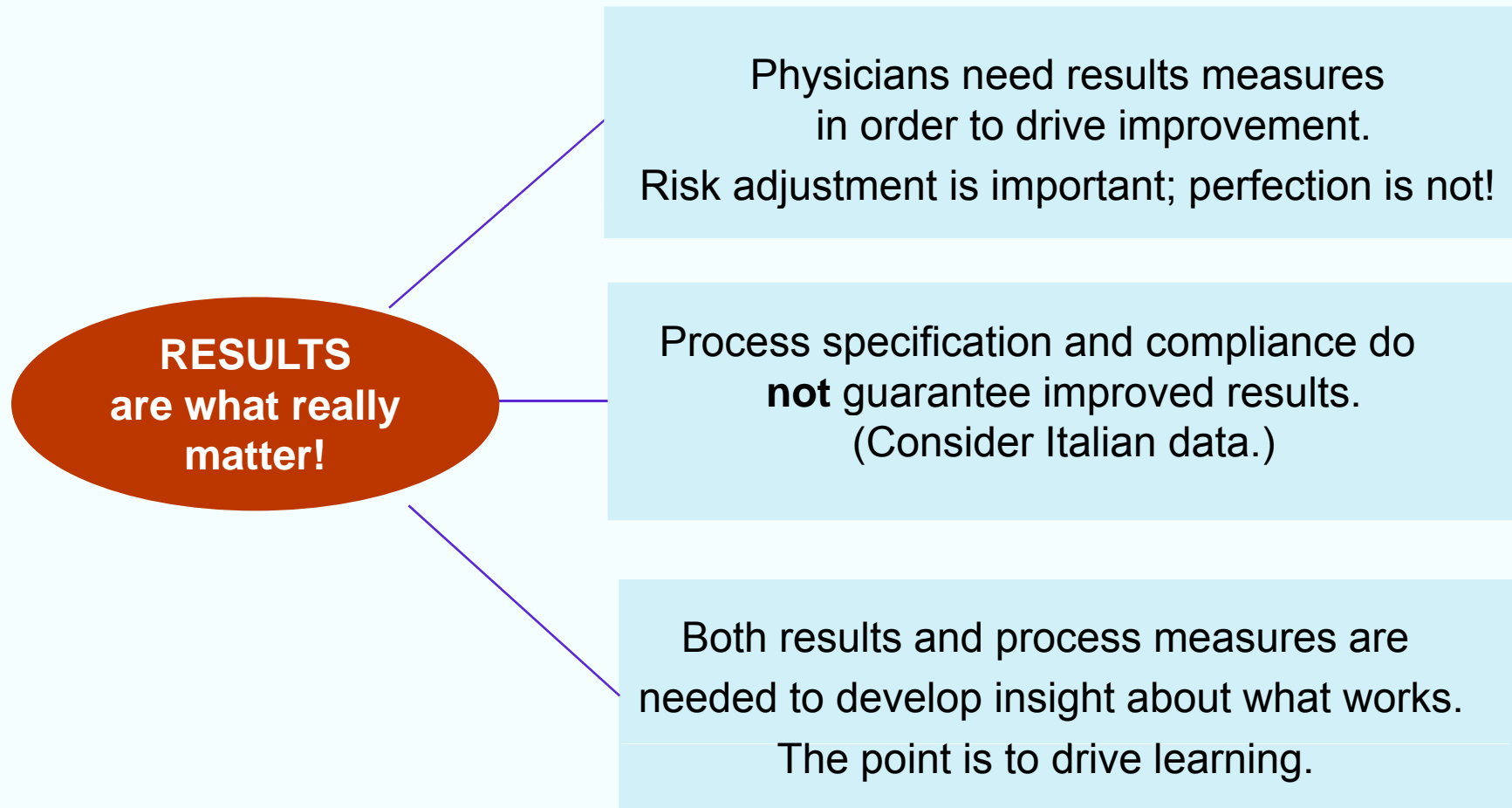
Healthy competition is about INCREASING VALUE.

**This means improving results (outcomes and costs),
not shifting costs or winning at someone else's expense.**

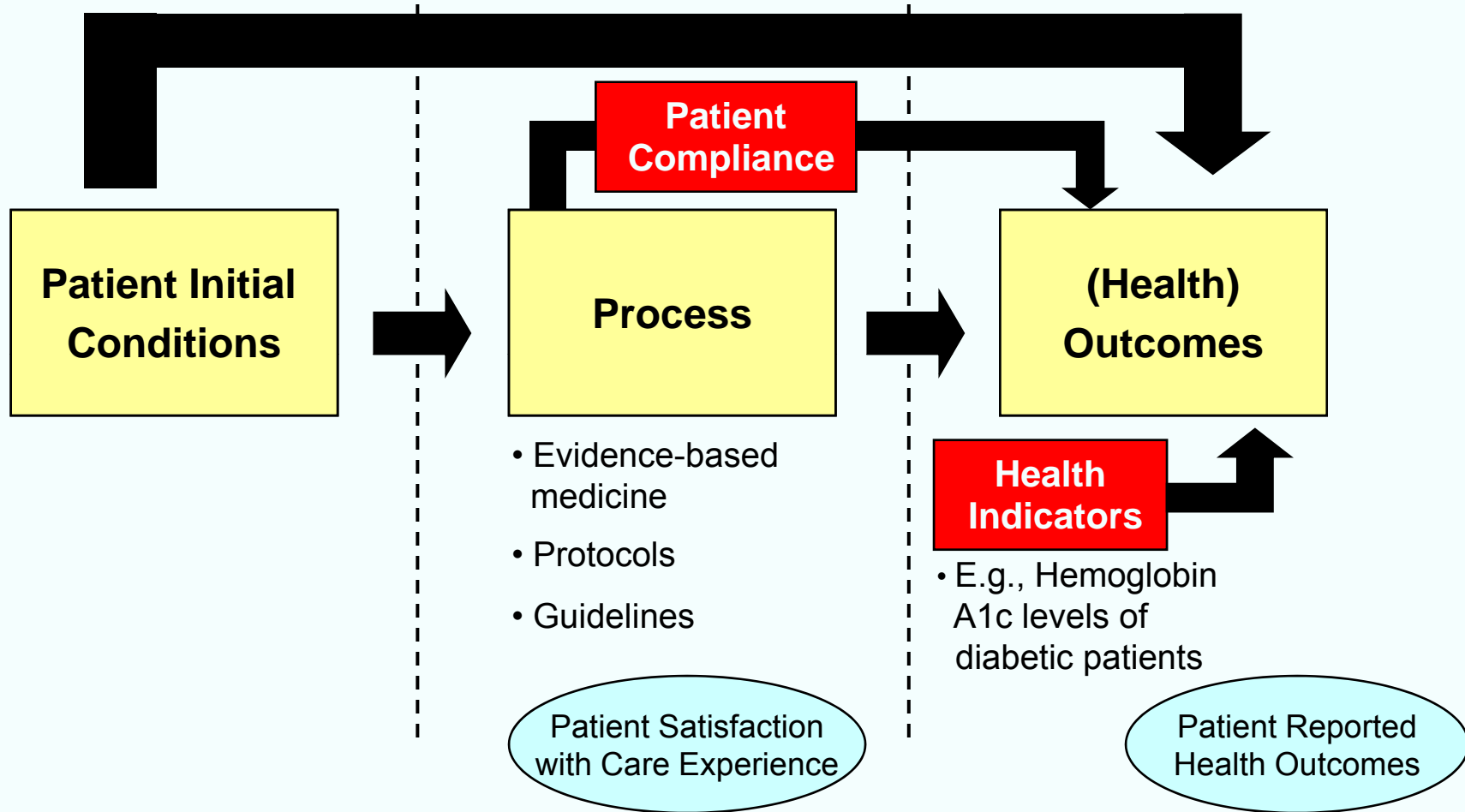
**Improving results for patients *increases value*
rather than dividing value.**

**And improving value aligns interests, rather than
having participants pursuing different goals.**

Widely available information on results drives improvement in outcomes for patients.

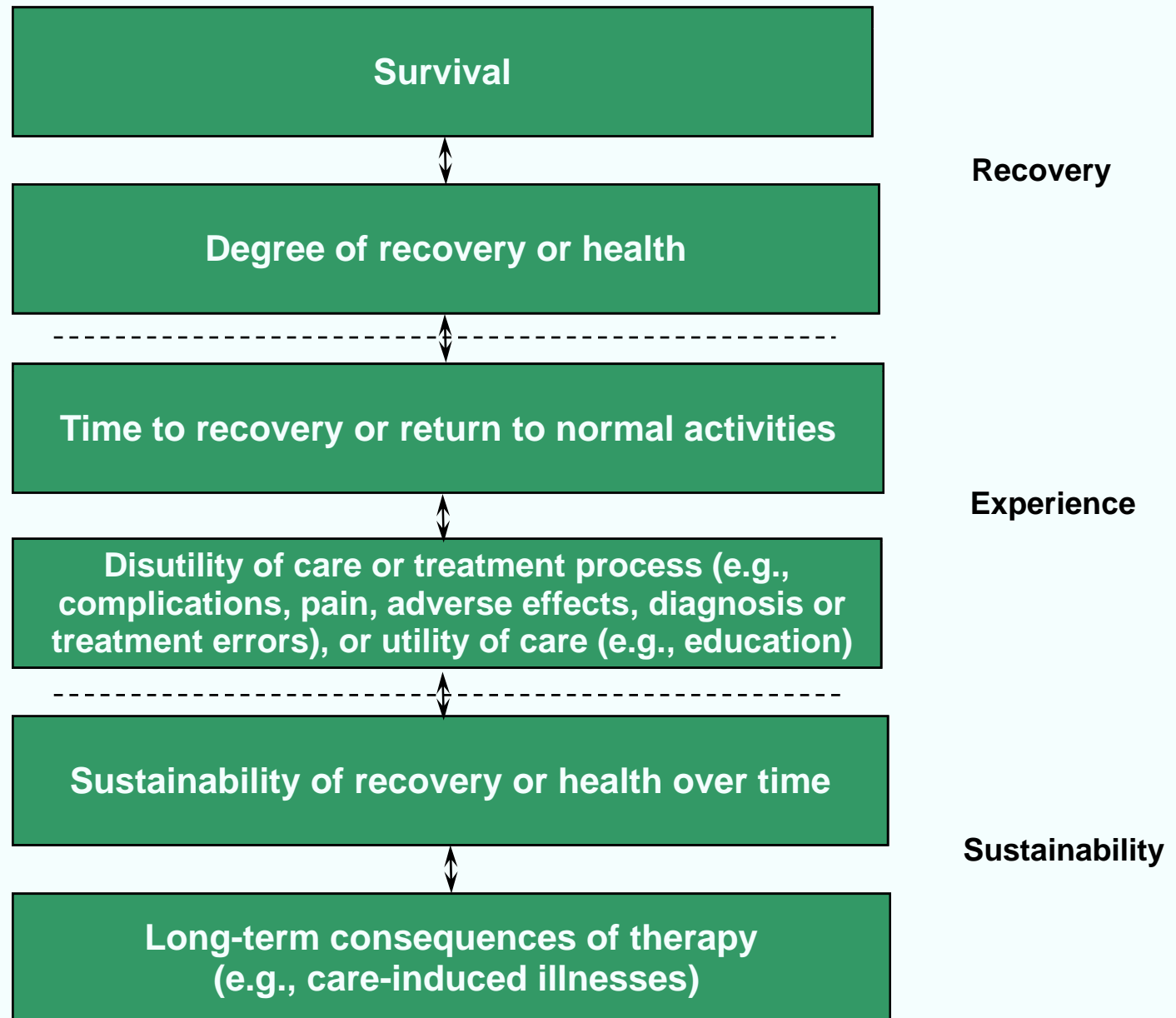


Measuring Value

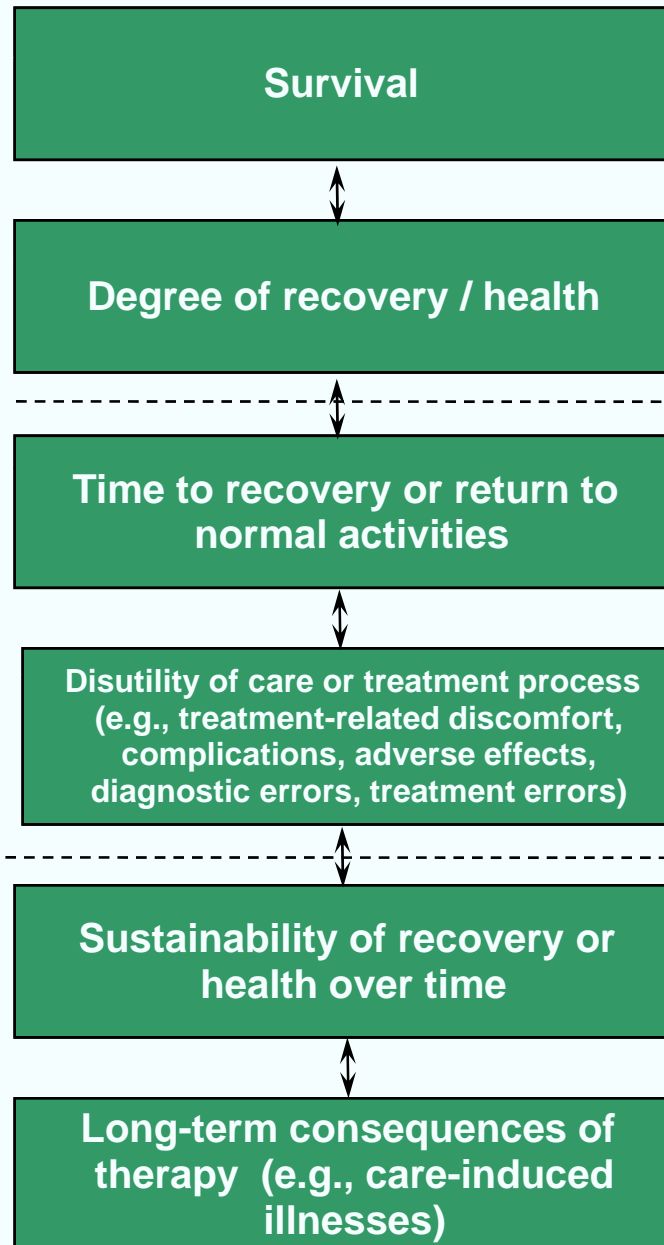


Measuring Results

There are Multiple Outcome Measures for every condition.



Measuring Breast Cancer Outcomes



- **Survival rate**
(One year, three year, five year, longer)

- **Remission**
- **Functional status**

- **Breast conservation surgery outcome**

- **Time to remission**

- **Time to achieve functional status**

- **Nosocomial infection**
- **Nausea**
- **Vomiting**

- **Febrile neutropenia**
- **Limitation of motion**
- **Depression**

- **Cancer recurrence**

- **Sustainability of functional status**

- **Incidence of secondary cancers**
- **Brachial plexopathy**

- **Premature osteoporosis**

"But, patients don't use outcome information when it IS available!"

The point is ... doctors do!

- New York, CABG surgery
- Cystic fibrosis national comparisons
- Minnesota public outcome measures for diabetes

- And... truly informed, involved patients take more personal health responsibility and choose less invasive, less expensive care. (Throwing information on the web is not enough.)
- Unfortunately, health plans tend to use “consumerism” as a renewed call for cost shifting to consumers.

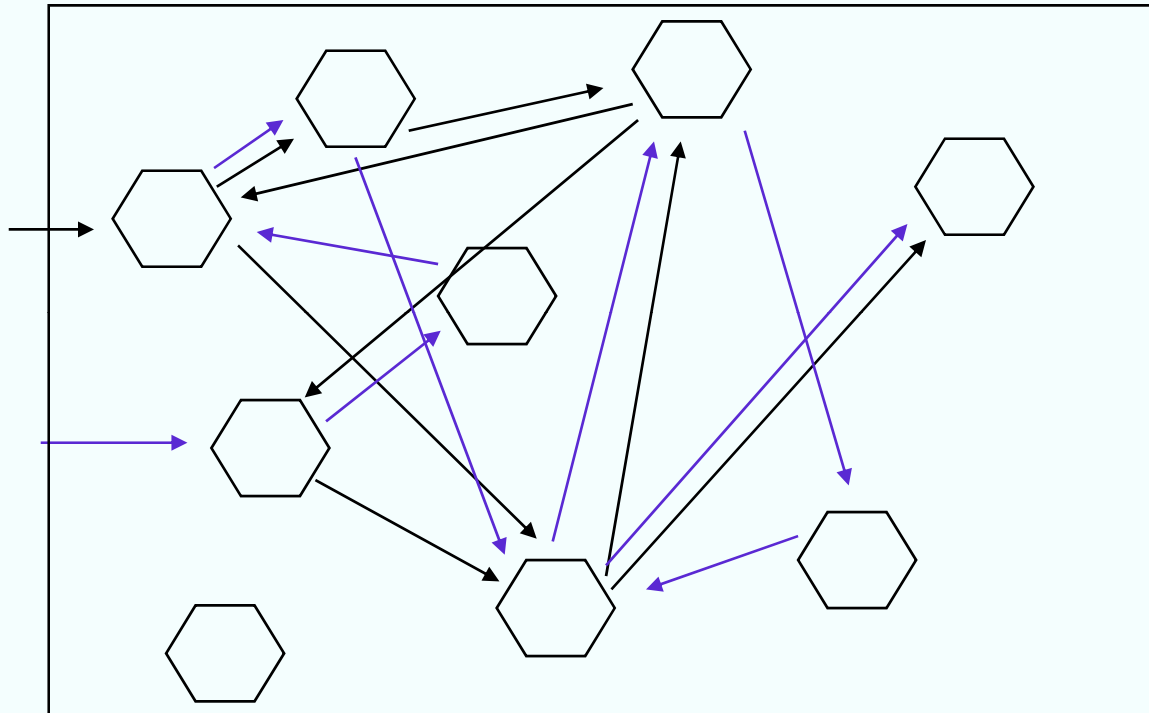
But are results really all that different?

- Consider heart transplants.
- **Too often, physicians and patients lack data on RESULTS.**

The feasibility of universal outcome measurement at the medical condition level has been **conclusively demonstrated**.

And *using* measures is the fastest way to ensure improvement -- not just in results, but in the measures themselves.

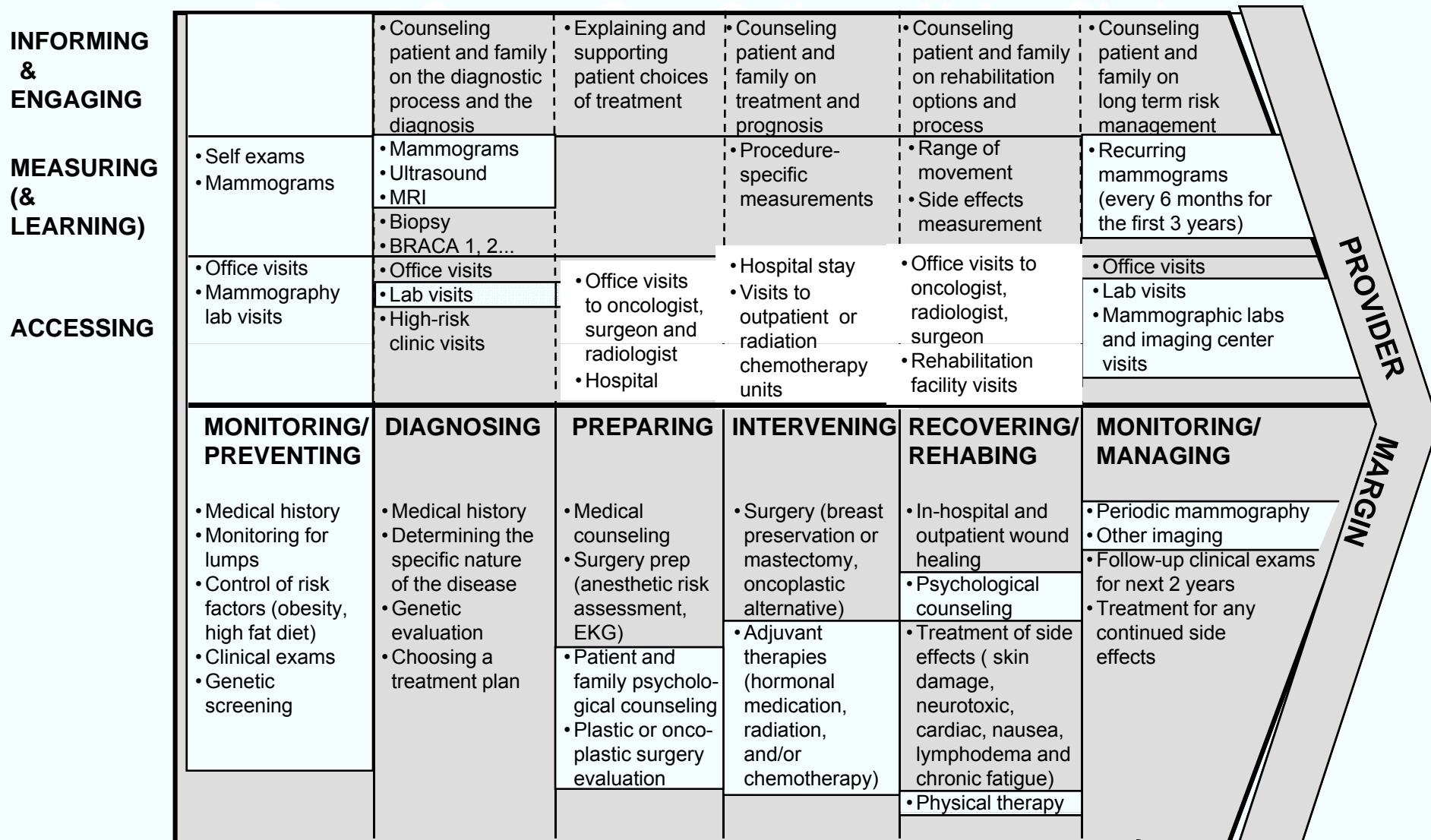
Today, most “integrated” care is not a team, but a collection of fragmented services.



The care differs, the judgments on which it is based differs, the outcomes differ... and the clinicians never really know the team’s results, or to what they should compare. They work hard, care a lot, and assume they’ve done very well.

But data show...most have not done “very well.”

Currently, most care is delivered with **fragmented** processes. (the value chain is a powerful tool for redesign insights)

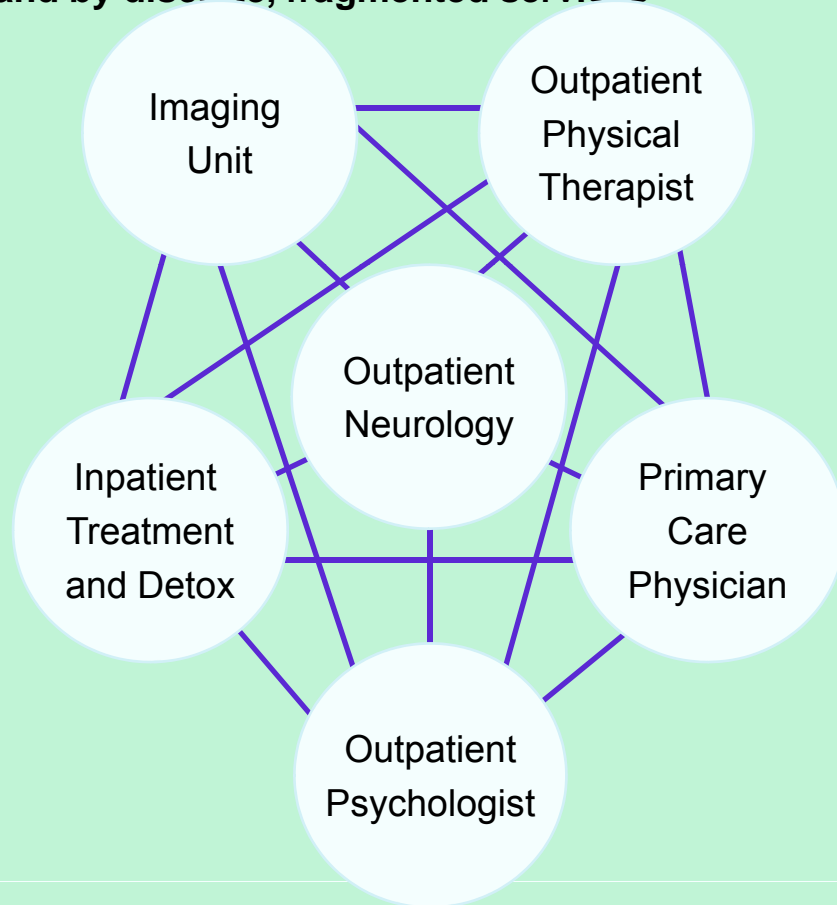


Today, EVERY patient requires special effort to coordinate care.

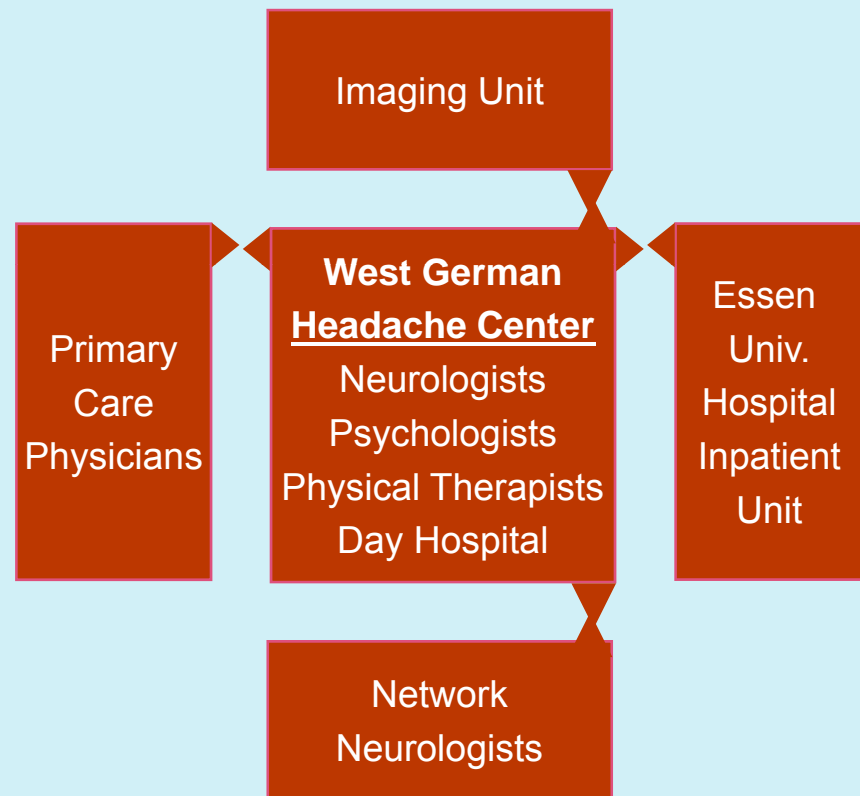
<input type="checkbox"/>	Breast Cancer Specialist
<input type="checkbox"/>	Other Provider Entities

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

Old model: Organized by specialty and by discrete, fragmented services



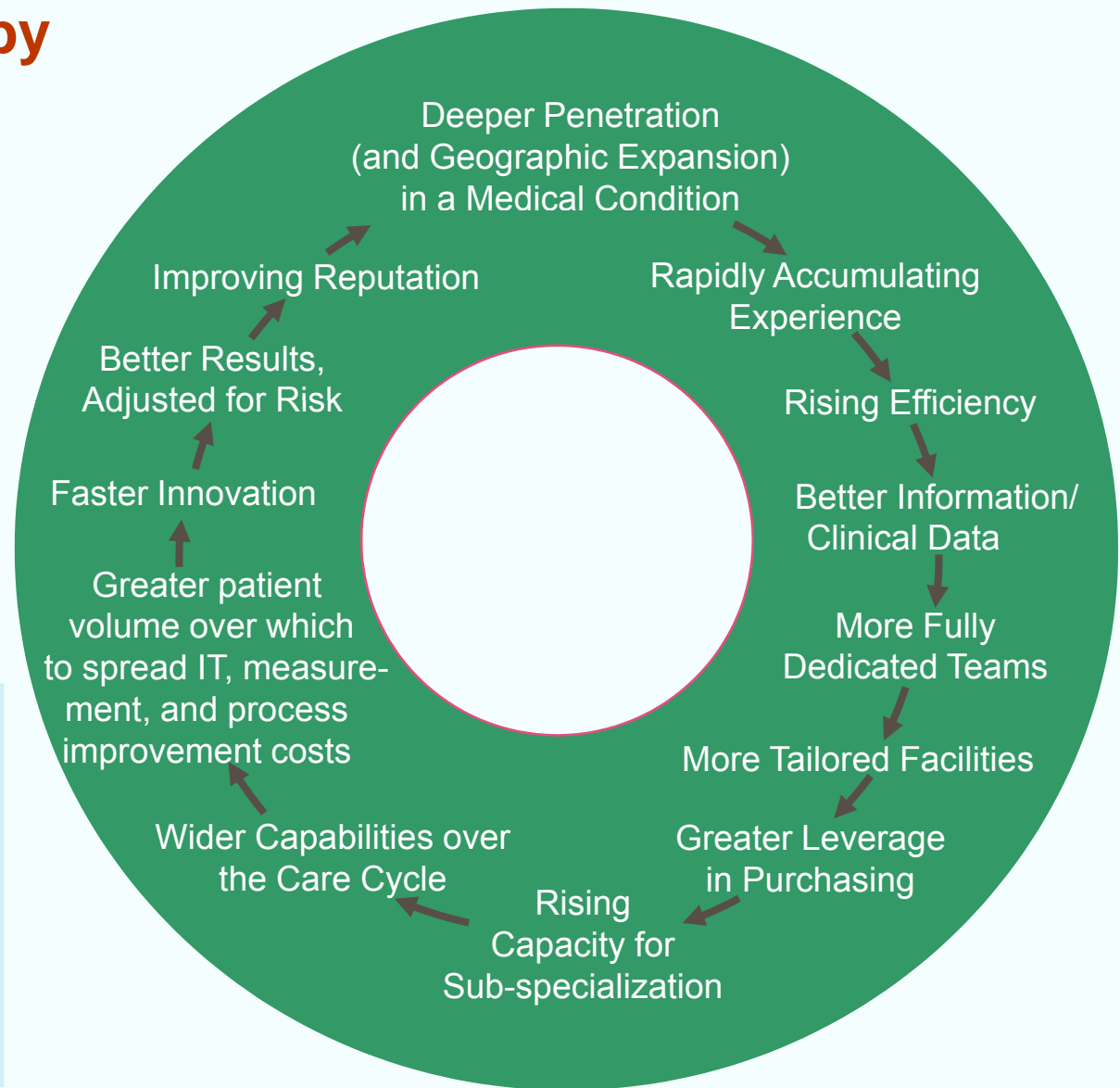
New model: integrated practice unit



Migraine care in Germany:

Integration of care simplifies coordination for patients and patients have far fewer days of disabling pain.

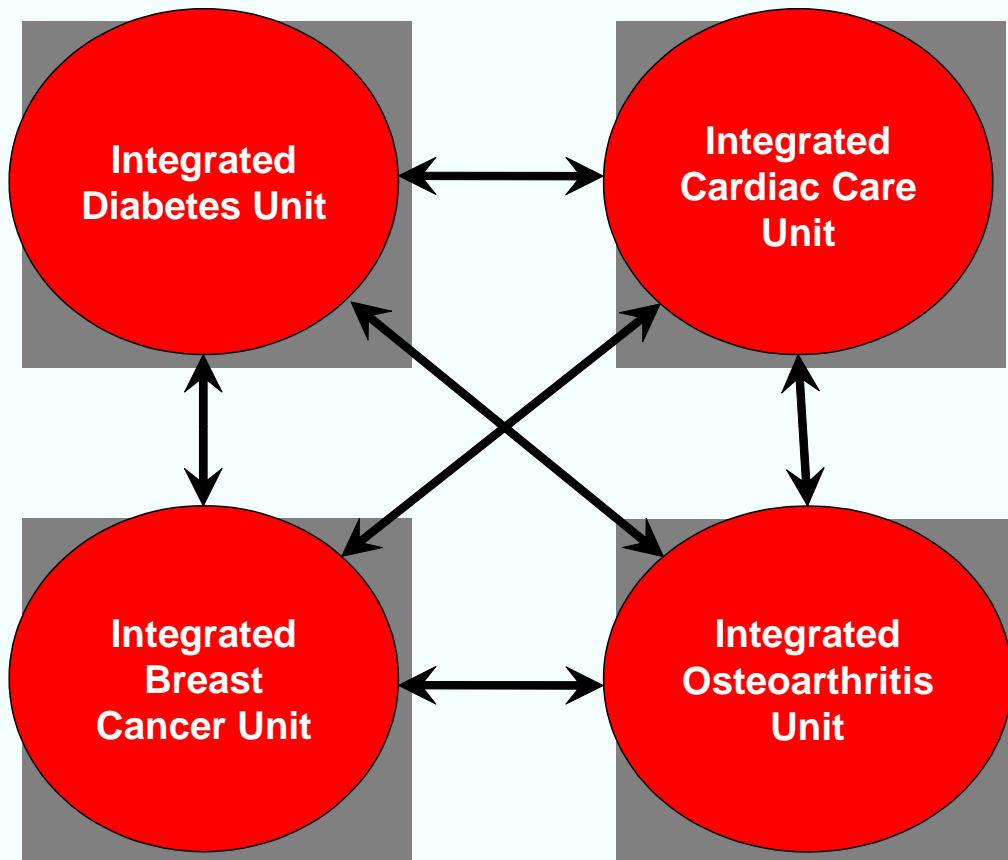
Integrated Practice Units drive improvement by driving learning at the medical condition level.



**This is not hyper-specialization.
It is not focused factories.
It is not archipelagos.
Broad expertise develops over the care cycle for the patient.
Consider cystic fibrosis.**

Patients with Multiple Medical Conditions

Coordinating Care Across IPUs



- The primary organization of care delivery should be around the integration required for **every patient**
- IPUs will greatly **simplify the coordination** of care for patients with multiple medical conditions
- The patient with multiple conditions will be **better off** in an IPU model

“But ...costs are rising worldwide, can we afford to focus on improving results and value?”

Yes. The best way to contain costs is to drive improvements in quality.

Health care IS different.

- Better health is the goal, not more treatment.
- And good health is inherently less expensive than poor health.
- We **can** afford to pursue better health for all... indeed we can't afford NOT to.

Health care IS different.

Even 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 of disease or progression
- Right diagnoses
- Treatment earlier in causal chain
- Right treatment to the right patients

Living in good health
is less expensive than
living in poor health.

Much delivered care does not meet best practices.

Process improvement, "waste reduction," and safety improvements can drive very large gains, but streamlining the pieces of a fragmented system and patching the fragments together have inherent limits.

We can achieve even more dramatic improvements in value by redefining care delivery across the care cycles for medical conditions.

Information Technology and Changes in Reimbursement

Information technology will **enable** restructuring of care delivery and **measuring results**, but is **not a solution by itself**.

- Common data definitions
- Interoperability standards
- Patient-centered database
- Cover the full care cycle, including referring entities

Reimbursement should be aligned with **value** and reward **innovation**.

- Reimbursement for **care cycles**, not discrete treatments or services
- Reimbursement for **prevention and screening**, not just treatment
- Reimbursement for **overall management of chronic condition**
- Most DRG systems are **too narrow**

Health plans, employers & clinicians will benefit by changing reimbursement -- share the gains of value improvement!

There is no need to wait.

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

Focusing on health results aligns interests.

Imagine...

health care systems that are truly about
health and care.