

Value-Based Health Care Delivery

Professor Michael E. Porter
Harvard Business School

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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 Porter, Michael E. "A Strategy for Health Care Reform." *New England Journal of Medicine*. June 3, 2009. Porter, Michael E. "Defining and Introducing value in Health Care." Evidence-Based Medicine and the Changing Nature of Healthcare: Meeting Summary (IOM Roundtable on Evidence-Based <http://www.nap.edu/catalog/12041.html>). 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>.

Principles of Value-Based Health Care Delivery

The central goal in health care must be **value for patients**, not access, volume, convenience, or cost containment

$$\text{Value} = \frac{\text{Health outcomes}}{\text{Costs of delivering the outcomes}}$$

- 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 value improvement, where quality is **health outcomes**

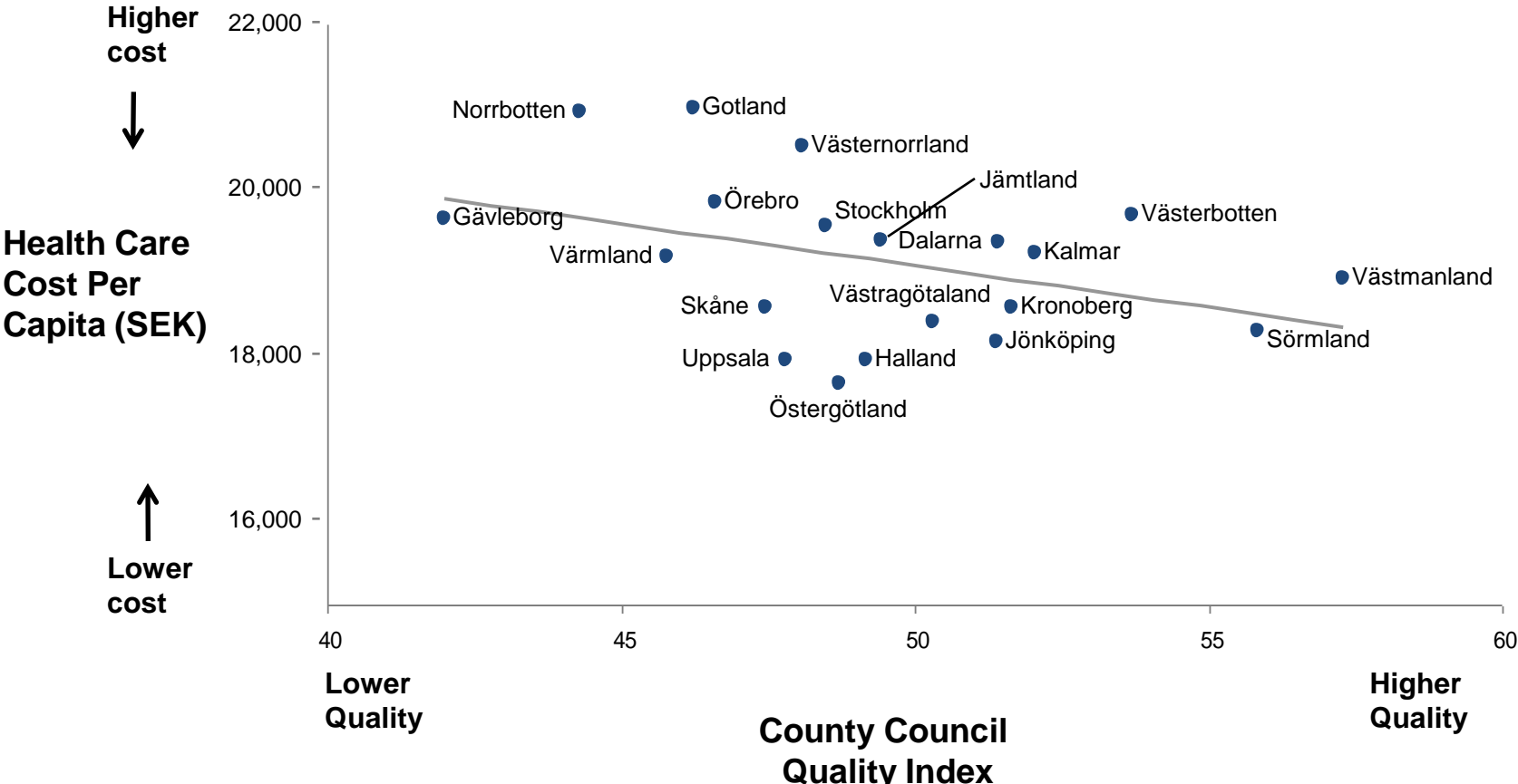
- Prevention
- Early detection
- Right diagnosis
- Right treatment to the right patient
- Early and timely treatment
- Treatment earlier in the causal chain of disease
- Rapid cycle time of diagnosis and treatment
- Less invasive treatment methods
- Fewer complications
- Fewer mistakes and repeats in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

Cost versus Quality, Sweden

Health Care Spending by County, 2008



Note: Cost including; primary care, specialized somatic care, specialized psychiatry care, other medical care, political health- and medical care activities, other subsidies (e.g. drugs)
 Source: Öppna jämförelser, Socialstyrelsen 2008; Sjukvårdsdata i fokus 2008; BCG analysis

Value-Based Health Care Delivery

The Strategic Agenda

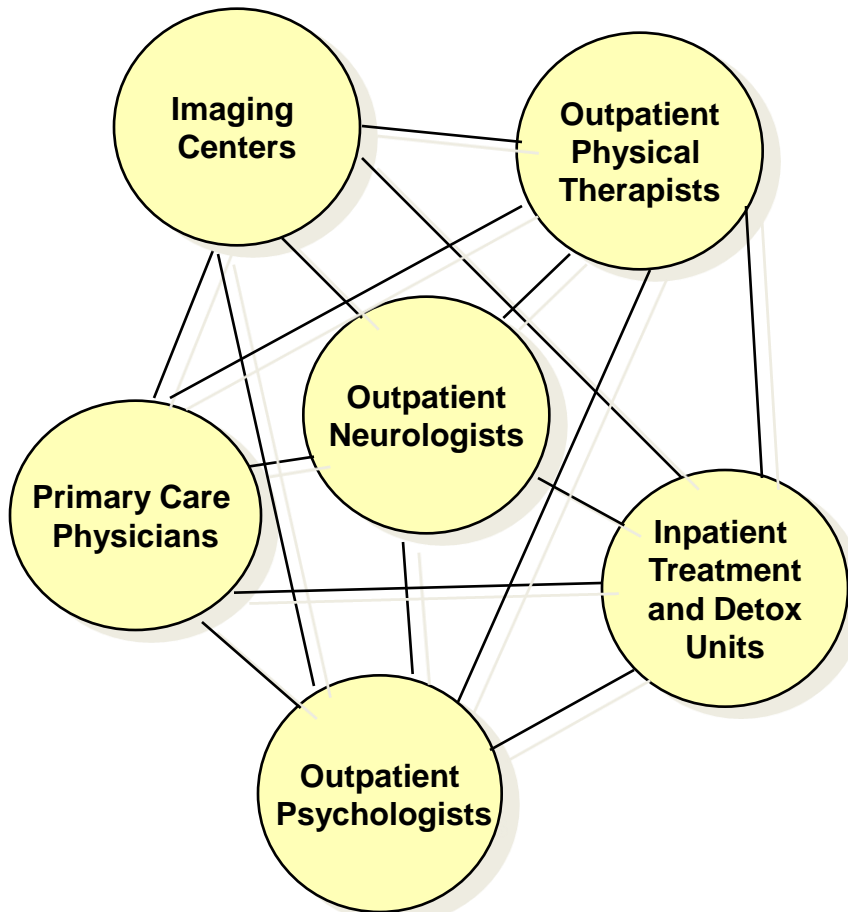
1. Organize into Integrated Practice Units around the Patient's Medical Condition (IPUs)
 - Including primary and preventive care for **distinct patient populations**
2. Measure Outcomes and Cost for Every Patient
3. Move to Bundled Prices for Care Cycles
4. Integrate Care Delivery Across Separate Facilities
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

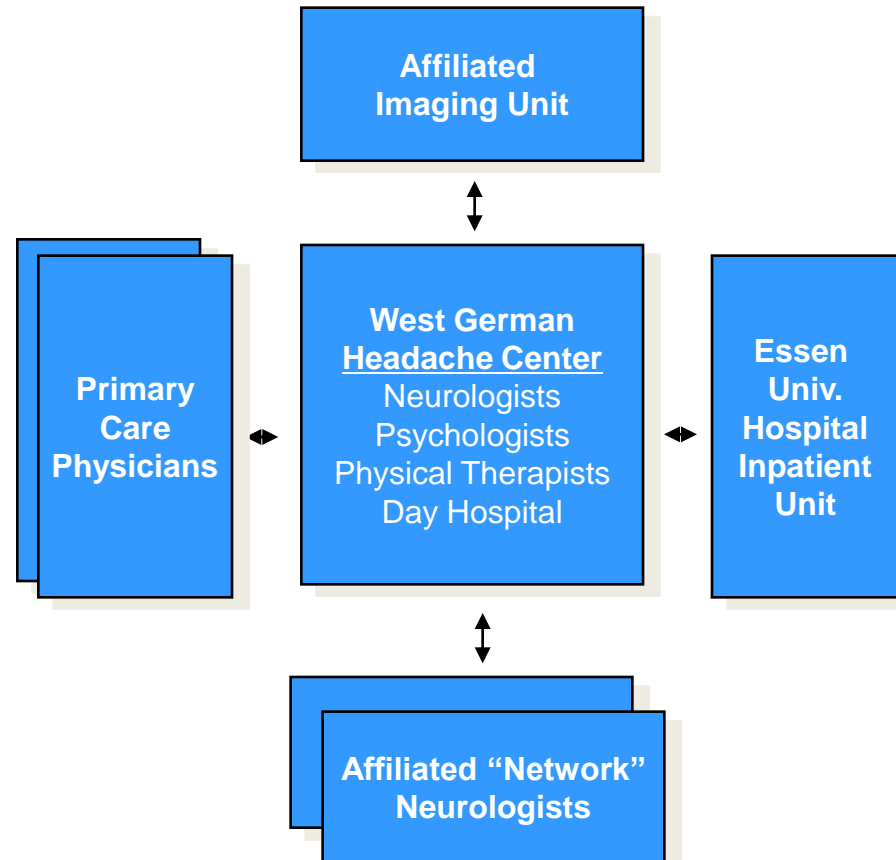
Existing Model:

Organize by Specialty and Discrete Services



New Model:

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

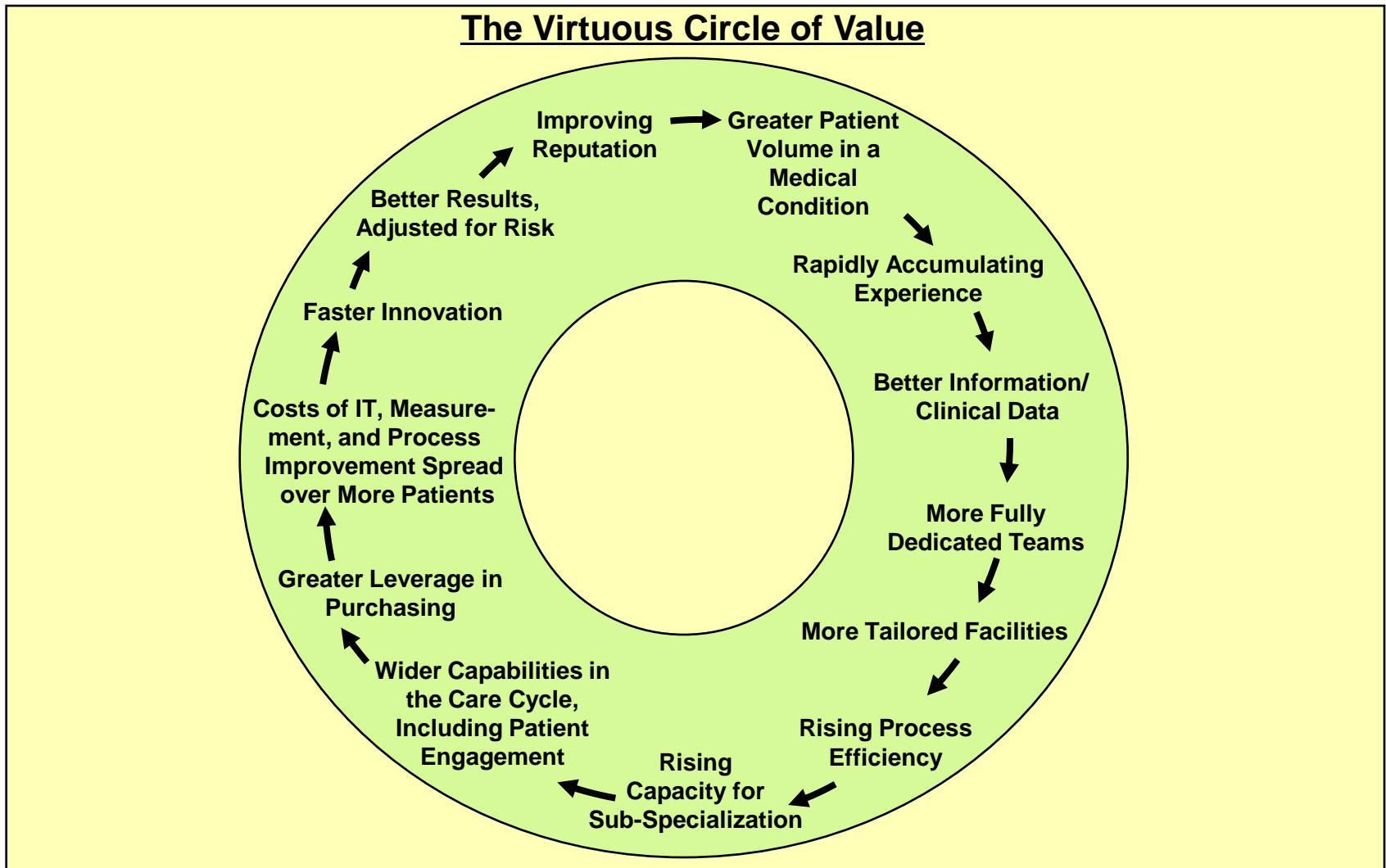
Integrating Across the Cycle of Care

Breast Cancer

INFORMING AND ENGAGING	<ul style="list-style-type: none"> ▪ Advice on self screening ▪ Consultations on risk factors 	<ul style="list-style-type: none"> ▪ Counseling patient and family on the diagnostic process and the diagnosis 	<ul style="list-style-type: none"> ▪ Explaining patient treatment options/shared decision making 	<ul style="list-style-type: none"> ▪ Counseling on the treatment process ▪ Education on managing side effects and avoiding complications of treatment ▪ Achieving compliance 	<ul style="list-style-type: none"> ▪ Counseling on rehabilitation options, process ▪ Achieving compliance ▪ Psychological counseling 	<ul style="list-style-type: none"> ▪ Counseling on long term risk management ▪ Achieving Compliance
			<ul style="list-style-type: none"> ▪ Patient and family psychological counseling 			
MEASURING	<ul style="list-style-type: none"> ▪ Self exams ▪ Mammograms 	<ul style="list-style-type: none"> ▪ Mammograms ▪ Ultrasound ▪ MRI ▪ Labs (CBC, Blood chems, etc.) 	<ul style="list-style-type: none"> ▪ Labs 	<ul style="list-style-type: none"> ▪ Procedure-specific measurements 	<ul style="list-style-type: none"> ▪ Range of movement ▪ Side effects measurement 	<ul style="list-style-type: none"> ▪ MRI, CT ▪ Recurring mammograms (every six months for the first 3 years)
ACCESSING	<ul style="list-style-type: none"> ▪ Office visits ▪ Mammography lab visits 	<ul style="list-style-type: none"> ▪ Office visits 	<ul style="list-style-type: none"> ▪ Office visits 	<ul style="list-style-type: none"> ▪ Hospital stays 	<ul style="list-style-type: none"> ▪ Office visits 	<ul style="list-style-type: none"> ▪ Office visits
		<ul style="list-style-type: none"> ▪ Biopsy ▪ BRACA 1, 2... ▪ CT ▪ Bone Scans 	<ul style="list-style-type: none"> ▪ Hospital visits ▪ Lab visits 	<ul style="list-style-type: none"> ▪ Visits to outpatient radiation or chemotherapy units ▪ Pharmacy 	<ul style="list-style-type: none"> ▪ Rehabilitation facility visits ▪ Pharmacy 	<ul style="list-style-type: none"> ▪ Lab visits ▪ Mammographic labs and imaging center visits
		<ul style="list-style-type: none"> ▪ Lab visits ▪ High risk clinic visits 				
MONITORING/PREVENTING DIAGNOSING PREPARING INTERVENING RECOVERING/REHABING MONITORING/MANAGING						
<ul style="list-style-type: none"> ▪ Medical history ▪ Control of risk factors (obesity, high fat diet) ▪ Genetic screening ▪ Clinical exams ▪ Monitoring for lumps 	<ul style="list-style-type: none"> ▪ Medical history ▪ Determining the specific nature of the disease (mammograms, pathology, biopsy results) ▪ Genetic evaluation ▪ Labs 	<ul style="list-style-type: none"> ▪ Choosing a treatment plan ▪ Surgery prep (anesthetic risk assessment, EKG) 	<ul style="list-style-type: none"> ▪ Surgery (breast preservation or mastectomy, oncoplastic alternative) 	<ul style="list-style-type: none"> ▪ In-hospital and outpatient wound healing ▪ Treatment of side effects (e.g. skin damage, cardiac complications, nausea, lymphedema and chronic fatigue) 	<ul style="list-style-type: none"> ▪ Periodic mammography ▪ Other imaging 	<ul style="list-style-type: none"> ▪ Follow-up clinical exams ▪ Treatment for any continued or later onset side effects or complications
		<ul style="list-style-type: none"> ▪ Plastic or onco-plastic surgery evaluation ▪ Neo-adjuvant chemotherapy 	<ul style="list-style-type: none"> ▪ Adjuvant therapies (hormonal medication, radiation, and/or chemotherapy) 	<ul style="list-style-type: none"> ▪ Physical therapy 		

Breast Cancer Specialist
 Other Provider Entities

Volume and Experience in a Medical Condition Drive Patient Value



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

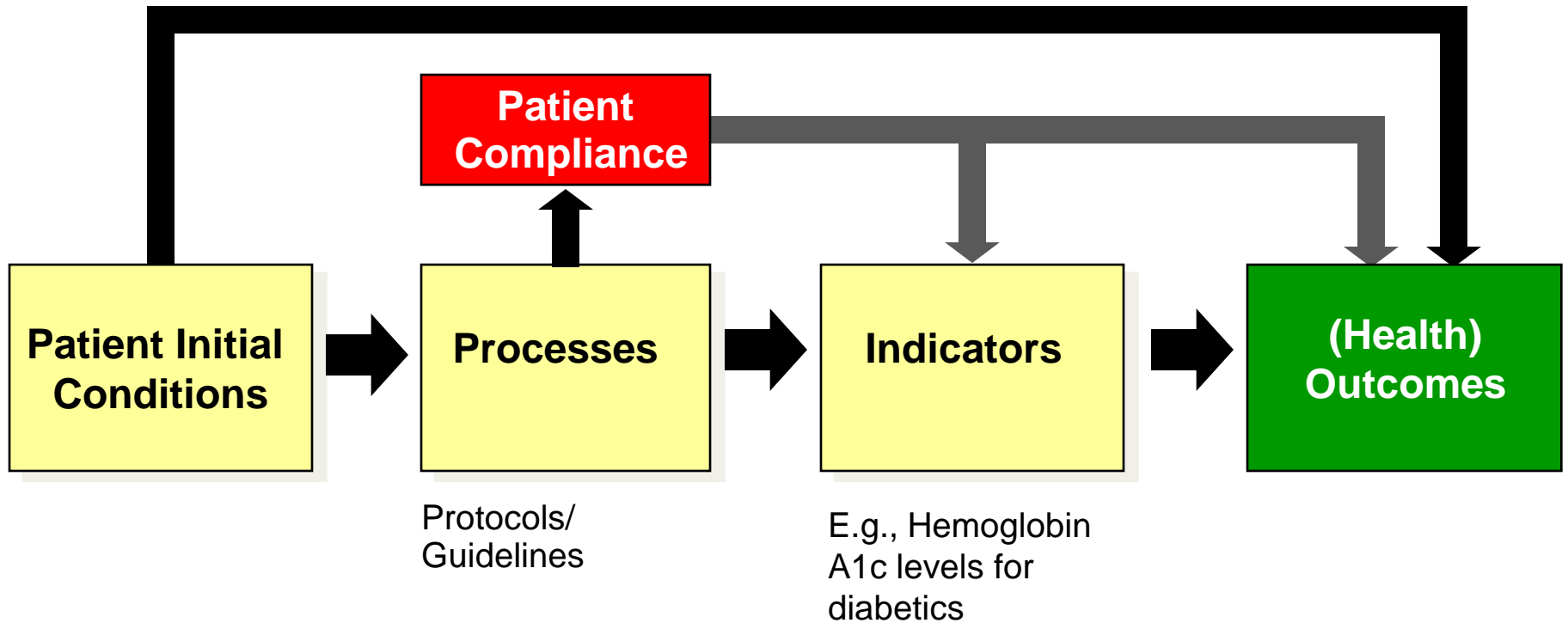
Fragmentation of Hospital Services

Sweden

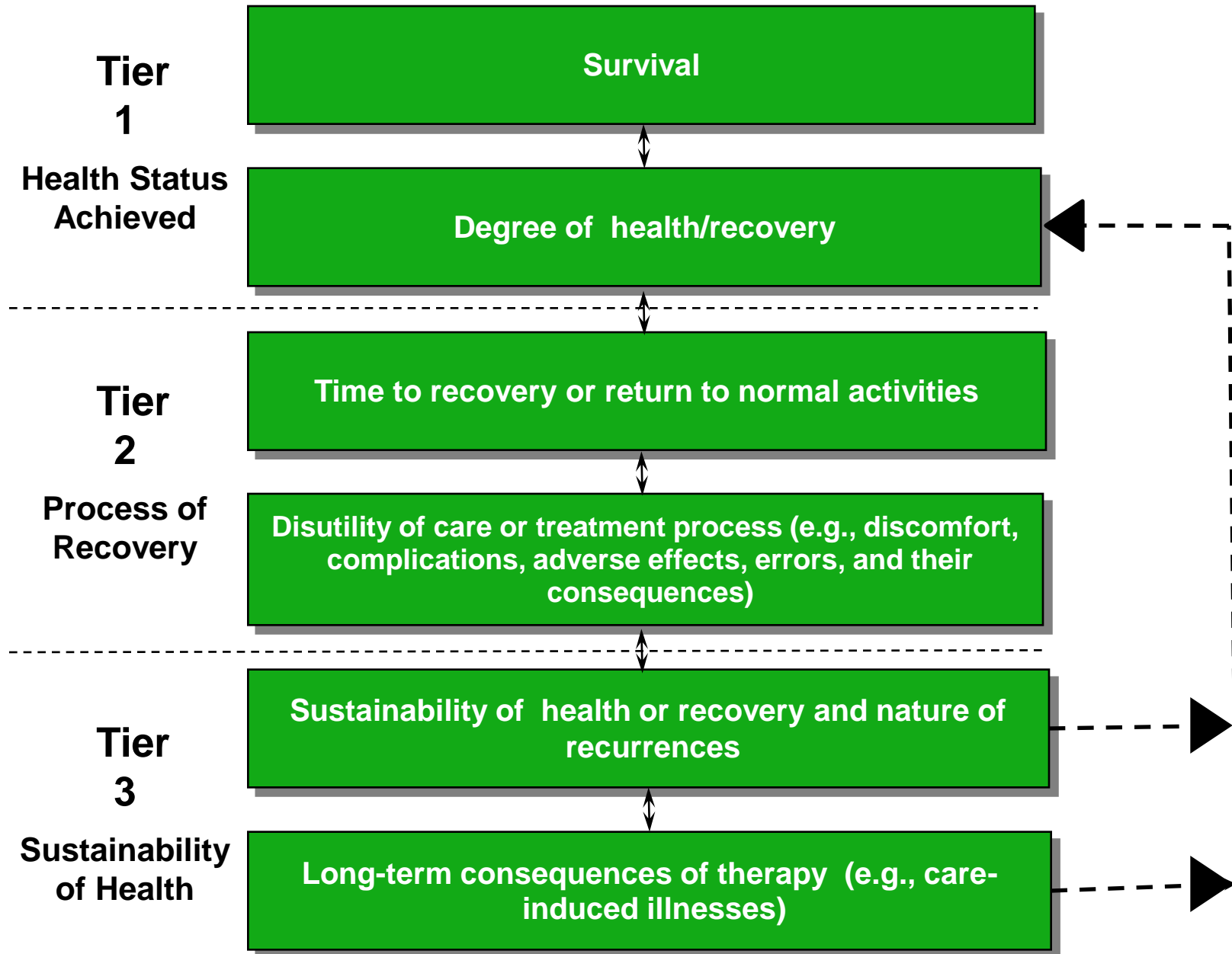
DRG	Number of admitting providers	Average percent of total national admissions	Average admissions/ provider/ year	Average admissions/ provider/ week
Knee Procedure	68	1.5%	55	1
Diabetes age > 35	80	1.3%	96	2
Kidney failure	80	1.3%	97	2
Multiple sclerosis and cerebellar ataxia	78	1.3%	28	1
Inflammatory 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. Measuring Outcomes and Cost for Every Patient



The Outcome Measures Hierarchy



3. Move to Bundled Prices for Care Cycles

What is a 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**

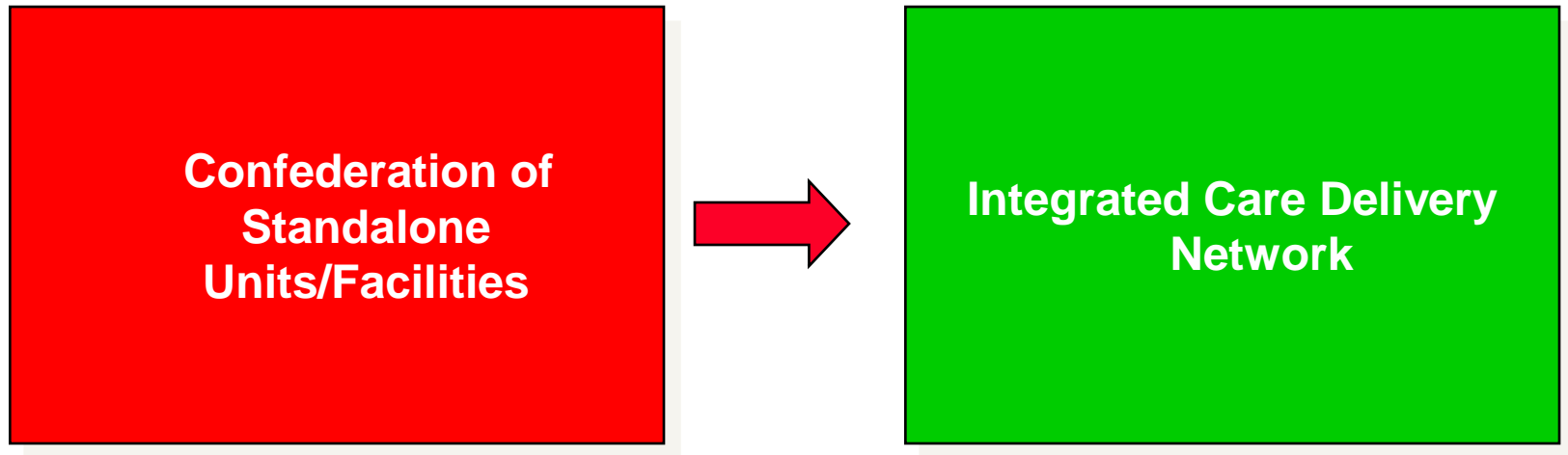
What is Not a Bundled Payment

- Price for a **short** episode (e.g. inpatient only, procedure only)
- **Separate** payments for physicians and facilities
- **Pay-for-performance** bonuses
- “**Medical Home**” payment for care coordination



- DRGs can be a **starting point** for bundled payment models

4. Integrate Care Delivery Across Separate Facilities

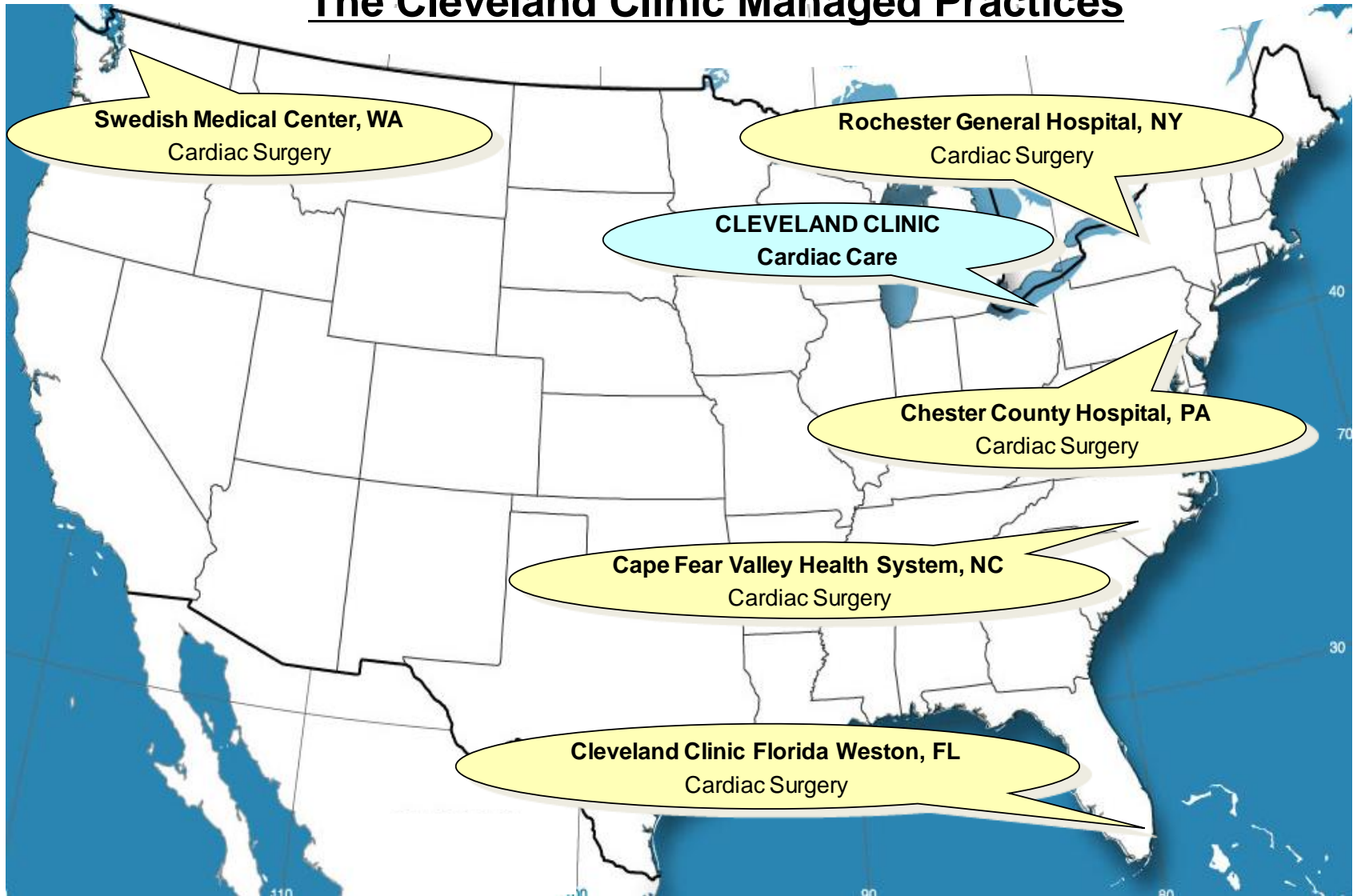


- Increase overall **volume**
↓
- Benefits limited to **contracting** and **spreading limited fixed overhead**

- Increase **value**
↓
- The network is **more than** the sum of its parts

5. Grow by Expanding Excellent IPU's Across Geography

The Cleveland Clinic Managed Practices



- Grow in ways that improve **value**, not just volume

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
- Allowing access and communication among **all involved parties**, including patients
- **“Structured”** data vs. free text
- **Templates** for medical conditions to enhance the user interface
- Architecture that allows **easy extraction of outcome, process, and cost measures**
- Interoperability standards enabling communication among **different provider systems**

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CDHCS: Value-Based Health Care Delivery Seminar

June 4, 2010, UCLA Anderson School of Management

8:30-9:00am	Check In
9:00-9:30am	Welcome and Introduction to Value-Based Health Care Delivery
9:30-11:00am	Session 1: Integrated Practice Units: Structure, Organization, Process, and Case Study: The University of Texas MD Anderson Cancer Center: Interdisciplinary Cancer Care
11:00-11:15am	Break
11:15am-11:30am	Protagonist Video Thomas Burke, Physician-in-Chief; Randal Weber, Chair, Dept. of Head and Neck Surgery; and Ehab Hanna, Deputy Chair, Dept. of Head and Neck Surgery; MD Anderson Cancer Center
11:30-12:15pm	Topic Lecture and Q&A: Integrated Practice Units, Outcome and Cost Measurement
12:15-1:15pm	Lunch
1:15-2:30pm	Session 2: Integrated Care, Reimbursement, and Measurement Case Study: The UCLA Health System: Kidney Transplantation
2:30-2:45pm	Break
2:45-3:30pm	Case Protagonists Guests: Amir Dan Rubin, COO, UCLA Medical Center & Hospital System; J. Thomas Rosenthal, Chief Medical Officer, UCLA Hospital System
3:30-4:15pm	Topic Lecture and Q&A: Bundled Reimbursement, System Integration and Growth
4:15-4:30pm	Course Wrap-Up

The Case Method

- **Raise your hand** to participate
- Use **case facts only** during the discussion
- **No questions** to the instructor are appropriate **during the case discussion**
- There are **no “right” answers**