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.
Redefining Health Care Delivery

• The core issue in health care is the **value of health care delivered**

Value: Patient health outcomes per dollar spent

• Value is the only goal that can **unite the interests** of all system participants

• How to design a health care delivery system that **dramatically improves patient value**

• 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, 21\textsuperscript{st} century medical technology is often delivered with 19\textsuperscript{th} century organization structures, management practices, measurement methods, and payment models

- Care pathways, process improvements, safety initiatives, disease management and other **overlays** to the current structure are beneficial, but not sufficient
Creating The Right Kind of 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 ≠ Patient success]

• Creating positive-sum **competition on value** is integral to health care reform in every country.
Principles of Value-Based Health Care Delivery

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

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

– Outcomes are the full set of patient health results 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 a powerful 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

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

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
1. 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)

Organizing Around the Patient’s 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
  – Including common co-occurring conditions and complications
  – Involving multiple specialties and services

• In primary / preventive care, the organizational unit for care is a defined patient population (e.g. healthy adults, frail elderly)

• IPUs can address a single medical condition or groups of closely related medical conditions involving similar specialties, services, and expertise

• The patient’s medical condition is the unit of value creation and unit of value measurement in health care delivery
Integrating Across the Cycle of Care
Breast Cancer

<table>
<thead>
<tr>
<th>INFORMING AND ENGAGING</th>
<th>MEASURING</th>
<th>ACCESSING THE PATIENT</th>
<th>MONITORING/PREVENTING</th>
<th>DIAGNOSING</th>
<th>PREPARING</th>
<th>INTERVENING</th>
<th>RECOVERING/REHABING</th>
<th>MONITORING/MANAGING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advice on self screening</td>
<td>Counseling patient and family on the diagnostic process and the diagnosis</td>
<td>Counseling on the treatment process</td>
<td>Explaining patient treatment options/shared decision making</td>
<td>Patient and family psychological counseling</td>
<td>Counseling on rehabilitation options, process</td>
<td>Achieving compliance</td>
<td>Psychological counseling</td>
<td>Counseling on long term risk management</td>
</tr>
<tr>
<td>Consultations on risk factors</td>
<td>Self exams</td>
<td>Counseling on the treatment process</td>
<td>Education on managing side effects and avoiding complications</td>
<td>Achieving compliance</td>
<td>MRI, CT</td>
<td>Recurring mammograms (every six months for the first 3 years)</td>
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</tr>
</tbody>
</table>

- Self exams
- Mammograms
- Office visits
- Mammography unit
- Lab visits
- Office visits
- Lab visits
- High risk clinic visits
- Office visits
- Hospital stays
- Hospital visits
- Lab visits
- Lab visits
- Hospital visits
- Pharmacy visits
- Office visits
- Rehabilitation facility visits
- Pharmacy visits
- Office visits
- Lab visits
- Mammographic labs and imaging center visits

- 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 oncoplastic surgery evaluation
- Neo-adjuvant chemotherapy
- Surgery (breast preservation or mastectomy, oncoplastic alternative)
- Adjuvant therapies (hormonal medication, radiation, and/or chemotherapy)
- 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
## Care Delivery Value Chain

### Severe Knee Osteoarthritis Requiring Replacement

<table>
<thead>
<tr>
<th>INFORMING AND ENGAGING</th>
<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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</thead>
<tbody>
<tr>
<td>• Education and promotion of exercise, weight reduction, proper nutrition</td>
<td>• Self-reported loss of function</td>
<td>• PCP office visit</td>
<td>• Review MRI, X-Ray results</td>
<td>• Anesthesia Options</td>
<td>• Surgical Procedure Options</td>
<td>• Surgical</td>
<td>• Regular consultations with orthopedic specialists (6 weeks, 6 months, 1 year, 3-4 yeas as needed (MORE?))</td>
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<tr>
<td>• Education on the meaning of diagnosis and prognosis of disease – short and long term outcomes</td>
<td>• Pain</td>
<td>• Health club</td>
<td>• Assess loss of cartilage</td>
<td>• General</td>
<td>• Devices</td>
<td>• Immediate return to OR for manipulation (1% of cases)</td>
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<td></td>
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<tr>
<td>• Expectation setting</td>
<td>• WOMAC, SF-36</td>
<td>• Physical therapy office</td>
<td>• Assess alterations in subchondral bone</td>
<td>• Epidural</td>
<td>• Dement</td>
<td>• Medical</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>• Orthopedic/Rheumatologic Evaluation</td>
<td>• Regional blocks</td>
<td>• Minimally Invasive</td>
<td>• Coagulation monitoring</td>
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<td>• 1 or 2 day</td>
<td>• Computer Assisted</td>
<td>• Living</td>
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<td>• Daily living support (e.g. showering, dressing)</td>
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<td>• Contact provider for specific set of risk indicators (e.g. fever, increased swelling, increased pain, breathing difficulties, other)</td>
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<td>• Physical Therapy</td>
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<td></td>
<td>• Extensive daily or twice daily PT sessions to build up lost muscle and assure range of motion</td>
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<td></td>
<td></td>
<td></td>
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<td></td>
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<td>• Education on exercises to perform between PT sessions</td>
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<td>• Continuous motion machine</td>
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<td>• Pain Management</td>
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<td>• Multimodal</td>
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<td>• Preemptive</td>
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<td>• Monitoring compliance</td>
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<td></td>
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<td>• Counseling on necessity of rehab, rehab exercises, and compliance</td>
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<td>• Counseling on necessity of rehab, rehab exercises, and compliance</td>
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<td>• Counsel to maintain exercise and healthy weight</td>
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</tbody>
</table>
Attributes of an Integrated Practice Unit (IPU)

1. Organized around the **patient medical condition** or set of closely related conditions
2. Involves a **dedicated, multidisciplinary team** who devotes a significant portion of their time to the condition
3. Providers are part of or affiliated with a **common organizational unit**
4. Provides 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. Includes **patient education**, **engagement**, and **follow-up**
6. Utilizes a **single administrative and scheduling structure**
7. **Co-located** in **dedicated facilities**
8. Care led by a **physician team captain** and a **care manager** who oversee each patient’s care process
9. **Meets formally and informally** on a regular basis to discuss patients, processes and results
10. **Measures** outcomes, costs, and processes for each patient using a **common information platform**
11. Accepts **joint accountability** for outcomes and costs
Volume in a Medical Condition Enables Value

- 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>
</tr>
<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>
</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>


- **Minimum volume standards** in lieu of rigorous outcome information are an interim step to drive service consolidation
2. Measure Outcomes and Cost for Every Patient

- **Patient Initial Conditions**
- **Processes**
- **Indicators**
- **(Health) Outcomes**

**Patient Compliance**

- Protocols/Guidelines
- E.g., Hemoglobin A1c levels for diabetics

**Structure**

- E.g., Staff certification, facilities standards
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

Sustainability of health/recovery and nature of recurrences

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

Source: NEJM Dec 2010

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The Outcomes Measures Hierarchy
Severe Knee-Osteoarthritis Requiring Replacement

1. **Survival**
   - Mortality

2. **Degree of recovery / health**
   - Functional level achieved
   - Range of motion achieved
   - Pain level relief achieved
   - Degree of independence
   - Extent of return to physical activities
   - Ability to return to work

3. **Time to recovery or return to normal activities**
   - Length of hospital stay
   - Time to highest functional level
   - Time to return to work
   - Time to return to physical activities and independence

4. **Disutility of care or treatment process**
   - Pain
   - Infection rate (Urinary Tract)
   - Pulmonary embolism
   - Deep vein thrombosis
   - Pneumonia
   - Myocardial infarction
   - Delirium

5. **Sustainability of recovery or health over time**
   - Need for revision/re-operation (immediate failure, implant failure secondary to wear)
   - Maintained functional level
   - Ongoing pain status
   - Ability to continue working
   - Ability to live independently
   - Susceptibility to infection
   - Stiff knee due to unrecognized complication
   - Regional pain syndrome

6. **Long-term consequences of therapy**
   - Loss of mobility due to inadequate rehab
   - Associated cardiac complications
   - Risk of complex fracture
   - Susceptibility to infection
   - Stiff knee due to unrecognized complication
   - Regional pain syndrome
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. Centers, 2005-2007

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%)
Measuring the Cost of Care Delivery: Principles

• Cost should be measured around the patient
• Cost depends on the actual use of resources involved in a patient’s care
• The only way to properly measure cost per patient is to track the time devoted to each patient by these resources (personnel, facilities, and support services) and resource capacity costs.
Mapping Resource Utilization  
MD Anderson Cancer Center

**Registration and Verification**
- Receptionist, Patient Access Specialist (PAS), Language Assistance

**Intake**
- Nurse (RN), Receptionist
- Verification of Information and Consent Forms PAS
- Pt. assessment; paperwork assembly; pt. placed in room; Medication Reconciliation RN

**Clinician Visit**
- MD, MLP, MA, PSC, RN
- Pt. work-up initiated; PHDB reviewed and physical exam of pt.
- MLP
- Attending MD discusses Plan of Care #1

**Plan of Care Discussion**
- RN REVIEWS Plan of Care #1; introduces team, reviews schedule for return visit
- Room cleaned, paperwork is completed RN
- Changes to Plan of Care?

**Plan of Care Scheduling**
- Test, consults are scheduled and communicated to pt. PSC
- Scheduled for Same Day? PSC
- Confirmation of Care: re-schedules, email, voicemails. Pt. is notified of charges RN (80%) MLP (20%)
- New appointments scheduled and charges entered into CARE PSC

**Legend**
- Receptionist
- Interpreter
- PAS: Patient Access Specialist
- MA: Medical Assistant
- PSC: Patient Service Coordinator
- RN: Registered Nurse
- Pt: Patient, outside of process
- MD: Medical Doctor, PHDB: Patient History Database

**Map Details**
- Patient arrives MDA
- Check In at Reception Desk and communicate pt. arrival with PAS Receptionist
- Verification of Information and Consent Forms PAS
- Pt. assessment; paperwork assembly; pt. placed in room; Medication Reconciliation RN
- Attending MD discusses Plan of Care #1
- RN REVIEWS Plan of Care #1; introduces team, reviews schedule for return visit
- Room cleaned, paperwork is completed RN
- Changes to Plan of Care?
- Confirmation of Care: re-schedules, email, voicemails. Pt. is notified of charges RN (80%) MLP (20%)
- New appointments scheduled and charges entered into CARE PSC

**Time (min)**
- Patient arrives MDA: 2
- Verification of Information and Consent Forms PAS: 40
- Pt. assessment; paperwork assembly; pt. placed in room; Medication Reconciliation RN: 20
- Attending MD discusses Plan of Care #1: 45
- RN REVIEWS Plan of Care #1; introduces team, reviews schedule for return visit: 30
- Room cleaned, paperwork is completed RN: 10
- Changes to Plan of Care?: 10
- Confirmation of Care: re-schedules, email, voicemails. Pt. is notified of charges RN (80%) MLP (20%): 30
- New appointments scheduled and charges entered into CARE PSC: 10

**Conversion Note**
- Y: Yes
- N: No
- 10%: 10%
- 90-95%: 90-95%
- 5-10%: 5-10%


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Measuring the Cost of Care Delivery: Principles

- Cost should be measured around the patient
- Cost depends on the actual use of resources involved in a patient’s care
- The only way to properly measure cost per patient is to track the time devoted to each patient by these resources (personnel, facilities, and support services) and resource capacity costs.
- Indirect and support costs should be allocated to direct resources based on the demand for the support they create
- Cost should be aggregated for the medical condition level for each patient over the full cycle of care, not for departments, services, or line items
- Cost measurement should be combined with outcome measurement to inform process improvement and cost reduction
  - E.g. Reduce high cost activities that do not contribute to superior outcomes
- Combining actual costs and outcomes will transform the discussion about care improvement
Selected Cost Reduction Opportunities in Health Care

- **Process variation** that reduces efficiency without improving outcomes
- Over-provision of *low-* or *non-value adding* services or tests
  - Sometimes to justify billing or follow rigid protocols
- Redundant *administrative* and *scheduling* units
- **Low utilization** of expensive physicians, staff, clinical space and equipment partly due to duplication and service fragmentation
- Use of *physicians and skilled staff* for less skilled activities
- Delivering care in *over-resourced* facilities
  - E.g. routine care delivered in expensive hospital settings
- **Long cycle times** and unnecessary delays
- Excess *inventory* and weak inventory management
- Focus on minimizing the costs of discrete services rather than *optimizing the total cost* of the care cycle
- Lack of *cost awareness* in clinical teams
- There are numerous cost reduction opportunities that do not require outcome *tradeoffs*, but will actually *improve outcomes*
3. Setting Bundled Prices for Care Cycles

Bundled Price

- A single price covering the **full care cycle for an acute medical condition**
- Time-based reimbursement for full care of a **chronic condition**
- Time-based reimbursement for **primary/preventive care for a defined patient population**
Bundled Payment in Practice
Hip and Knee Replacement in Stockholm, Sweden

- **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
- Provider participation is **voluntary**. All providers are participating
- The Stockholm bundled price for a knee or hip replacement is about **US $8,000**
Four Levels of Provider System Integration

1. Choosing the **overall scope of service lines** in which each provider entity can achieve excellence

2. **Rationalizing service lines / IPUs** across facilities to improve volume, avoid duplication, and deepen teams

3. Offering specific services at the **appropriate facility**
   - E.g. acuity level, resource intensity, cost level, need for convenience

4. Clinically integrating care **across facilities and entities**, within an IPU structure
   - **Widening and integrating** the care cycle
   - Better **connecting** preventive/primary care units to specialty IPUs
   - **Satellite units and affiliations** with excellent IPUs

- There are major value improvements from **aggregating medical condition volume** and **moving care out** of heavily resourced hospital, tertiary and quaternary facilities
5. Expanding Excellent IPUs Across Geography

Leading Providers

- Grow **areas of excellence across locations**:
  - Satellite pre- and post-acute services
  - Affiliations with community providers
  - New IPU hubs

  **NOT:**
  - Further widening the service line locally
  - Growing through new broad line, stand-alone units

Community Providers

- **Affiliate with excellent providers** in medical conditions and patient populations to access sufficient volume, expertise, and sophisticated facilities and services to achieve superior value
  - New roles for rural and community hospitals
Expanding 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 and Knowledge Services**
  - Affiliation Agreements with Independent Provider Organizations
  - Second Opinions and Telemedicine

- **Dispersed Services (Hub and Spoke)**
  - Convenient Sensitive Services Closer to Patients
  - Dispersed Diagnostic Centers
  - Complex IPU Components (e.g. surgery) in Additional Locations

- **New Hubs**
  - New Specialty Hospitals or Referral Centers
  - New Broader-Line Hubs
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
- Measure Outcomes and Cost For Every Patient
- Move to Bundled Prices for Care Cycles
- Integrate Care Delivery Across Separate Facilities
- Grow Excellent Services Across Geography

Build an Enabling IT Platform
Creating a Value-Based Health Care Delivery Organization

Implications for Physician Leaders

1. Organize into Integrated Practice Units (IPUs) Around Patient Medical Conditions
   - Lead **multidisciplinary teams**, not specialty divisions or departments

2. Establish Universal Measurement of Outcomes and Cost for Every Patient
   - Become an **expert in measurement and process improvement**

3. Move to Bundled Prices for Care Cycles
   - **Redefine the financial model and the way to generate income**

4. Integrate Care Delivery Across Separate Facilities
   - View relationships across inpatient and outpatient units or with sister hospitals from a **value perspective**, not based on autonomy or power

5. Expand Excellent IPUs Across Geography
   - Aspire to influence patient care **outside the local area**

6. Create an Enabling Information Technology Platform
   - Become a **champion for the right EMR systems**, not an obstacle to adoption and use
Moving to a Value-Based System

Leverage Points for Government

1. Organize into Integrated Practice Units (IPUs) Around Patient Medical Conditions and Patient Populations
   - Provider **certification** based on **care integration measures** (e.g. multidisciplinary teams, unified outcome measurement, dedicated facilities)
   - Reduce **regulatory obstacles** to care integration (e.g. Stark Laws, corporate practice of medicine)

2. Establish Universal Measurement of Outcomes and Cost for Every Patient
   - Create a **national outcome registry framework**
   - Tie reimbursement to outcome **reporting** (e.g. through registries)
   - Require provider reporting of **patient volume by medical condition** as an interim step
   - Measure **costs at the patient level unit of analysis** across the care cycle and assign these accurately
   - **Modify reimbursement levels** based on comprehensive outcome and cost data

3. Move to Bundled Prices for Care Cycles
   - Combine evaluation, treatment, and follow-up reimbursement in a **single payment**
   - **Expand DRG** care episodes and set guidelines for bundled payment reimbursement requirements
   - Create a **bundled pricing framework** and rollout schedule
Moving to a Value-Based System
Leverage Points for Government

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

5. Expand Excellent IPUs Across Geography
   - Encourage **affiliations** between community / rural providers and qualifying centers of excellence for complex care

6. Create an Enabling Information Technology Platform
   - Set **standards** for common data definitions, interoperability, and the ability to easily extract outcome, process, and costing measures for all HIT systems