Value-Based Health Care Delivery

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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.
Principles of Value-Based Health Care Delivery

• The overarching goal in health care must be value for patients, not access, cost containment, convenience, or customer service.

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

– Outcomes are the full set of health results for a patient’s condition over the care cycle.
– Costs are the total costs of care for a patient’s condition over the care cycle.
Principles of Value-Based Health Care Delivery

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

| - Prevention of illness | - Fewer complications |
| - Early detection       | - Fewer mistakes and repeats in treatment |
| - Right diagnosis       | - Faster recovery |
| - Right treatment to the right patient | - More complete recovery |
| - Rapid cycle time of diagnosis and treatment | - Greater functionality and less need for long term care |
| - Treatment earlier in the causal chain of disease | - Fewer recurrences, relapses, flare ups, or acute episodes |
| - Less invasive treatment methods | - Reduced need for ER visits |
|                           | - Slower disease progression |
|                           | - Less care induced illness |

- **Better health** is the goal, not more treatment
- Better health is **inherently less expensive** than poor health
Creating a Value-Based Health Care Delivery System

The Strategic Agenda

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

2. Measure Outcomes and Cost for Every Patient

3. Reimburse through Bundled Prices for Care Cycles

4. Integrate Care Delivery Across Separate Facilities

5. Expand Geographic Coverage by Excellent Providers or Affiliated Providers

6. Build an Enabling Information Technology Platform
1. Organizing Care Around Patient Medical Conditions
Migraine Care in Germany

Existing Model:
Organize by Specialty and Discrete Service

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Migraine Care in Germany

Existing Model:
Organize by Specialty and Discrete Service

New Model:
Organize into Integrated Practice Units (IPUs)

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
  - Involving **multiple** specialties and services
  - **Including** common co-occurring conditions and complications
  - E.g., diabetes, breast cancer, knee osteoarthritis
What is a Medical Condition?

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• In primary / preventive care, the unit of value creation is defined patient segments with similar preventive, diagnostic, and primary treatment needs (e.g. healthy adults, frail elderly)

• The medical condition / patient segment is the proper unit of value creation and the unit of value measurement in health care delivery
Value-Based Primary Care

Organize primary care around patient segments with similar health circumstances and primary care needs:

**Illustrative Segments**
- **Healthy** adults
- **Mothers** and **young children**
- Adults **at risk** of developing chronic or acute disease
  - E.g. family history, environmental exposures, lifestyle
- Chronically ill adults with one or more complex chronic conditions
  - E.g. diabetes, COPD, heart failure
- Adults with **rare** conditions
- **Frail elderly** or **disabled**

**Primary Care Integrated Practice Units:**
- **Care Delivery Team:** The set of physicians, nurses, educators, and other staff best equipped to meet the medical and non-medical needs of the segment
- **Facilities:** Care delivered in facilities and locations reflecting patient circumstances

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Attributes of an Integrated Practice Unit (IPU)

1. Organized around the patient medical condition or set of closely related condition (patient segments in primary care)

2. Involves a dedicated, multidisciplinary team who devotes a significant portion of their time to the condition

3. Providers affiliated with a common organizational unit

4. Taking responsibility for the full cycle of care for the condition
   - Encompassing outpatient, inpatient, and rehabilitative care as well as supporting services (e.g. nutrition, social work, behavioral health)

5. Incorporating patient education, engagement, and follow-up as integral to care

6. Utilizing a single administrative and scheduling structure

7. Co-located in dedicated facilities

8. A physician team captain and a care manager oversee each patient’s care process

9. Measure outcomes, costs, and processes for each patient using a common information platform

10. Function as a team, meeting formally and informally on a regular basis to discuss patients, processes and results

11. Accept joint accountability for outcomes and costs
• Volume and experience will have an even greater impact on value in an IPU structure than in the current system
## 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>
</tr>
<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>
</tr>
<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>

Low Volume Undermines Value
Mortality of Low-birth Weight Infants in Baden-Württemberg, Germany

- Minimum volume standards are an interim step to drive value and service consolidation in the absence of rigorous outcome information.

Source: Hummer et al, Zeitschrift für Geburtshilfe und Neonatologie, 2006; Results duplicated in AOK study: Heller G, Gibt et al.
2. Measuring Outcomes and Cost for Every Patient
The Measurement Landscape

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

Tier 1

Health Status Achieved or Retained

Survival

Degree of health/recovery

Tier 2

Process of Recovery

Time to recovery and 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/recovery and nature of recurrences

Long-term consequences of therapy (e.g., care-induced illnesses)

Source: NEJM Dec 2010
The Outcome Measures Hierarchy

Tier 1
Health Status
Achieved or Retained
- Survival

Tier 2
Process of Recovery
- Degree of health/recovery

Tier 3
Sustainability of Health
- Time to recovery and return to normal activities

Dimension
- Mortality
- Achieved clinical status
- Achieved functional status
- Time to care completion and recovery
- Care-related pain and discomfort
- Complications
- Reintervention/Readmission
- Long-term clinical status
- Long-term functional status
- Long-term consequences of therapy

Source: NEJM Dec 2010
Adult Kidney Transplant Outcomes
U.S. Centers, 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, 2008-2010

Number of programs included: 236
Number of transplants: 38,535
1-year graft survival: 93.55%

8 greater than expected graft survival (3.4%)
14 worse than expected graft survival (5.9%)
Measuring the Cost of Care Delivery: Principles

- Cost is the **actual expense** of patient care, not the **charges** billed or collected.

- Cost should be measured around the **patient**.

- Cost should be aggregated over the **full cycle of care for the patient’s medical condition**, not for departments, services, or line items.

- Cost depends on the **actual use of resources** involved in a patient’s care process (personnel, facilities, supplies)
  - The **time** devoted to each patient by these resources
  - The **capacity cost** of each resource
  - The **support costs** required for each patient-facing resource
3. Reimbursing through Bundled Prices for Care Cycles

**Bundled Price**

- A single price covering the *full care cycle for an acute medical condition*
- Time-based reimbursement for overall care of a *chronic condition*
- Time-based reimbursement for *primary/preventive care* for a *defined patient segment*
Components of the bundle

- Pre-op evaluation
- Lab tests
- Radiology
- Surgery & related admissions
- Prosthesis
- Drugs
- Inpatient rehab, up to 6 days
- All physician and staff fees and costs
- 1 follow-up visit within 3 months
- Any additional surgery to the joint within 2 years
- If post-op infection requiring antibiotics occurs, guarantee extends to 5 years

Currently 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

Applies to all qualifying patients. Provider participation is voluntary, but all providers are continuing to offer total joint replacements

The Stockholm bundled price for a knee or hip replacement is about US $8,000
4. Integrating Care Delivery Across Separate Facilities
Children’s Hospital of Philadelphia Care Network

The Children’s Hospital of Philadelphia®

Network Hospitals:
- CHOP Newborn Care
- CHOP Pediatric Care
- CHOP Newborn & Pediatric Care

Wholly-Owned Outpatient Units:
- Pediatric & Adolescent Primary Care
- Pediatric & Adolescent Specialty Care Center
- Pediatric & Adolescent Specialty Care Center & Surgery Center
- Pediatric & Adolescent Specialty Care Center & Home Care

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Four Levels of Provider System Integration

1. Choosing an **overall scope of services** where the provider can achieve excellence in value

2. **Rationalizing service lines / IPUs across facilities** to improve volume, deepen dedicated teams and better utilize resources

3. Offering specific services at the **appropriate facility**
   - Based on medical condition, acuity level, resource intensity, cost level and need for convenience
   - E.g., shifting routine surgeries to smaller, more specialized facilities

4. Clinically integrating care **across units and facilities** using an IPU structure
   - Integrate services across the care cycle
   - Integrate preventive/primary care units with specialty IPUs

There are major value improvements available from **concentrating volume** by medical condition and moving care **out of heavily resourced** secondary, tertiary and quaternary facilities
5. Expanding Geographic Coverage by Excellent or Affiliated Providers

Leading Providers

• Grow **areas of excellence across geography:**
  − **Hub and spoke** expansion of satellite pre- and post-acute services
  − **Affiliations** with community providers to extend the reach of IPUs

• Increase the **volume of patients** in medical conditions or primary care segments vs. **widening** service lines locally, or adding new **broad line** units

Community Providers

• **Affiliate with excellent providers** in more complex medical conditions and patient segments in order to access expertise, facilities and services to enable high value care
  − New roles for **rural** and **community** hospitals
Expanding Geographic Coverage by Excellent Providers
The Cleveland Clinic Affiliate Programs
6. Building 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
- Data encompasses the **full care cycle**, including care by referring entities
- Allow access and communication among **all involved parties**, including with patients
- **Templates** for medical conditions to enhance the user interface
- “**Structured**” data vs. free text
- Architecture that allows easy extraction of **outcome measures**, **process measures**, and **activity-based cost measures** for each patient and medical condition
- Interoperability standards enabling communication among **different provider** (and payor) **organizations**
A Mutually Reinforcing Strategic Agenda

Organize into Integrated Practice Units

Grow Excellent Services Across Geography

Measure Outcomes and Cost For Every Patient

Integrate Care Delivery Across Separate Facilities

Move to Bundled Prices for Care Cycles

Build an Enabling IT Platform
Creating a Value-Based Health Care Delivery System
Implications for Physician Leaders

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<tr>
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<tbody>
<tr>
<td>1. Integrated Practice Units (IPUs)</td>
<td>• Lead <strong>multidisciplinary teams</strong>, not specialty silos</td>
</tr>
<tr>
<td>2. Measure Cost and Outcomes</td>
<td>• Become an expert in <strong>measurement and process improvement</strong></td>
</tr>
<tr>
<td>3. Move to Bundled Prices</td>
<td>• Proactively develop new <strong>bundled reimbursement options and care guarantees</strong></td>
</tr>
<tr>
<td>4. Integrate Across Separate Facilities</td>
<td>• Champion <strong>value enhancing rationalization, relocation, and integration</strong> with sister hospitals, as well as between inpatient and outpatient units, instead of protecting turf</td>
</tr>
<tr>
<td>5. Expand Excellence Across Geography</td>
<td>• Create networks and affiliations to expand high-value care <strong>across geography</strong></td>
</tr>
<tr>
<td>6. Enabling IT Platform</td>
<td>• Become a <strong>champion for the right EMR systems</strong>, not an obstacle to their adoption and use</td>
</tr>
</tbody>
</table>
Creating a Value-Based Health Care Delivery System

Implications for Payors

1. Integrated Practice Units (IPUs)
   • Encourage and reward integrated practice unit models by providers

2. Measure Cost and Outcomes
   • Encourage or mandate provider outcome reporting through registries by medical condition
   • Create standards for meaningful provider cost measurement and reporting

3. Move to Bundled Prices
   • Design new bundled reimbursement structures for care cycles instead of fees for discrete services
   • Share information with providers to enable improved outcomes and cost measurement

4. Integrate Across Separate Facilities
   • Assist in coordinating patient care across the care cycle and across medical conditions
   • Direct care to appropriate facilities within provider systems

5. Expand Excellence Across Geography
   • Provide advice to patients (and referring physicians) in selecting excellent providers
   • Create relationships to increase the volume of care delivered by or affiliated with centers of excellence

6. Enabling IT Platform
   • Assemble, analyze, manage members’ total medical records
   • Require introduction of compatible medical records systems
Creating a Value-Based Health Care Delivery System

Implications for Government

1. Integrated Practice Units (IPUs)
   - Reduce regulatory obstacles to care integration across the care cycle

2. Measure Cost and Outcomes
   - Create a national framework of medical condition outcome registries and a path to universal measurement
   - Tie reimbursement to outcome reporting
   - Set accounting standards for meaningful cost reporting

3. Move to Bundled Prices
   - Create a bundled pricing framework and rollout schedule

4. Integrate Across Separate Facilities
   - Introduce minimum volume standards by medical condition

5. Expand Excellence Across Geography
   - Encourage rural providers and providers who fall below minimum volume standards to affiliate with qualifying centers of excellence for more complex care

6. Enabling IT Platform
   - Set standards for common data definitions, interoperability, and the ability to easily extract outcome, process, and costing measures for qualifying HIT systems