Value-Based Health Care Delivery: Implications for Providers

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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.
Issues in Health Care Reform

- Health Insurance and Access
- Standards for Coverage
- Structure of Health Care Delivery
Redefining Health Care

• Universal insurance is essential, but not enough
• The core issue in health care is the value of health care delivered

Value: Patient outcomes per dollar spent

• How to design a health care system that dramatically improves value
  – Ownership of entities is secondary
• How to create 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, 21st century medical technology is delivered with 19th century organization structures, management practices, and pricing models

- TQM, process improvements, and safety initiatives are beneficial but **not sufficient**
Creating a Value-Based Health Care System

- Competition 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 competition on value is the central challenge in health care reform.
Zero-Sum Competition in U.S. Health Care

Bad Competition

• Competition to **shift costs** or capture a bigger share of revenue
• Competition to **increase bargaining power**
• Competition to **capture patients** and **restrict choice**
• Competition to **restrict services** in order to maximize revenue per visit or reduce costs

Zero or Negative Sum

Good Competition

• Competition to **increase value for patients**

Positive Sum
Principles of Value-Based Competition

1. The goal should be value for patients, not community service or lowering costs
   - This will require going beyond waste reduction and administrative savings
Principles of Value-Based Competition

1. The goal should be **value for patients**, not community service or lowering costs

2. The best way to **contain costs** is to drive **improvement in quality**

   Quality = Health outcomes

   - Prevention
   - Early detection
   - Right diagnosis
   - Early treatment
   - Right treatment to the right patients
   - Treatment earlier in the causal chain of disease
   - Fewer mistakes and repeats in treatment

   - Fewer delays in the care delivery process
   - Less invasive treatment methods
   - Faster recovery
   - More complete recovery
   - Less disability
   - Fewer relapses or acute episodes
   - Slower disease progression
   - Less need for long term care

• Better health is **inherently less expensive** than poor health
Principles of Value-Based Competition

1. The goal should be **value for patients**, not community service or lowering costs.

2. The best way to contain costs is to drive improvement in **quality**.

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

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<tr>
<th>Value:</th>
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- Reward **results** vs. process compliance.
- Get **patients** to excellent providers vs. “lift all boats” or “pay for performance”.
- Expand the **proportion of patients** cared for by the most effective teams.
- **Grow the excellent teams** by reallocating capacity and expanding across locations.
Principles of Value-Based Competition

1. The goal should be **value for patients**, not community service or lowering costs
2. The best way to contain costs is to drive improvement in **quality**
3. There must be **unrestricted competition** based on **results**
4. Competition should center on **medical conditions** over the **full cycle of care**
Restructuring Health Care Delivery
Migraine Care in Germany

Old Model: Organize by Specialty and Discrete Services

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

New Model: Organize into Integrated Practice Units (IPUs)

- Imaging Unit
- West German Headache Center
  - Neurologists
  - Psychologists
  - Physical Therapists
  - Day Hospital

- Primary Care Physicians
- Network Neurologists

Source: KKH, Westdeutsches Kopfschmerzzentrum
What is a Medical Condition?

• A medical condition is an interrelated set of patient medical circumstances best addressed in an integrated way
  – Defined from the patient’s perspective
  – Involves multiple specialties and services

• Includes the most common co-occurring conditions

• Examples
  – Diabetes (including vascular disease, hypertension, others)
  – Breast Cancer
  – Stroke
  – Migraine
  – Asthma
  – Congestive Heart Failure

• The medical condition is the unit of value creation in health care delivery
### The Cycle of Care: Care Delivery Value Chain for Breast Cancer

**INFORMING & ENGAGING**
- Advice on self-screening
- Consultation on risk factors

**MEASURING**
- Self exams
- Mammograms
  - Mammograms
  - Ultrasound
  - MRI
  - Biopsy
  - BRACa 1, 2...

**ACCESSING**
- Office visits
- Mammography lab visits
  - Office visits
  - Lab visits
  - High-risk clinic visits

**MONITORING/PREVENTING**
- Medical history
- Control of risk factors (obesity, high fat diet)
- Genetic screening
- Clinical exams
- Monitoring for lumps

**DIAGNOSING**
- Medical history
- Determining the specific nature of the disease
- Genetic evaluation
- Choosing a treatment plan

**PREPARING**
- Medical counseling
- Surgery prep (anesthetic risk assessment, EKG)

**INTERVENING**
- Surgery (breast preservation or mastectomy, oncoplastic alternative)
- Adjuvant therapies (hormonal medication, radiation, and/or chemotherapy)

**RECOVERING/REHABING**
- In-hospital and outpatient wound healing
- Psychological counseling
- Treatment of side effects (skin damage, neurotoxic, cardiac, nausea, lymphedema, and chronic fatigue)
- Physical therapy

**MONITORING/MANAGING**
- Recurring mammograms (every 6 months for the first 3 years)
- Lab visits
- Mammographic labs and imaging center visits

- Office visits
- Hospital visits
- Visits to outpatient or radiation chemotherapy units
- Rehabilitation facility visits

- Provider Margin

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- **Primary care providers** are often the beginning and end of care cycles

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5. Value is driven by provider **experience, scale, and learning** at the medical condition level
The Virtuous Circle in a Medical Condition

- The virtuous cycle extends **across geography** within integrated organizations
- Fragmentation of provider services works **against** patient value
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5. Value is driven by provider **experience**, **scale**, and **learning** at the medical condition level
6. Competition should be **regional** and **national**, not just local
   - Manage integrated care **across geography**
   - Utilize partnerships and inter-organizational integration among separate institutions
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7. **Results** must be universally measured and reported

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Measuring Value: Unit of Analysis

• The appropriate unit for measuring value must align with how value is created for patients
  – Across services
  – Across time

• Value should be measured for medical conditions over the cycle of care
  – vs. for hospitals, practices, or clinics
  – vs. types of service (e.g. inpatient, outpatient, tests, rehabilitation)
  – vs. for interventions or short episodes

• Current efforts suffer from measuring value at differing/inappropriate levels
Measuring Results

Principles

• Measure outcomes versus processes of care

• Outcomes must be adjusted for risk/patient initial circumstances
Measuring Value in Health Care
Outcomes versus Processes

- Patient Initial Conditions
- Process
- (Health) Outcomes

- Patient Compliance

- Health Indicators
  - E.g., Hemoglobin A1c levels (blood sugar) of diabetic patients

- Process compliance is not quality
Measuring Results
Principles

• Measure **outcomes** versus processes of care

• Outcomes must be **adjusted for risk/patient initial circumstances**

• Outcome measurement should take place:
  – At the **medical condition** level
  – Over the **cycle of care**

• There are **multiple outcomes** for every medical condition
Measuring Outcomes

The Outcome Measures Hierarchy

- Survival

- Degree of recovery / health

- Time to recovery or return to normal activities

- Disutility of care or treatment process (e.g., treatment-related discomfort, complications, or adverse effects, diagnostic errors, treatment errors)

- Sustainability of recovery or health over time

- Long-term consequences of therapy (e.g., care-induced illnesses)
Measuring Breast Cancer Outcomes

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

- **Degree of recovery / health**
  - Remission
  - Functional status
  - Breast conservation surgery outcome

- **Time to recovery or return to normal activities**
  - Time to remission
  - Time to achieve functional status

- **Disutility of care or treatment process**
  - Nosocomial infection
  - Nausea
  - Vomiting
  - Febrile neutropenia
  - Limitation of motion
  - Depression

- **Sustainability of recovery or health over time**
  - Cancer recurrence
  - Sustainability of functional status

- **Long-term consequences of therapy**
  - Incidence of secondary cancers
  - Brachial plexopathy
  - Premature osteoporosis
Measuring Breast Cancer Outcomes

Initial Conditions

- Stage of disease
- Type of cancer (infiltrating ductal carcinoma, tubular, medullary, lobular, etc.)
- Estrogen and progesterone receptor status (positive or negative)
- Sites of metastases
- Age
- Menopausal status
- General health, including co-morbidities

- As care delivery improves, some initial conditions will **decline in importance** for outcomes
Measuring Results

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• Measure outcomes versus processes of care

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• Outcome measurement should take place:
  – At the medical condition level
  – Over the cycle of care

• There are multiple outcomes for every medical condition

• Outcomes are as important for physicians as for consumers and health plans

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

• Providers and health plans must measure outcomes (and costs) for every patient
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6. Competition should be regional and national, not just local
7. Results must be universally measured and reported
8. Reimbursement should be aligned with value and reward innovation
   - Reimbursement for care cycles, not per diem or for discrete treatments or services
   - Reimbursement for prevention and screening, not just treatment
Organ Transplantation Care Cycle

- Evaluation
- Waiting for a Donor
- Transplant Surgery
- Immediate Convalescence
- Long Term Convalescence

Alternative therapies to transplantation

Addressing organ rejection
Fine-tuning the drug regimen
Adjustment and monitoring

- Leading transplantation centers quote a **single price**
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8. Reimbursement should be aligned with value and reward innovation

9. Information technology is an enabler of restructuring care delivery and measuring results, not a solution itself
   - Common data definitions
   - Interoperability standards
   - Patient-centered database
   - Full care cycle
Moving to Value-Based Competition
Implications for Providers

- Organize around **integrated practice units** (IPUs) for each medical condition
- Choose the appropriate **scope of services** in each facility based on excellence in **patient value**
- IPUs should **integrate services** for each medical condition **across geographic locations**
- Employ formal **partnerships and alliances** with outside entities involved in the care cycle to integrate care and improve capabilities
- Measure **results** by medical condition
- Expand high-performance IPUs **across geography** using an integrated model
  - Instead of merging broad line, stand-alone facilities
- Lead the development of **new contracting models** with health plans based on care cycle delivery structures and bundled reimbursement
Moving to Value-Based Competition
Health Plans

“Payor”

Value-Added Health Organization
Moving to Value-Based Competition

Value-Adding Roles of Health Plans

- Monitor and compare provider results by medical condition
- Provide advice to patients (and referring physicians) in selecting excellent providers
- Assist in coordinating patient care across the full care cycle and across medical conditions
- Provide for comprehensive prevention and chronic disease management services to all members
- Design new reimbursement models for care cycles
- Assemble and manage the total medical records of members
- Measure and report overall health results for members
How Will Redefining Health Care Begin?

• It is already happening

• Providers, as well as health plans and employers, can take voluntary steps in these directions, and will benefit irrespective of other changes

• The changes will be mutually reinforcing

• Once competition begins working, value improvement will no longer be discretionary or optional

• Those organizations that move early will gain major benefits

• Providers can and should take the lead