Value-Based Health Care Delivery
Part I

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Medicaid Leadership Institute
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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 at 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

• Achieving 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 payment models

- Process improvements, safety initiatives, disease management and other overlays to the current structure are beneficial, but not sufficient
- Consumers alone cannot fix the dysfunctional structure of the current system
Creating Competition on Value

- **Competition** and **choice** for patients/subscribers are powerful forces to encourage restructuring of care and continuous improvement in value.

- Today’s competition in health care is often 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
Defining the Goal

• 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

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

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

- Prevention of illness
- 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 recurrences, relapses, flare ups, or acute episodes
- Slower disease progression
- Greater functionality and less need for long term care
- Less care induced illness
Cost versus Quality
Health Care Spending by Swedish County, 2008

Health Care Cost Per Capita (SEK)

Higher cost

Lower cost

Higher Quality

Lower Quality

County Council Quality 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: Öpna jämförelser, Socialstyrelsen 2008; Sjukvårdsdata i fokus 2008; BCG analysis
## Role of Volume in Value Creation
### Fragmentation of Hospital Services in 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>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>
</tr>
<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>
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</tbody>
</table>


- **Minimum volume standards** in lieu of compelling outcome information is an interim step to drive service consolidation.
Creating a Value-Based Health Care Delivery System

The Strategic Agenda

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

2. Establish Universal Measurement of Outcomes and Cost for Every Patient

3. Move to Bundled Prices for Care Cycles

4. Integrate Care Delivery Across Separate Facilities

5. Expand Excellent IPUs Across Geography

6. Create an Enabling Information Technology Platform
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**
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:45-9:00 am</td>
<td>Check In</td>
</tr>
<tr>
<td>9:00-9:15 am</td>
<td><strong>Introductions</strong></td>
</tr>
<tr>
<td>9:15-9:45 am</td>
<td><strong>Welcome and Introduction to Value-Based Health Care Delivery</strong></td>
</tr>
<tr>
<td>9:45-11:00 am</td>
<td><strong>Session 1: Integrated Care and Reimbursement</strong></td>
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<tr>
<td></td>
<td>Case Study: The West German Headache Center: Integrated Migraine Care</td>
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<tr>
<td>11:00-11:15 am</td>
<td>Break</td>
</tr>
<tr>
<td>11:15-11:30 am</td>
<td><strong>Case Protagonists</strong></td>
</tr>
<tr>
<td></td>
<td>Video: Klaus Bottcher, Sr. Manager, KKH &amp; Astrid Gendolla, Sr. Physician, West German Headache Center</td>
</tr>
<tr>
<td>11:30 am-12:00 pm</td>
<td><strong>Topic Lecture and Q&amp;A: Integrated Practice Units, Outcome and Cost Measurement</strong></td>
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<tr>
<td>12:00-1:00 pm</td>
<td>Lunch</td>
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<tr>
<td>1:00-2:15 pm</td>
<td><strong>Session 2: Value-Based Models of Primary Care</strong></td>
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<td>Case Study: Commonwealth Care Alliance: Elderly and Disabled Care</td>
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<tr>
<td>2:15-2:30 pm</td>
<td>Break</td>
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<tr>
<td>2:30-3:15 pm</td>
<td><strong>Case Protagonists</strong></td>
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<tr>
<td></td>
<td>Guests: Bob Master, CEO, Lois Simon, COO, and Bob Fallon, CFO, Commonwealth Care Alliance</td>
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<tr>
<td>3:15-3:45 pm</td>
<td><strong>Topic Lecture and Q&amp;A: Bundled Reimbursement</strong></td>
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<tr>
<td>3:45-4:45 pm</td>
<td>The Patient Protection and Affordable Care Act: Opportunities and Challenges for States</td>
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<td>4:45-5:00 pm</td>
<td><strong>Course Wrap-Up</strong></td>
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