Creating a Value-Based Health Care Organization: The Strategic Agenda

Professor Michael E. Porter
Harvard Business School

Cerner CEO Summit
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This presentation draws on Redefining Health Care: Creating Value-Based Competition on Results (with Elizabeth O. Teisberg), Harvard Business School Press, May 2006; “A Strategy for Health Care Reform—Toward a Value-Based System,” New England Journal of Medicine, June 3, 2009; “Value-Based Health Care Delivery,” Annals of Surgery 248: 4, October 2008; “Defining and Introducing Value in Healthcare,” Institute of Medicine Annual Meeting, 2007. Additional information about these ideas, as well as case studies, can be found the Institute for Strategy & Competitiveness Redefining Health Care website at http://www.hbs.edu/rhc/index.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 O. Teisberg.
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
Creating 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**

<table>
<thead>
<tr>
<th>Financial success of system participants</th>
<th>≠</th>
<th>Patient success</th>
</tr>
</thead>
</table>

• Creating positive-sum **competition on value** is a central challenge in health care reform in every country
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** over the care cycle.

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 of illness and recurrences
- 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
Creating a Value-Based Health Care Delivery Organization

The Strategic Agenda

1. Organize into Integrated Practice Units Around Patient Medical Conditions (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. Create an Integrated Health System

5. Grow and Affiliate to Drive Excellence

6. Develop an Enabling Information Technology Platform
1. Organize into Integrated Practice Units Around Patient Medical Conditions (IPUs)

- 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

Examples of Medical Conditions:
- Diabetes
- Asthma
- Multiple Sclerosis
- Breast Cancer
Organizing Around Patient Medical Conditions
Migraine Care in Germany

Existing Model:
Organize by Specialty and Discrete Services

New Model:
Organize into Integrated Practice Units (IPUs)

# Integration Across the Care Cycle
## Breast Cancer Care Delivery Value Chain

### Informing and Engaging
- Advice on self-screening
- Consultations on risk factors
- Counseling patient and family on the diagnostic process and the diagnosis
- Explaining patient treatment options/shared decision making
- Patient and family psychological counseling
- Counseling on the treatment process
- Education on managing side effects and avoiding complications of treatment
- Achieving compliance
- Counseling on rehabilitation options, process
- Achieving compliance
- Psychological counseling
- Counseling on long-term risk management
- Achieving Compliance

### Measuring
- Self-exams
- Mammograms
- Mammograms
- Ultrasound
- MRI
- Labs (CBC, etc.)
- Blood chems, etc.
- Biopsy
- BRACAs, 1, 2
- CT
- Bone Scans
- Labs
- Procedure-specific measurements
- Range of movement
- Side effects measurement
- MRI, CT
- Recurring mammograms (every six months for the first 3 years)

### Accessing
- Office visits
- Mammography lab visits
- Office visits
- Lab visits
- High risk clinic visits
- Office stays
- Hospital visits
- Visits to outpatient radiation or chemotherapy units
- Pharmacy
- Rehabilitation facility visits
- Pharmacy
- Lab visits
- Mammographic labs and imaging center visits

### Monitoring/Preventing
- Medical history
- Control of risk factors (obesity, high fat diet)
- Genetic screening
- Clinical exams
- Monitoring for lumps
- Medical history
- Determining the specific nature of the disease (mammograms, pathology, biopsy results)
- Genetic evaluation
- Labs
- Choosing a treatment plan
- Surgery prep (anesthetic risk assessment, EKG)
- Plastic or onco-plastic surgery evaluation
- Neo-adjuvant chemotherapy
- Adjuvant therapies (hormonal medication, radiation, and/or chemotherapy)

### Recovering/Rehabilitating
- In-hospital and outpatient wound healing
- Treatment of side effects (e.g., skin damage, cardiac complications, nausea, lymphedema and chronic fatigue)
- Physical therapy
- Periodic mammography
- Other imaging
- Follow-up clinical exams
- Treatment for any continued or later onset side effects or complications

### Managing
- Breast Cancer Specialist
- Other Provider Entities
# Integration Across the Care Cycle

## Breast Cancer Care Delivery Value Chain

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<thead>
<tr>
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<th>MEASURING</th>
<th>ACCESSING</th>
<th>MONITORING/PREVENTING</th>
<th>DIAGNOSING</th>
<th>PREPARING</th>
<th>INTERVENING</th>
<th>RECOVERING/REHABING</th>
<th>MONITORING/MANAGING</th>
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*Ultrasound*  
*MRI*  
*Labs (CBC, etc.)* | *Blood chems,* | *Side effects measurement* | *Recurring mammograms (every six months for the first 3 years)* | *MRI, CT* |
| Office visits | Office visits | Office visits | Hospital stays | Office visits | Office visits |
| Mammography lab visits | Office visits | Hospital stays | Lab visits | Visits to outpatient radiation or chemotherapy units | Pharmacy |
| Lab visits | Lab visits | Laboratory visits | Pharmacy |
| High risk clinic visits | | | |

## MONITORING/MANAGING

- Periodic mammography
- Other imaging
- Follow-up clinical exams
- Treatment for any continued or later onset side effects or complications

- Breast Cancer Specialist
- Other Provider Entities
Volume and experience have an **even greater** impact on value in an IPU structure than in the current system.
## 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>
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<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>2</td>
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<tr>
<td>Multiple sclerosis and cerebellar ataxia</td>
<td>78</td>
<td>1.3%</td>
<td>28</td>
<td>1</td>
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<tr>
<td>Inflammatory bowel disease</td>
<td>73</td>
<td>1.4%</td>
<td>66</td>
<td>1</td>
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<tr>
<td>Implantation of cardiac pacemaker</td>
<td>51</td>
<td>2.0%</td>
<td>124</td>
<td>2</td>
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<tr>
<td>Splenectomy age &gt; 17</td>
<td>37</td>
<td>2.6%</td>
<td>3</td>
<td>&lt;1</td>
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<tr>
<td>Cleft lip &amp; palate repair</td>
<td>7</td>
<td>14.2%</td>
<td>83</td>
<td>2</td>
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<tr>
<td>Heart transplant</td>
<td>6</td>
<td>16.6%</td>
<td>12</td>
<td>&lt;1</td>
</tr>
</tbody>
</table>

What is Integrated Care?

Attributes of an Integrated Practice Unit (IPU):

1. Organized around the patient’s medical condition
2. Provides the full cycle of care for the condition
   - Encompasses inpatient, outpatient, and rehabilitative care as well as supporting services (e.g. nutrition, social work, behavioral health)
   - Includes patient education, engagement and follow-up
3. Involves a dedicated team who devote a significant portion of their time to the condition
4. Where providers are part of a common organizational unit
5. Co-located in dedicated facilities
6. Utilizing a single administrative and scheduling structure
7. With a physician team captain and a care manager who oversee each patient’s care process
8. Where the team meets formally and informally on a regular basis
9. And measures processes and outcomes as a team, not individually
10. And accepts joint accountability for outcomes and costs
Integrated care is not the same as:

- A clinical pathway
- Co-location per se
- Care delivered by the same organization
- A multispecialty group practice
- Freestanding focused factories
- An institute or center
- A Center of Excellence
- Medical homes
- Accountable care organizations
- A health plan/provider system (e.g. Kaiser Permanente)
Integrated Models of Primary Care

• Organized around **specific patient populations** (e.g. healthy adults, frail elderly, type II diabetics) rather than attempting to be all things to all patients

• **Defined service bundles** covering appropriate prevention, screening, diagnosis, wellness and health maintenance

• Services are provided by **multidisciplinary teams**, including ancillary health professionals and support staff in **dedicated facilities**

• **Alliances with specialty IPUs** covering the prevalent medical conditions represented in the patient population

• Delivered not only in traditional settings but at the **workplace**, **community organizations**, and in **other locations** that offer regular patient contact and the ability to develop a group culture of wellness

• Today’s primary care is **fragmented** and attempts to address **overly broad needs** with limited resources
2. Measure Outcomes and Cost for Every Patient

- **For** medical conditions
- **Real time** and “on-line” in care delivery, not just retrospectively or in clinical studies
- **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 and reporting **volume** by medical condition
Measuring Value

- Patient Initial Conditions
  - Protocols/Guidelines
    - E.g., Staff certification, facilities
  - Structure
    - E.g., Hemoglobin A1c levels for diabetics
- Patient Compliance
- Processes
- Indicators
- (Health) Outcomes
The Outcome Measures Hierarchy

**Tier 1**
- **Health Status Achieved**
  - **Survival**
  - **Degree of health/recovery**

**Tier 2**
- **Process of Recovery**
  - **Time to recovery or return to normal activities**
  - **Disutility of the care or treatment process (e.g., diagnostic errors and ineffective care, treatment-related discomfort, complications, or adverse effects, treatment errors and their consequences in terms of additional treatment)**

**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
- Breast conservation
- Depression

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

Disutility of the care or treatment process (e.g., diagnostic errors and ineffective care, treatment-related discomfort, complications, or adverse effects, treatment errors and their consequences in terms of additional treatment)
- Nosocomial infection
- Nausea/vomiting
- Febrile neutropenia

Sustainability of recovery or health over time
- Suspension of therapy
- Failed therapies
- Limitation of motion
- Depression

Long-term consequences of therapy (e.g., care-induced illnesses)
- Cancer recurrence
- Sustainability of functional status

Initial Conditions/Risk Factors
- Stage upon diagnosis
- 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 comorbidities
- 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)
- Fertility/pregnancy complications
- Premature osteoporosis
MD Anderson Oral Cavity Cancer Survival by Registration Year

Source: MD Anderson Cancer Center
In-vitro Fertilization
Success Rates Over Time

Percent Live Births per Fresh, Non-Donor Embryo Transferred by Clinic Size
Women Age <38, 1997-2005

Adult Kidney Transplant Outcomes, U.S. Center Results, 1987-1989

Number of programs: 219
Number of transplants: 19,588
One year graft survival: 79.6%

- 16 greater than predicted survival (7%)
- 20 worse than predicted survival (10%)
Adult Kidney Transplant Outcomes, U.S. Center Results, 1998-2000

Number of programs included: 219
Number of transplants: 23,849
One year graft survival: 90.9%

- 10 greater than predicted survival (4.5%)
- 14 worse than predicted survival (6.4%)
Adult Kidney Transplant Outcomes
U.S. Center Results, 2005-2007

Percent 1 Year Graft Survival

- Number of programs: 240
- Number of transplants: 38,515
- One year graft survival: 93.2%

- 16 greater than expected graft survival (6.6%)
- 19 worse than expected graft survival (7.8%)
## 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)

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

### Gastrointestinal Disorders
- National Diabetes Registry (NDR)
- Swedish Obesity Surgery Registry (SOReg)
- Scandinavian Quality Register for Thyroid and Parathyroid Surgery

### 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)

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* Registers Receiving Funding from the Executive Committee for National Quality Registries in 2007
Creating an Outcome Measurement System
Schön Kliniken

1. Define medical conditions to measure
   - Identified medical conditions

2. Develop outcome dimensions, measures, and risk adjustments
   - Measures developed by convening groups of involved physicians and members of Schön’s quality improvement team
   - Five metrics per medical condition

3. Data collection infrastructure
   - Physicians and nurses enter data during the patient’s stay
   - Data can be extracted from the EMR reducing the burden of capture
   - Long term follow-up still done manually

4. Incentives and mechanisms for data reporting
   - Reporting of all metrics is mandated for all physician groups
   - Involvement in the metrics development process increases physician buy-in

5. Compliance and accuracy validation
   - Validates accuracy through trend analysis

6. Outcome reporting
   - Capture outcome data for 70% of patients
   - Report results internally at the individual physician level
   - Annual quality report (27 process and outcome measures)

7. Process for outcome improvement
   - Physicians trust metrics and are convinced of their value in driving improvement
   - Link physician pay to quality of care delivered
Cost Analysis Principles

• Cost should be aggregated at the **medical condition level** (which includes common co-occurring conditions and complications), not for services or entire facilities.

• Cost should be aggregated **for each patient** across the **full cycle of care**.

• The cost of each activity or input attributed to a patient should reflect **that patient’s use of resources** (e.g. time, staff, facilities, service), not average allocations or allocations based on charges.

• The only way to properly measure cost per patient is to track the **time** or **shared resource capacity** devoted to each patient by physicians, staff, facilities, support services, and other shared costs.

• **Time-Driven Activity Based Costing**
  – Chart the CDVC
  – Assess **capacity cost** of each shared resource involved in the care process
  – Assess **actual capacity use** in transactions with each patient
  – Enable **aggregation** by patient, by medical condition, etc.

• Cost measurement should be accompanied by **outcome measurement**
3. Move to Bundled Prices for Care Cycles

Fee for service

Bundled reimbursement for medical conditions

Global budgeting

Global capitation
What is a Bundled Payment?

• A total package price for the care cycle for a medical condition
  – Including time-based bundled reimbursement for managing chronic conditions and for primary/preventive service bundles
  – Including responsibility for avoidable complications

• 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
• “Medical Home” payment for care coordination
• Pay-for-performance bonuses

• DRGs can be a starting point for bundled payment models
Bundled Payment in Practice
Hip and Knee Replacement in Stockholm, Sweden

• **Components** of the bundle

<table>
<thead>
<tr>
<th>Components</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-op evaluation</td>
<td>1 follow-up visit within 3 months</td>
</tr>
<tr>
<td>Lab tests</td>
<td>Any additional surgery to the joint within 2 years</td>
</tr>
<tr>
<td>Radiology</td>
<td>If post-op infection requiring antibiotics occurs, guarantee extends to 5 years</td>
</tr>
<tr>
<td>Surgery &amp; related admission</td>
<td></td>
</tr>
<tr>
<td>Prosthesis</td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td></td>
</tr>
<tr>
<td>Inpatient rehab, up to 6 days</td>
<td></td>
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• Applies to all **relatively healthy patients** (i.e. ASA scores of 1 or 2)
• The same **referral process** from PCPs is utilized as the traditional system
• **Mandatory reporting** by providers to the joint registry plus supplementary reporting
• Provider participation is **voluntary** but all providers are involved

• The bundled price for a knee or hip replacement is about **US $8,000**
Creating a Bundled Pricing System

• Defining the Bundle
  – **Scope** of the medical condition
  – **Range of services** included
  – **Complications** and **comorbidities** included/excluded
  – **Duration** of care cycle/time period
    o Must be long enough to minimize the risk of cost shifting
  – **Flexibility** on methods/process of care essential

• Pricing the Bundle: Key Choices
  – Price relative to **sum of current costs**
    o Extent of **incentive** to improve value by reducing avoidable complications, improving efficiency, etc.
  – Extent of “**guarantees**” by providers
  – Extent of **severity/risk** adjustments
  – Mechanism for handling **unanticipated** complications and **outliers**

• Implementing the Bundle
  – Internal **distribution of payment** among providers (dividing the pie)
    o Degree of risk sharing by specialty
  – **Claims** management process and infrastructure
  – **Outcome measurement** is essential to measure success and minimize incentives to limit value-enhancing services
4. Integrate Care Delivery Across Separate Facilities

**Traditional Motivations for Health Systems**

- Expand geographic coverage
- Increase patient volume
- Expand coverage of the care cycle
- Gather volume for high acuity facilities
- Reduce crowding
Levels of System Integration

- Determine the **scope of service lines**
- **Rationalize service lines/IPUs** across facilities to improve volume, avoid duplication, and concentrate excellence
- **Offer specific services at the appropriate facility**
  - E.g. acuity level, cost level, need for convenience
  - Patient referrals across units
- **Clinically integrate care across facilities**, within an IPU structure
  - Expand and integrate the care cycle
  - Better connect **preventive/primary care** units to specialty IPUs
- There is a major opportunity to improve value through **moving care out** of heavily resourced, tertiary and quaternary facilities
Provider System Integration
Children’s Hospital of Philadelphia (CHOP)
Hospital Affiliates
Enabling System Integration

Practice Structure
• **IPU structure**
  – First step is to increase *consistency* of protocols/processes across sites
  – “*Virtual*” IPUs even if providers practice at different locations
  – Case management structure spanning units where appropriate

Scheduling
• Common or federated *patient scheduling service* across units

Physician Organization
• **Employed** physicians
• Formal *affiliations* with independent physicians
  – Support service as an inducement for affiliation (E.g. IT, back office)
• Rotation of staff across locations

Common Systems
• **Common EMR platform** which aggregates information across units
• Common *outcome and process measurement* systems

Cost Measurement
• Ability to accurately accumulate *cost per patient* across the entire care cycle
• Ability to measure *cost by location* for each service/activity

Culture
• Management practices that foster *affiliation with the organization*, developing *personal relationships*, and *regular contact* among dispersed staff
5. Expand Excellent IPUs Across Geography

• Grow in ways that improve **value**, not just increase volume

• Grow **areas of excellence** and **leverage across locations**, rather than adding broad line, stand-alone units

• **Affiliate with excellent providers** in medical conditions where there is insufficient volume or expertise to achieve superior value
Expanding Excellent IPUs Across Geography
The Cleveland Clinic Managed Practices

- Rochester General Hospital, NY
  Cardiac Surgery

- CLEVELAND CLINIC
  Cardiac Care

- Chester County Hospital, PA
  Cardiac Surgery

- Cape Fear Valley Health System, NC
  Cardiac Surgery

- McLeod Heart & Vascular Institute, SC
  Cardiac Surgery

- Cleveland Clinic Florida Weston, FL
  Cardiac Surgery
Models of Geographic Expansion

Affiliations
- Affiliation Agreements with Independent Provider Organizations
- Second Opinions and Telemedicine

Dispersed Services
- Dispersed Diagnostic Centers
- Convenience Sensitive Service Locations in the Community
- Complex IPU Components (e.g. surgery) in Additional Locations

New Hubs
- Specialty Hospitals as Referral Hubs in Additional Locations
- New Broader-Line Hospital Hubs
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**
Creating a Value-Based Health Care Delivery Organization

The Strategic Agenda

1. Organize into Integrated Practice Units Around Patient Medical Conditions (IPUs)
   - Including primary and preventive care for distinct patient populations

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6. Develop an Enabling Information Technology Platform
Value-Based Healthcare Delivery: Implications for Contracting Parties/Health Plans

• Providers can lead in developing new relationships with health plans through their role in **providing health benefits for their own employees**
Value-Based Health Care: The Role of Employers

• Employer interests are more closely aligned with patient interests than any other system participant
  – Employers need healthy, high performing employees
  – Employers bear the costs of chronic health problems and poor quality care
  – The cost of poor health is 2 to 7 times more than the cost of health benefits
    o Absenteeism
    o Presenteeism

• Employers are uniquely positioned to improve employee health
  – Daily interactions with employees
  – On-site clinics for quick diagnosis and treatment, prevention, and screening
  – Group culture of wellness

• Providers should establish direct relationships with employers to enable value based approaches
Value-Based Health Care Delivery: Implications for Government

- Establish **universal measurement** and **reporting** of provider **health outcomes**
- Require universal reporting by health plans of **health outcomes for members**
- Shift reimbursement systems to **bundled prices for cycles of care** instead of payments for discrete treatments or services
- Remove obstacles to the **restructuring of health care delivery** around the integrated care of medical conditions
- **Open up competition** among providers and across geography
- Set policies that encourage greater **responsibility of individuals** for their health and their health care
- Mandate **EMR adoption** that enables integrated care and supports outcome measurement
  - **National standards** for data definitions, communication, and aggregation
  - **Software as a service** model for smaller providers