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 “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.
Value-Based Health Care Delivery
The Strategic Agenda for Providers

1. Organize into Integrated Practice Units (IPUs)
   • Including primary care

2. Measure Outcomes and Cost for Every Patient

3. Lead the Development of New Reimbursement Models
   • Engage health plans but also seek direct relationships with employers/employer groups

4. Provider System Integration
   • **Rationalize service lines/ IPUs** across facilities to improve volume, avoid duplication, and enable excellence
   • Offer specific services at the **appropriate facility**
     - e.g. acuity level, cost level, benefits of convenience
   • Clinically integrate care **across facilities** within an IPU structure
     - The **care delivery organization should span facilities**
   • Formally link **primary care** units to specialty IPUs

5. Grow Excellent IPUs Across Geography

6. Create an Enabling Information Technology Platform
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 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, 21st century medical technology is often delivered with 19th century organization structures, management practices, and pricing models

- Process improvements, lean production concepts, safety initiatives, care pathways, 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 $\neq$ 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

1. Set the goal as **value for patients**, not access, equity, 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 the care for the patient’s condition**, not just the cost of a single provider or a single service
## Principles of Value-Based Health Care Delivery

1. Set the goal as **value for patients**, not containing costs
2. **Quality improvement** is the key driver of cost containment and value improvement, where quality is **health outcomes**

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

<table>
<thead>
<tr>
<th>Better Health</th>
<th>Value for Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention</td>
<td>Fewer complications</td>
</tr>
<tr>
<td>Early detection</td>
<td>Fewer mistakes and repeats in treatment</td>
</tr>
<tr>
<td>Right diagnosis</td>
<td>Faster recovery</td>
</tr>
<tr>
<td>Early and timely treatment</td>
<td>More complete recovery</td>
</tr>
<tr>
<td>Treatment earlier in the causal chain of disease</td>
<td>Less disability</td>
</tr>
<tr>
<td>Right treatment to the right patient</td>
<td>Fewer relapses or acute episodes</td>
</tr>
<tr>
<td>Rapid cycle time of diagnosis and care</td>
<td>Slower disease progression</td>
</tr>
<tr>
<td>Less invasive treatment methods</td>
<td>Less need for long term care</td>
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<tr>
<td></td>
<td>Less care induced illness</td>
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</table>
Cost versus Quality Sweden
Health Care Spending by County, 2008

Health care cost/capita (SEK)

County council health care index

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
Principles of Value-Based Health Care Delivery

1. Set the goal as **value for patients**, not containing costs

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

3. Care delivery should be organized around the patient’s **medical condition** over the **full cycle of care**

- A medical condition is **an interrelated set of patient medical circumstances** best addressed in an **integrated way**
  - Defined from the **patient’s** perspective
  - **Including** the most common co-occurring conditions and complications
  - Involving **multiple** specialties and services

- The patient’s medical condition is the **unit of value creation** in health care delivery
Restructuring Care Delivery
Migraine Care in Germany

Existing Model:
Organize by Specialty and Discrete Services

New Model:
Organize into Integrated Practice Units (IPUs)

# Integrating Across the Cycle of Care: Breast Cancer

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

Core Team
- Endocrinologist
- Diabetes Nurse Educator

Extended Team
- Nephrologists
- Ophthalmologists/Optometrists
- Psychiatrists, Psychologists, Social Workers
- Nutritionists
- Exercise Physiologists

Shared Facilities
- Common Exam Rooms
- Dedicated Just-in-Time Lab
- Eye Scan
- Laser Eye Surgery Suite

Acute Complications
- Hyperglycemia
- Hypoglycemia

Long-Term Complications
- Cardiovascular Disease
- Neuropathy
- End Stage Renal Disease
- Dialysis Transplantation
Principles of Value-Based Health Care Delivery

4. Provider **experience**, **scale**, and **learning** at the medical condition level drive value improvement

- Volume and experience will have an **even greater impact** on value in an IPU structure
- The virtuous circle **extends across geography in integrated care organizations**
## Fragmentation of Hospital Services

### Sweden

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

Principles of Value-Based Health Care Delivery

5. **Integrate care across facilities** and **geography**, rather than duplicating services in stand-alone units.

Children’s Hospital of Philadelphia (CHOP) Affiliations

- Deliver services in the **appropriate** facility, not every facility.
- Excellent providers can manage care delivery across **multiple geographic areas**.
System Integration

- **Rationalize service lines/IPUs** across facilities to improve volume, avoid duplication, and achieve excellence.
  - Offer specific services at the **appropriate facility**
    - e.g. acuity level, cost level, need for convenience
  - Clinically integrate care **across facilities**, within an IPU structure
    - Common organizational unit across facilities
- Link **preventative/primary care** to IPUs
Growth Across Geography
The Cleveland Clinic

- Affiliate Programs in Cardiac Surgery and Urology
- Internet-based Second Opinion Services
- Community Hospitals in the Region
- Hospitals and Outpatient Clusters in Other Regions
- Hospital Management in Other Countries
Principles of Value-Based Health Care Delivery

1. Set the goal as **value for patients**, not containing costs
2. **Quality improvement** is the key driver of cost containment and value improvement, where quality is **health outcomes**
3. Care delivery should be organized around the patient’s **medical condition** over the **full cycle of care**
4. Provider **experience, scale, and learning** at the medical condition level drive value improvement
5. **Integrate care across facilities** and **geography**, rather than duplicating services in stand-alone units

6. Measure and report **outcomes** and **costs**, by medical condition, for every provider and every patient
   - **Not** for interventions or short episodes
   - **Not** separately for types of service (e.g. inpatient, outpatient, tests, rehabilitation)
   - **Not** for practices, departments, clinics, or entire hospitals
Measuring Value in Health Care

- **Patient Initial Conditions**
- **Processes**
  - Protocols/Guidelines
- **Indicators**
  - E.g., Hemoglobin A1c levels for diabetics
- **(Health) Outcomes**

Patient Compliance
The Outcome Measures Hierarchy

Tier 1
Health Status Achieved
Degree of health/recovery

Tier 2
Process of Recovery
Time to recovery or return to normal activities
Disutility of care or treatment process (e.g., discomfort, complications, adverse effects, errors, and their consequences)

Tier 3
Sustainability of Health
Sustainability of health or recovery and nature of recurrences
Long-term consequences of therapy (e.g., care-induced illnesses)
The Outcome Measures Hierarchy
Breast Cancer

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

Degree of recovery / health
- Degree of remission
- Functional status
- Depression
- Breast conservation

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

Disutility of care or treatment process (e.g., treatment-related discomfort, complications, adverse effects, diagnostic errors, treatment errors)
- Nosocomial infection
- Nausea/Vomiting
- Febrile neutropenia

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

Long-term consequences of therapy (e.g., care-induced illnesses)
- Incidence of secondary cancers
- Brachial plexopathy

Initial Conditions/Risk Factors
- Stage of disease
- Type of cancer (infiltrating ductal carcinoma, tubular, medullary, lobular, etc.)
- Estrogen and progesterone receptor status (positive or negative)
- Sites of metastases
- Previous treatments
- Age
- Menopausal status
- General health, including co-morbidities
- Psychological and social factors

Sustainability of recovery or health over time
- Incidence of secondary cancers
- Brachial plexopathy

Long-term consequences of therapy (e.g., care-induced illnesses)
- Incidence of secondary cancers
- Brachial plexopathy

Sustainability of functional status
- Time to recovery or return to normal activities

Disutility of care or treatment process (e.g., treatment-related discomfort, complications, adverse effects, diagnostic errors, treatment errors)
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- Age
- Menopausal status
- General health, including co-morbidities
- Psychological and social factors
MD Anderson Oral Cavity Cancer Survival by Registration Year

Source: MD Anderson Cancer Center
Swedish National Quality Registers, 2007*

Respiratory Diseases
- Respiratory Failure Register (Swedevox)
- Swedish Quality Register of Otorhinolaryngology

Childhood and Adolescence
- The Swedish Childhood Diabetes Registry (SWEDIABKIDS)
- Childhood Obesity Registry in Sweden (BORIS)
- Perinatal Quality Registry/Neonatology (PNQn)
- National Registry of Suspected/Confirmed Sexual Abuse in Children and Adolescents (SÖK)

Circulatory Diseases
- Swedish Coronary Angiography and Angioplasty Registry (SCAAR)
- Registry on Cardiac Intensive Care (RIKS-HIA)
- Registry on Secondary Prevention in Cardiac Intensive Care (SEPHIA)
- Swedish Heart Surgery Registry
- Grown-Up Congenital Heart Disease Registry (GUCH)
- National Registry on Out-of-Hospital Cardiac Arrest
- Heart Failure Registry (RiksSvikt)
- National Catheter Ablation Registry
- Vascular Registry in Sweden (Swedvasc)

- National Quality Registry for Stroke (Riks-Stroke)
- National Registry of Atrial Fibrillation and Anticoagulation (AuriculA)

Endocrine Diseases
- National Diabetes Registry (NDR)
- Swedish Obesity Surgery Registry (SOReg)
- Scandinavian Quality Register for Thyroid and Parathyroid Surgery

Gastrointestinal Disorders
- Swedish Hernia Registry
- Swedish Quality Registry on Gallstone Surgery (GallRiks)
- Swedish Quality Registry for Vertical Hernia

Musculoskeletal Diseases
- Swedish Shoulder Arthroplasty Registry
- National Hip Fracture Registry (RIKSHÖFT)
- Swedish National Hip Arthroplasty Register
- Swedish Knee Arthroplasty Register
- Swedish Rheumatoid Arthritis Registry
- National Pain Rehabilitation Registry
- Follow-Up in Back Surgery
- Swedish Cruciate Ligament Registry – X-Base
- Swedish National Elbow Arthroplasty Register (SAAR)

* Registers Receiving Funding from the Executive Committee for National Quality Registries in 2007
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4. Provider **experience, scale, and learning** at the medical condition level drive value improvement

5. **Integrate care across facilities** and **geography**, rather than duplicating services in stand-alone units

6. Measure and report **outcomes** and **costs**, by medical condition, for every provider and every patient

7. **Align reimbursement** with value and reward innovation

   - **Bundled reimbursement** for **cycles of care** for medical conditions
     - Not payment for discrete services or short episodes
   - **Time-base bundled reimbursement** for **managing chronic conditions**
   - Reimbursement for defined **prevention, screening, wellness/health maintenance** service bundles

   - **Providers** and **health plans** should be proactive in driving new reimbursement models, not wait for government
• Bundled reimbursement for care cycles motivates **value improvement, care cycle optimization**, and **spending to save**

• **Outcome measurement and reporting** at the medical condition level is needed for any reimbursement system to ultimately succeed
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6. Measure and report **outcomes** and **costs**, by medical condition, for every provider and every patient
7. **Align reimbursement** with value and reward innovation
8. Utilize information technology to enable **restructuring of care delivery** and **measuring results**, rather than treating it as a solution itself

- Common data definitions
- “Structured” data vs. free text
- Data encompasses the full care cycle, including referring entities
- Structure for combining all types of data (e.g. notes, images) for each patient over time
- Templates for medical conditions to enhance the user interface
- Accessible by, and allowing communication among, all involved parties, including patients
- Architecture that allows easy extraction of outcome measures
- Interoperability standards enabling communication among different provider systems
Value-Based Health Care Delivery
The Strategic Agenda for Providers

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   • Including primary care

2. Measure Outcomes and Cost for Every Patient

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   • Offer specific services at the **appropriate facility**
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   • Clinically integrate care **across facilities** within an IPU structure
     - The **care delivery organization should span facilities**
   • Formally link **primary care** units to specialty IPUs

5. Grow Excellent IPUs Across Geography

6. Create an Enabling Information Technology Platform
Other Issues for the Cleveland Clinic

1. Leveraging the health plan for clinic employees
2. Establishing direct relationships with employers
3. Revitalizing Cleveland’s disadvantaged communities
   • Health
   • Economic Development
Cleveland Clinic

Every life deserves world class care.
Back-up
What is Integrated Care?

Key Elements of Integrated Care:

- Care for the full care cycle of a **medical condition**
- Encompassing **inpatient/outpatient/rehabilitation** care
- By **dedicated teams** focused around the patient
- **Co-located** in **dedicated facilities**
- In which providers are all part of the **same organizational entity**
- Utilizing a **single administrative and scheduling structure**
- With **joint accountability** for outcomes and overall costs

**Integrated care is not the same as:**

- Co-location
- Care delivered by the same organization
- A multispecialty group practice
- Clinical Pathways
- Freestanding focused factories
- An Institute or Center
- A Center of Excellence
- A health plan/provider system (e.g. Kaiser Permanente)
- Medical home
- Accountable Care Organization
IPUs and Value

**Outcomes**

- **Better decisions** in terms of diagnosis and treatment
  - Specialized experience and expertise
  - Better coordination/peer review
  - Better integration of co-occurrences

- **Better execution** of treatment
  - Specialized experience and expertise
  - Tailored facilities
  - Seamless management of common co-occurrences

- **Faster** cycle time

- **Improved** patient **compliance and engagement** with care

- **Full range of support services** needed to achieve success for the patient (e.g., nutrition, rehabilitation, counseling, psychological support)

- **Vastly greater patient convenience**

**Cost**

- **Greater provider efficiency**
- **Better utilization of facilities**
- **Streamlined administrative costs**
Coordinating Care Across IPUs
Patients with Multiple Medical Conditions

- The primary organizational structure for care delivery should be around the forms of integration required for every patient
  - The current system is organized around the exception, not the rule
- Overlay mechanisms are then utilized to manage coordination across IPUS
- The IPU model will greatly simplify coordination of care for patients with multiple medical conditions
Value-Based Healthcare Delivery: Implications for Health Plans

“Payor”

Value-Added Health Organization
# Transforming the Roles of Employers

<table>
<thead>
<tr>
<th>Old Role</th>
<th>New Role</th>
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</thead>
<tbody>
<tr>
<td>• Set the goal of <strong>reducing health premium costs</strong></td>
<td>• Set the goal of <strong>employee health</strong></td>
</tr>
<tr>
<td>• Focus on <strong>direct cost</strong> of health benefits</td>
<td>• Focus on the <strong>overall cost of poor health</strong> (e.g., productivity, lost days)</td>
</tr>
<tr>
<td>• Use bargaining power to negotiate <strong>discounts</strong> from health plans and providers</td>
<td>• Work with health plans and providers to improve overall <strong>value</strong> delivered</td>
</tr>
<tr>
<td>• <strong>Shift costs to employees</strong> via premium payments, co-payments</td>
<td>• Improve access to <strong>high-value care</strong> (e.g., wellness, prevention, screening, and disease management)</td>
</tr>
<tr>
<td>• Evaluate plans and providers based on <strong>process compliance</strong> (P4P)</td>
<td>• Evaluate plans and providers based on <strong>health outcomes</strong></td>
</tr>
<tr>
<td>• <strong>Limit or eliminate the employer role</strong> in health insurance</td>
<td>• Take a leadership role in <strong>expanding the insurance system</strong> to encompass individually purchased plans on favorable terms</td>
</tr>
</tbody>
</table>
A Strategy for U.S. Health Care Reform

Shift Insurance Market:

• Build upon the current employer based system

• Shift insurance market competition by ending discrimination based on pre-existing conditions and re-pricing upon illness

• Aggregate volume and buying power to create a viable insurance option for individuals and small groups through large statewide and multistate insurance pools, coupled with a reinsurance system for high cost individuals

• Establish income-based subsidies on a sliding scale for lower income individuals

• Once viable insurance options are established, mandate the purchase of health insurance for all Americans

• Give employers a choice of providing insurance or a payroll tax based on the proportion of employees requiring public assistance
Restructure Delivery:

- Establish universal and mandatory measurement and reporting of provider health outcomes
  - 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 for patient segments
- Encourage restructuring of health care delivery around the integrated care for medical conditions
  - Eliminate obstacles such as Stark Laws, Corporate Practice of Medicine, Anti-kickback
  - Minimum volume standards as an interim step
- Create new integrated primary and preventive care models for defined patient groups
- Open up value-based competition for patients within and across state boundaries
- Mandate EMR adoption that enables integrated care and supports outcome measurement
  - National standards for data, communication, and aggregation
  - Software as a service model for smaller providers
- Encourage responsibility of individuals for their health and health care through incentives for healthy behavior
Cleveland Clinic

Every life deserves world class care.