Webinar

The Strategy that Will Fix Health Care

Professor Michael E. Porter and Dr. Thomas H. Lee

September 24, 2013

This presentation draws on Porter, Michael E. and Thomas H. Lee. "The Strategy that Will Fix Health Care," *Harvard Business Review*, October 2013; Porter, Michael E. with Thomas H. Lee and Erika A. Pabo. "Redesigning Primary Care: A Strategic Vision to Improve Value by Organizing Around Patients' Needs," *Health Affairs*, March 2013; Porter, Michael E. and Robert Kaplan. "How to Solve the Cost Crisis in Health Care," *Harvard Business Review*, September 2011; Porter, Michael E. "What is Value in Health Care" and supplementary papers, *New England Journal of Medicine*, December 2010; Porter, Michael E. "A Strategy for Health Care Reform—Toward a Value-Based System," *New England Journal of Medicine*, June 2009; Porter, Michael E. and Elizabeth Olmsted Teisberg. Redefining Health Care: Creating Value-Based Competition on Results. (2006) Additional information about these ideas, as well as case studies, can be found at the Institute for Strategy and Competitiveness Redefining Health Care website at http://www.hbs.edu/rhc/index.html.

Solving the Health Care Problem

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

> Value: Patient health outcomes per dollar spent

- Delivering high and improving value is the **fundamental purpose** of health care
- Value is the only goal that can **unite the interests** of all system participants
- Improving value is the only **real solution** versus cost shifting or restricting services

Principles of Value-Based Health Care Delivery

$$\text{Value} = \frac{\text{Health outcomes that matter to patients}}{\text{Costs of delivering the outcomes}}$$

- Value is measured for the **care of a patient's medical condition** over the full cycle of care
  - 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

Creating a Value-Based Health Care Delivery System

The Strategic Agenda

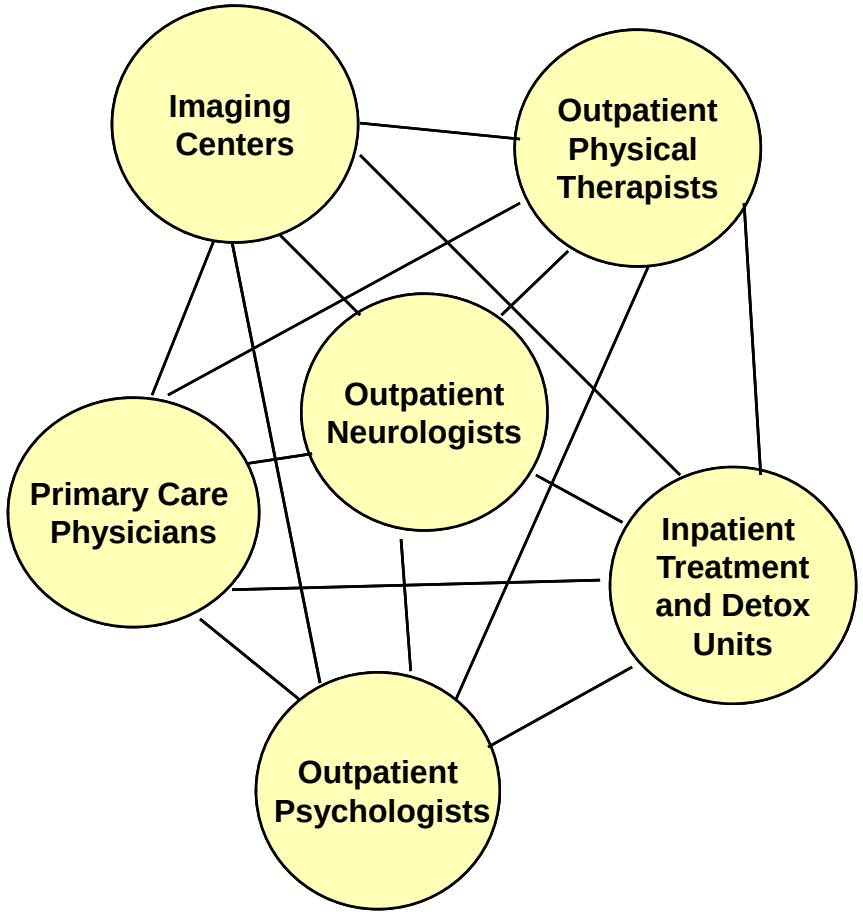
1. Organize Care into Integrated Practice Units (IPUs) around Patient Medical Conditions
   - Organize primary and preventive care to serve distinct patient segments
2. Measure Outcomes and Costs for Every Patient
3. Move to Bundled Payments for Care Cycles
4. Integrate Care Delivery Systems
5. Expand Geographic Reach
6. Build an Enabling Information Technology Platform

1. Organize Care Around Patient Medical Conditions

Migraine Care in Germany

Existing Model:

Organize by Specialty and Discrete Service



Source: Porter, Michael E., Clemens Guth, and Elisa Dannemiller, *The West German Headache Center: Integrated Migraine Care*, Harvard Business School Case 9-707-559, September 13, 2007

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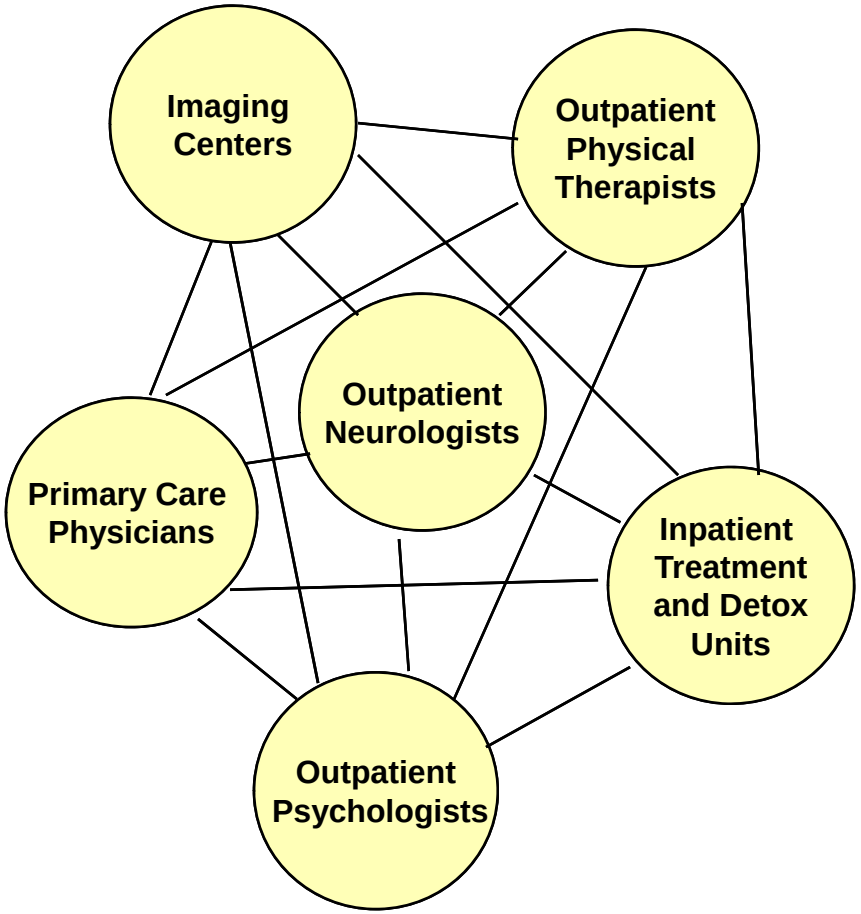
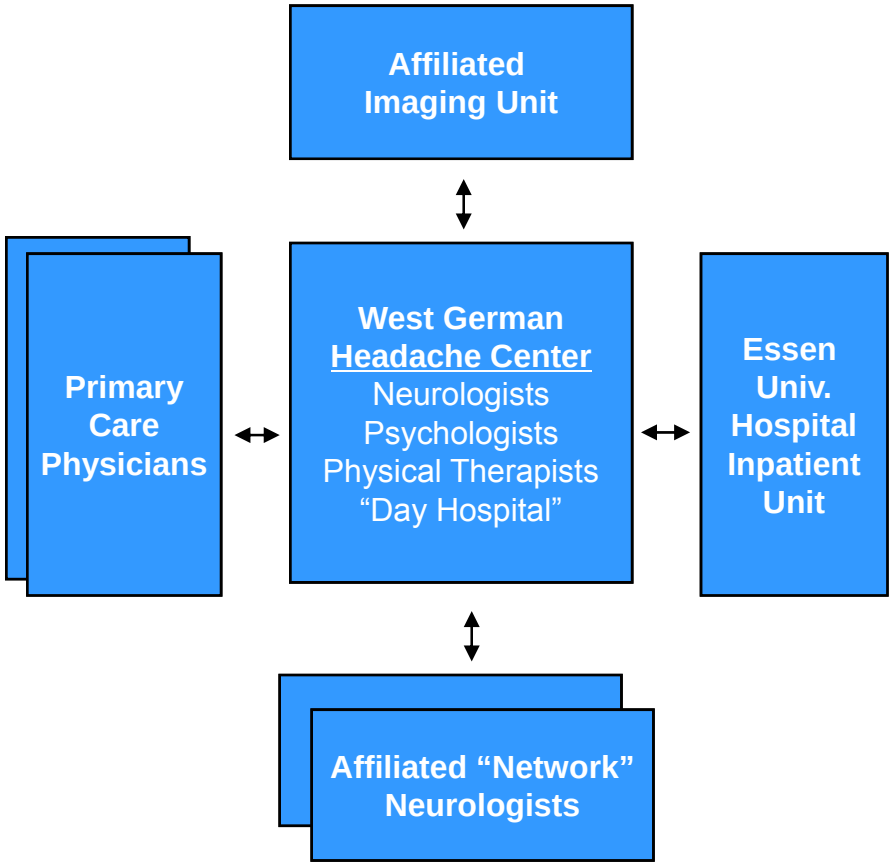


New Model:
Organize into Integrated Practice Units (IPUs)



Source: Porter, Michael E., Clemens Guth, and Elisa Dannemiller, *The West German Headache Center: Integrated Migraine Care*, Harvard Business School Case 9-707-559, September 13, 2007

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

  Examples: diabetes, breast cancer, knee osteoarthritis

- 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 value measurement** in health care delivery

Source: Porter, Michael E. with Thomas H. Lee and Erika A. Pabo. "Redesigning Primary Care: A Strategic Vision to Improve Value by Organizing Around Patients' Needs," *Health Affairs*, Mar, 2013

Attributes of an Integrated Practice Unit (IPU)

1. Organized around a **medical condition** or set of **closely related conditions** (or around defined patient segments for primary care)
2. Care is delivered by a **dedicated**, **multidisciplinary team** who devote a significant portion of their time to the medical condition
3. Providers see themselves as part of a **common organizational unit**
4. The team takes responsibility for the **full cycle of care** for the condition
   - Encompassing **outpatient**, **inpatient**, and **rehabilitative** care, as well as **supporting services** (such as nutrition, social work, and behavioral health)
5. **Patient education**, **engagement**, and **follow-up are integrated** into care
6. The unit has a **single administrative** and **scheduling structure**
7. To a large extent, **care is co-located** in **dedicated facilities**
8. A **physician team captain** or a **clinical care manager** (or both) oversees each patient's care process
9. The **team measures** outcomes, costs, and processes for each patient using a **common measurement platform**
10. The providers on the team meet **formally and informally** on a regular basis to discuss patients, processes, and results
11. **Joint accountability** is accepted for outcomes and costs

The Role of Volume in Value Creation

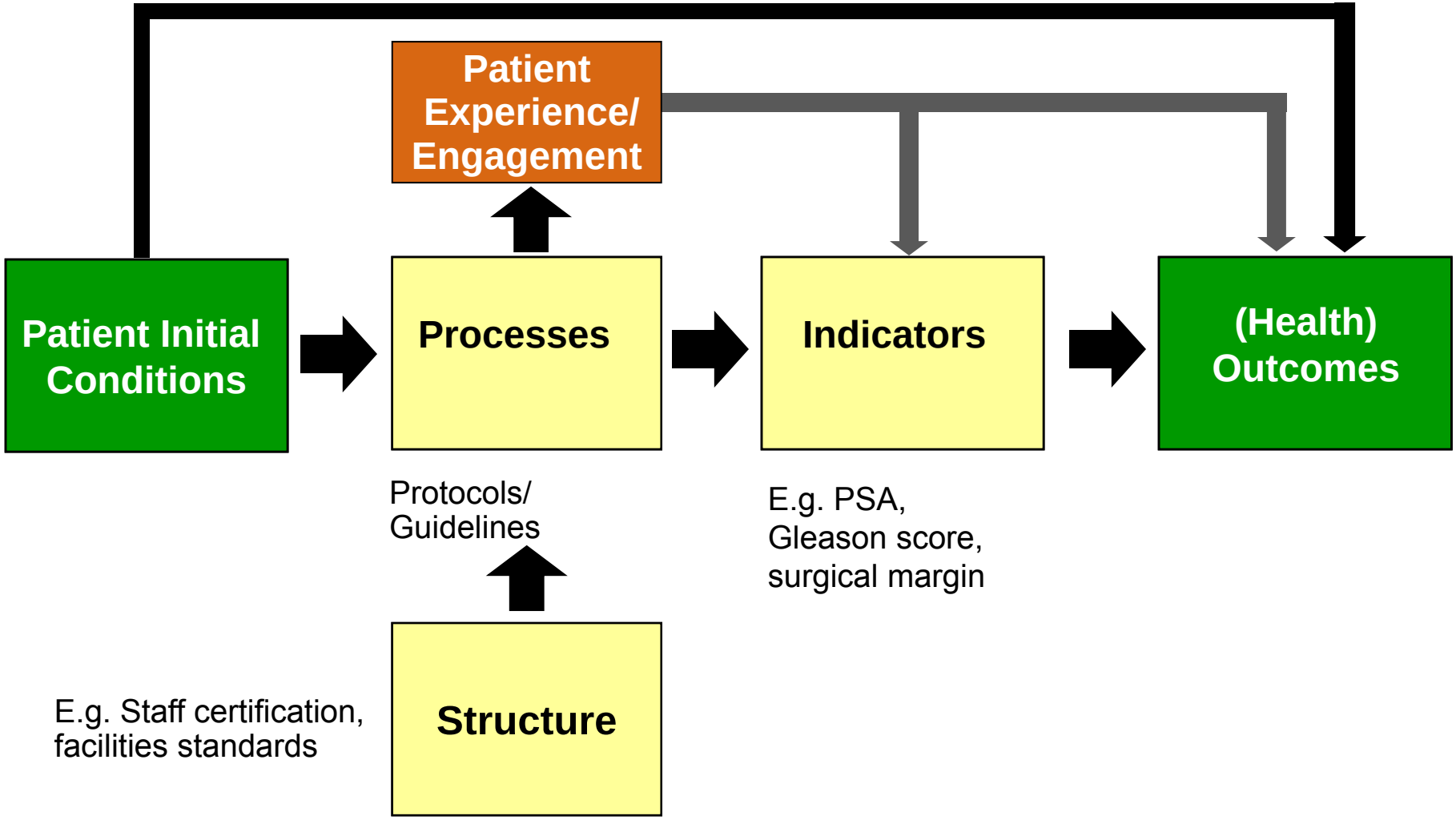
Fragmentation of Hospital Services in Sweden

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

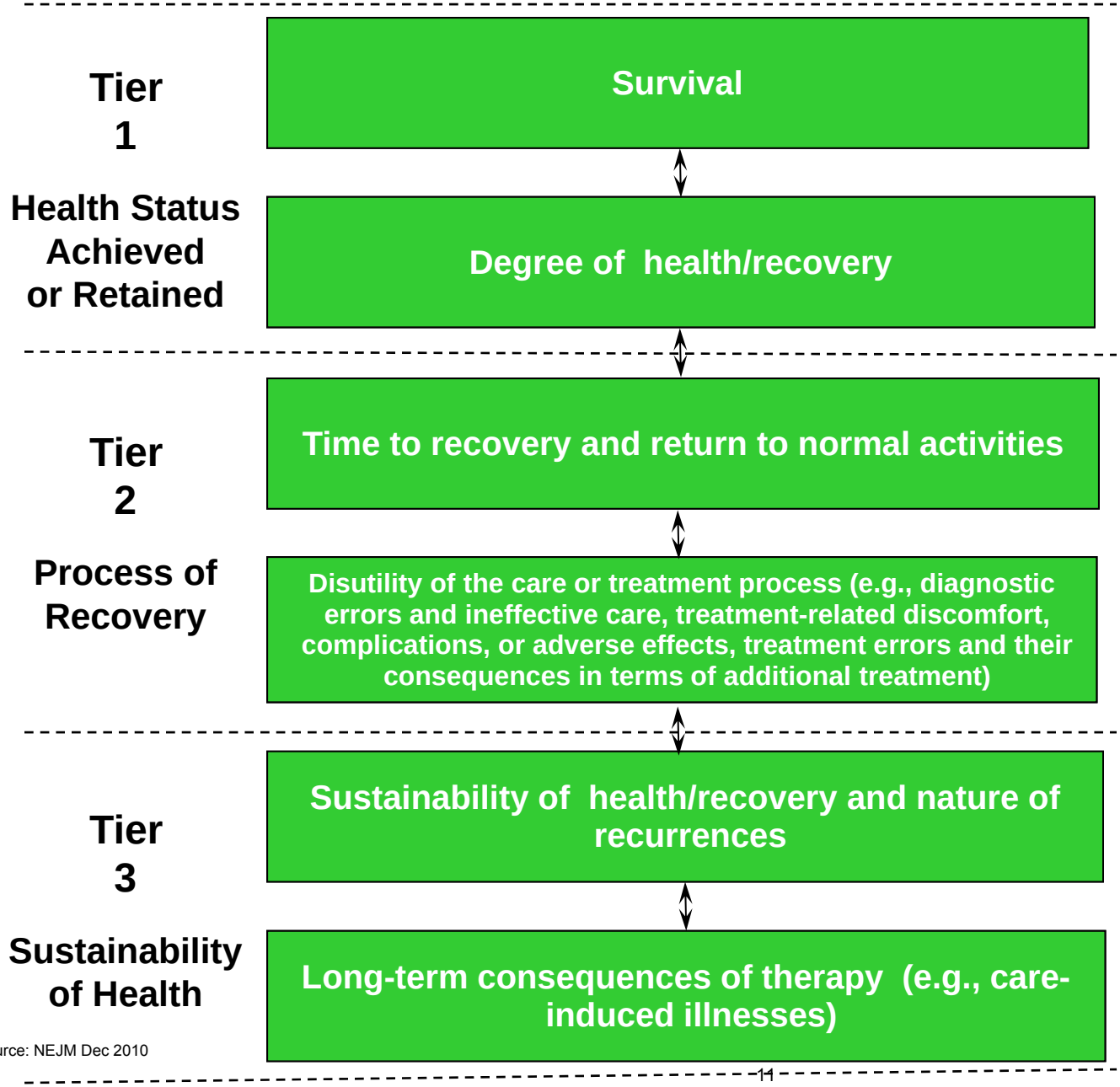
Source: Compiled from The National Board of Health and Welfare Statistical Databases – DRG Statistics, Accessed April 2, 2009.

2. Measure Outcomes and Costs for Every Patient

The Measurement Landscape



The Outcome Measures Hierarchy



Source: NEJM Dec 2010

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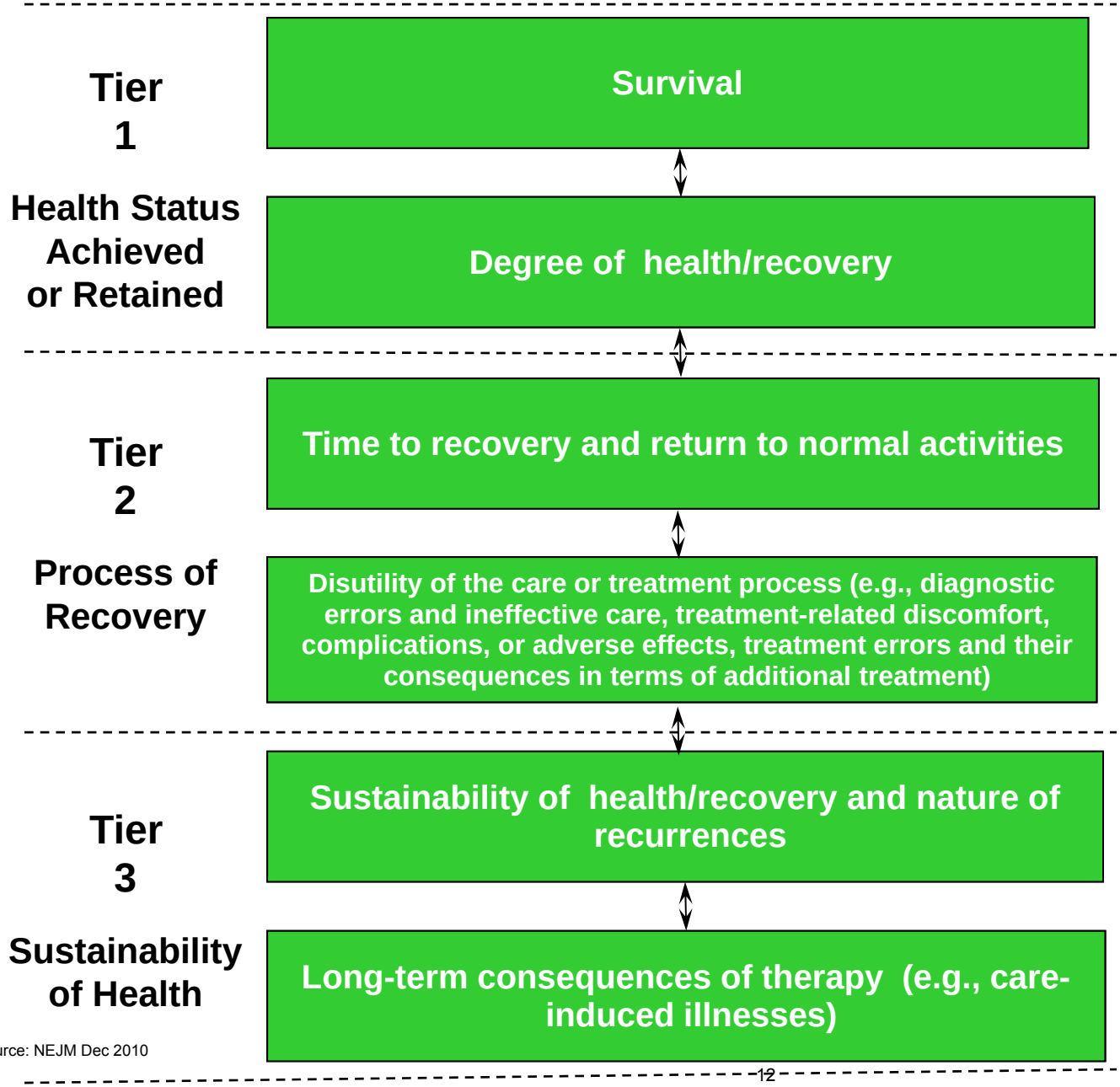

- Achieved clinical status
- Achieved functional status

Source: NEJM Dec 2010

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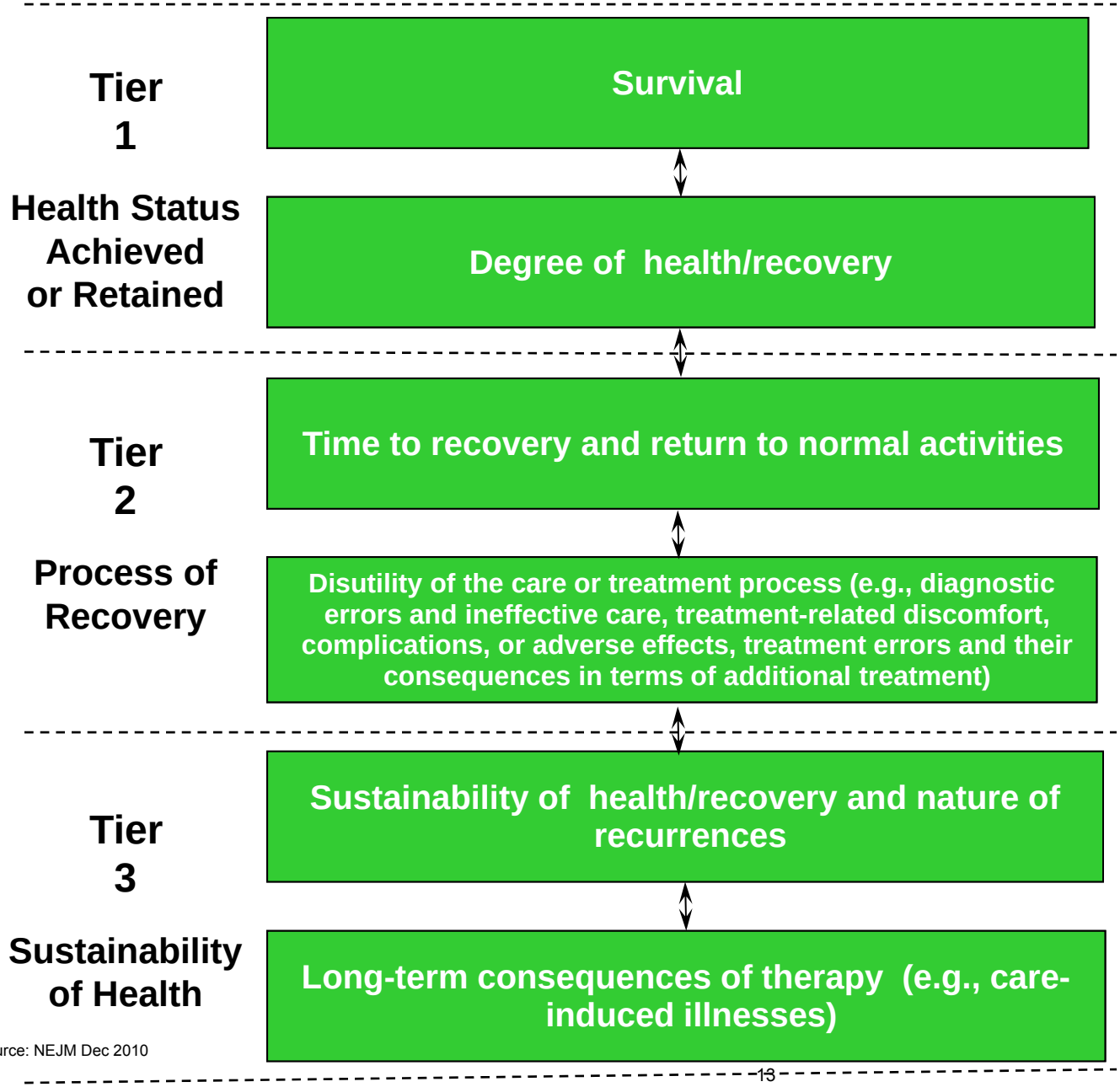

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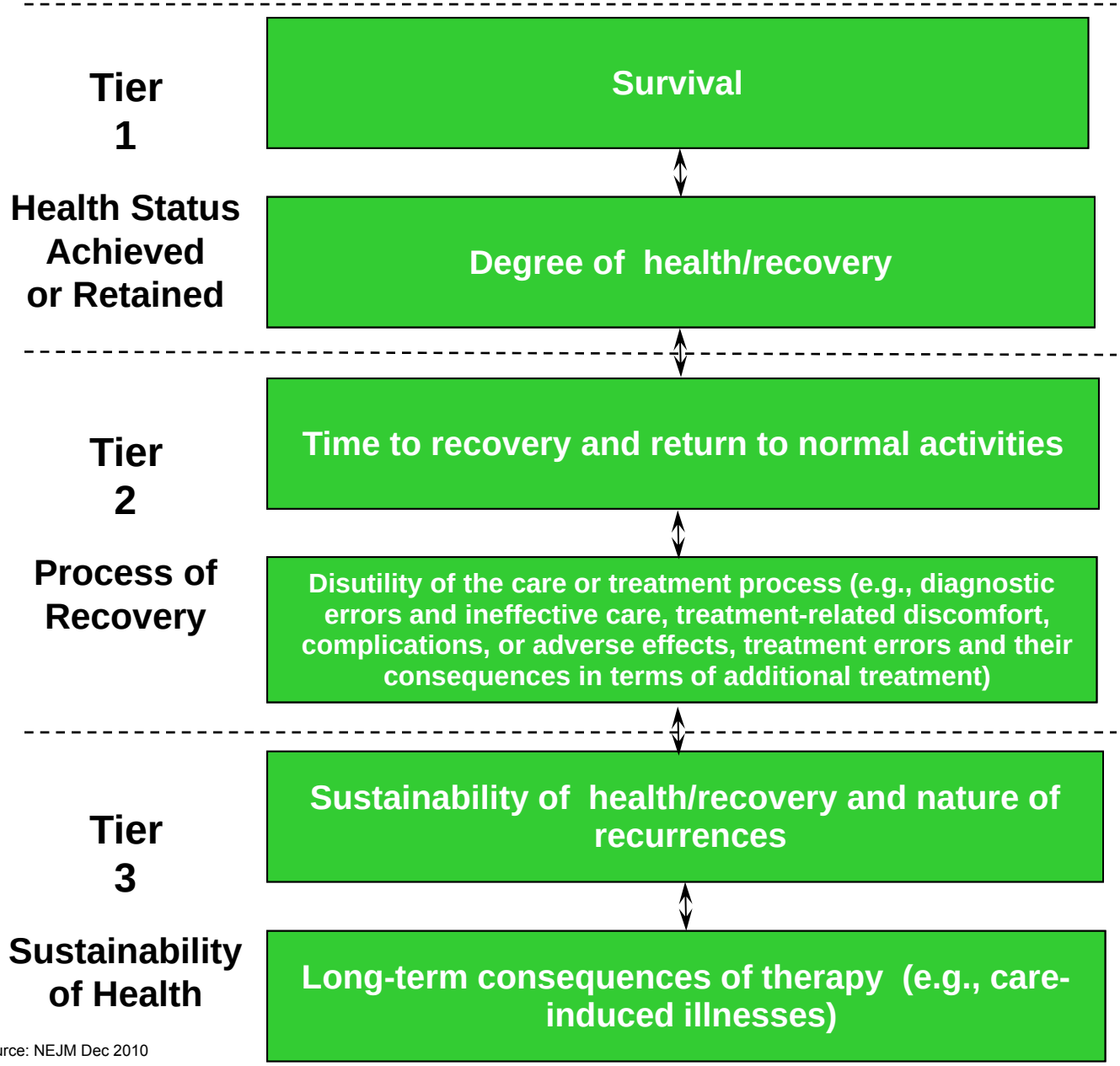
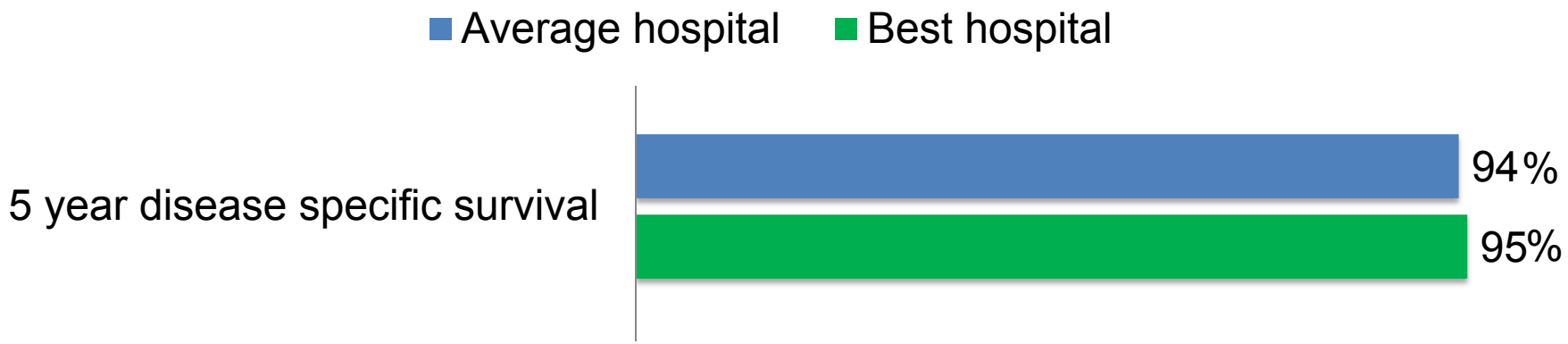


Source: NEJM Dec 2010

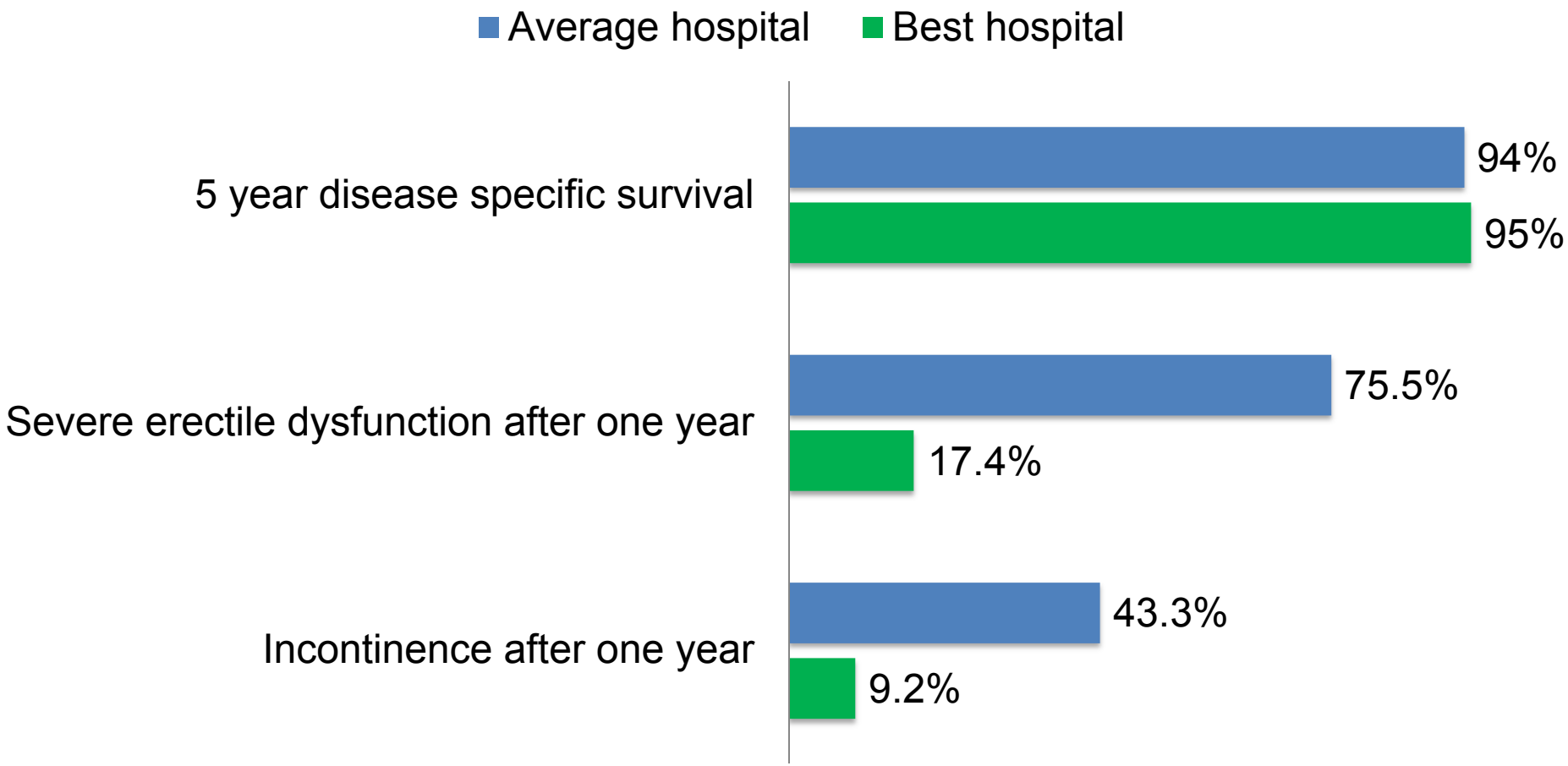
Measuring Multiple Outcomes
Prostate Cancer Care in Germany



Source: ICHOM

Measuring Multiple Outcomes -- Continued

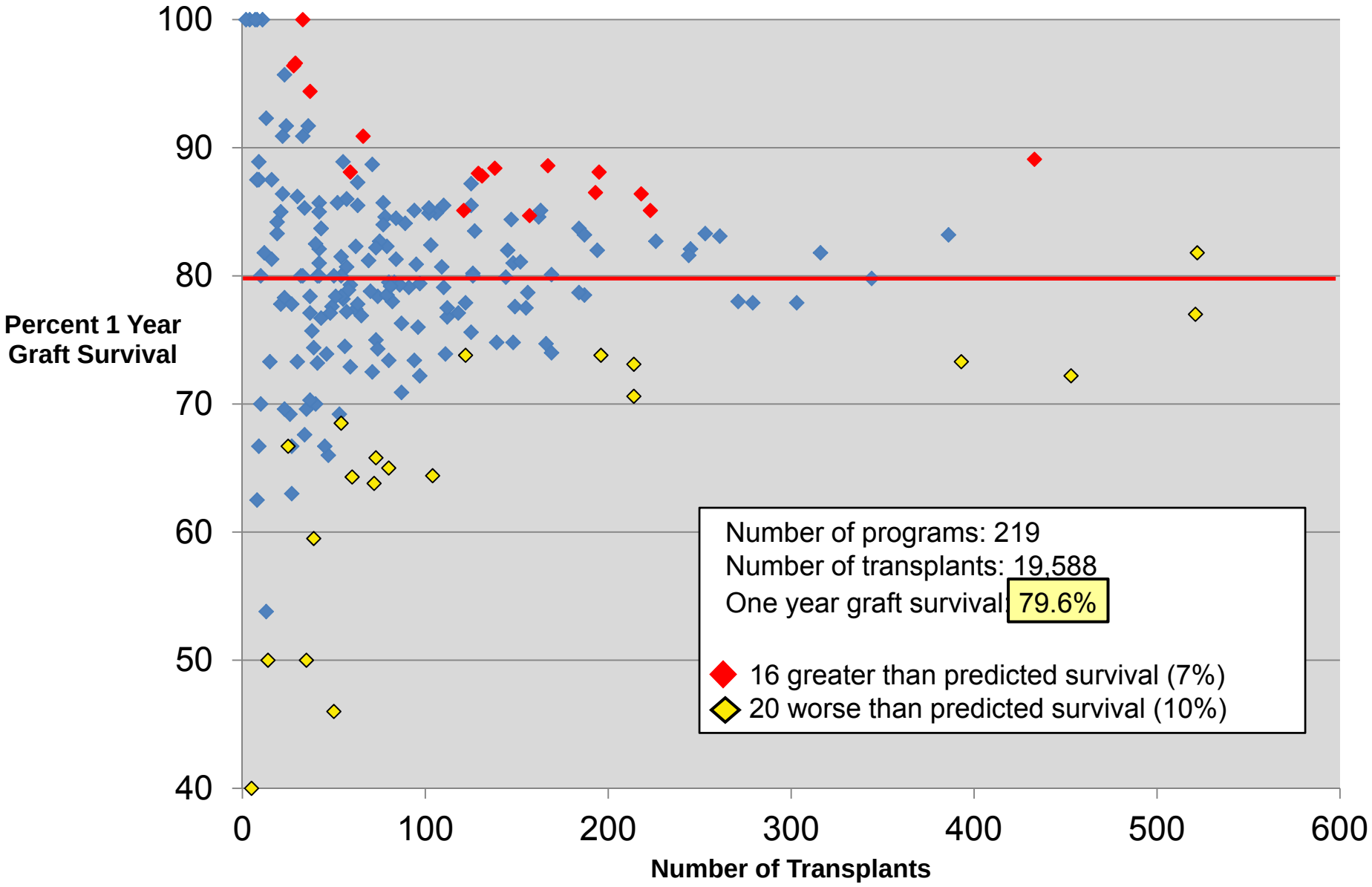
Prostate Cancer Care in Germany



Source: ICHOM

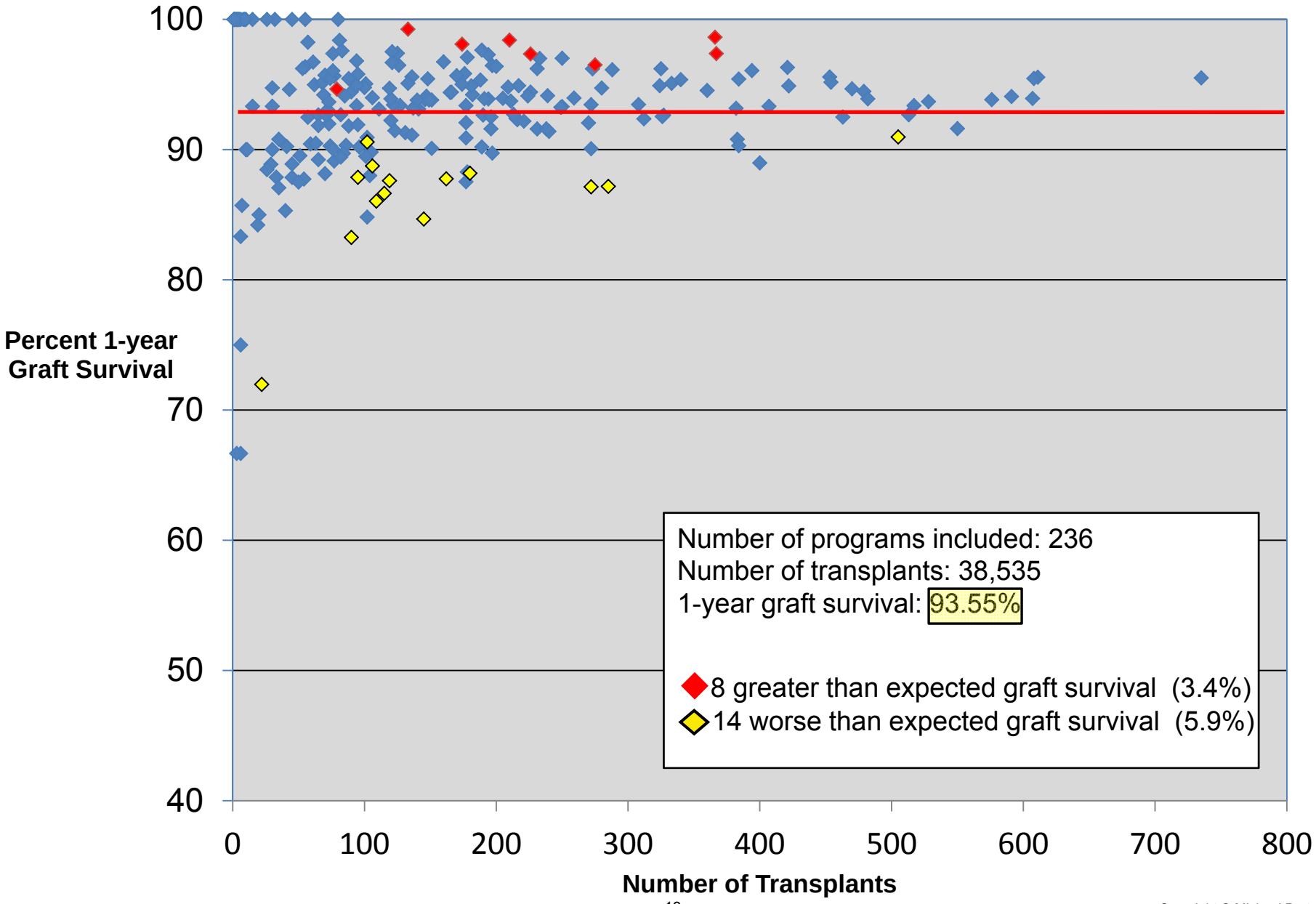
Adult Kidney Transplant Outcomes

U.S. Centers, 1987-1989



Adult Kidney Transplant Outcomes

U.S. Center Results, 2008-2010



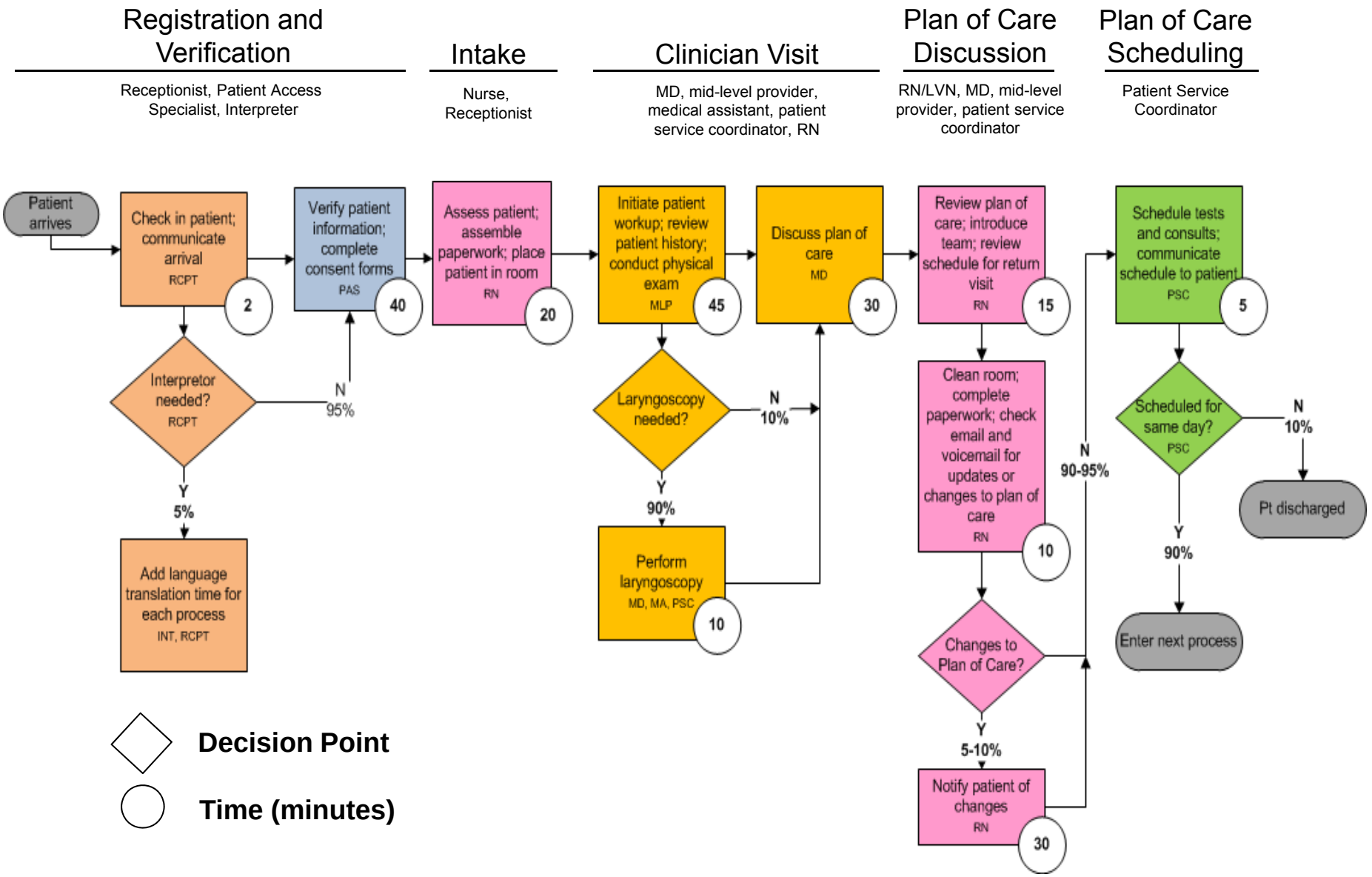
Measuring the Cost of Care Delivery: Principles

- Cost is the **actual expense** of patient care, not the **charges** billed or collected
- Cost should be measured around the **patient**, not just the department
- Cost should be aggregated over the **full cycle of care for the patient's medical condition**
- 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

Source: Kaplan, Robert and Michael E. Porter, "The Big Idea: How to Solve the Cost Crisis in Health Care", *Harvard Business Review*, September 1. 2011

Mapping Resource Utilization

MD Anderson Cancer Center – New Patient Visit

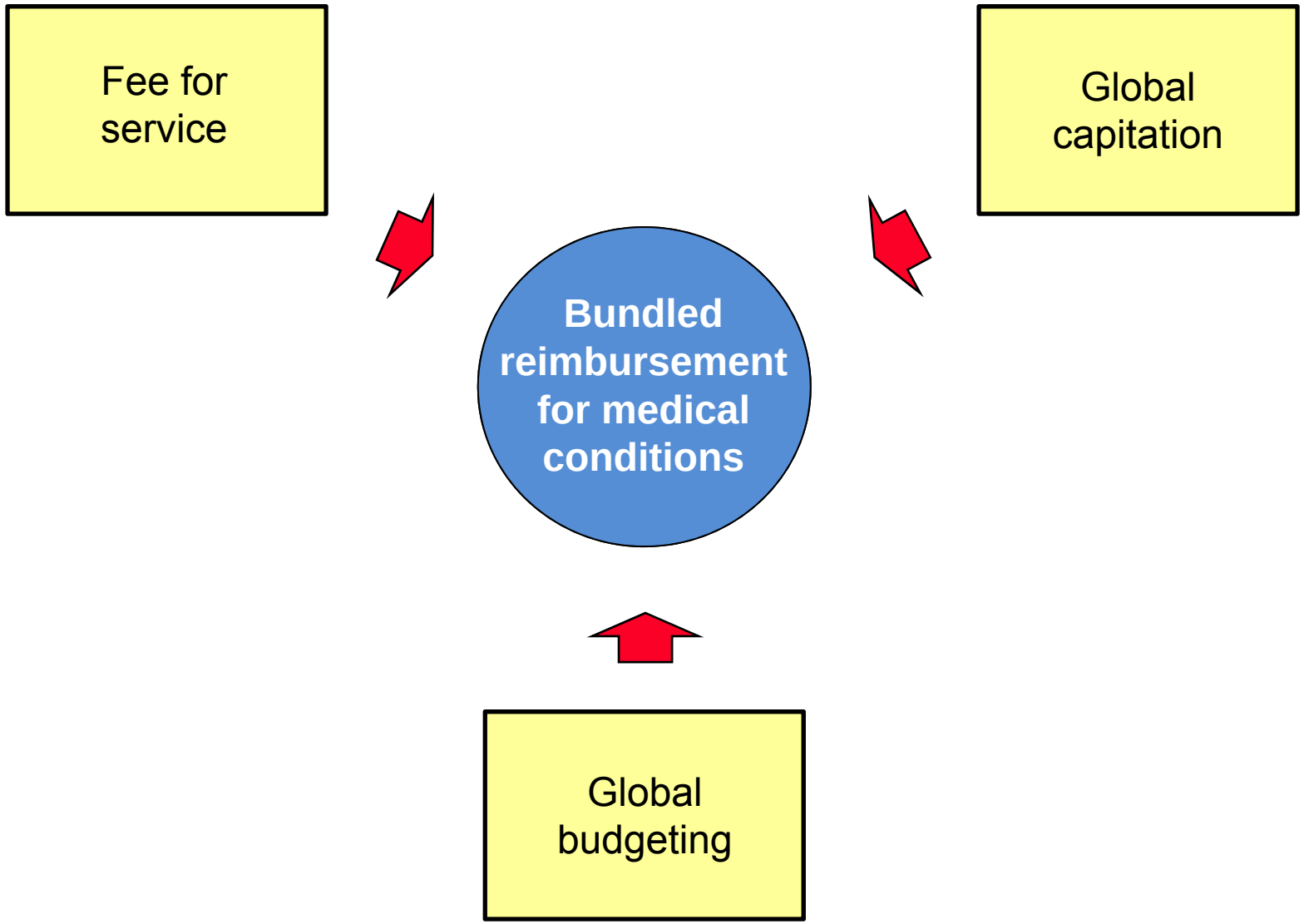


Major Cost Reduction Opportunities in Health Care

- Reduce **process variation** that lowers efficiency and raises inventory without improving outcomes
- Eliminate **low-** or **non-value added** services or tests
  - Sometimes driven by protocols or to justify billing
- Rationalize redundant **administrative** and **scheduling** units
- **Improve utilization** of expensive physicians, staff, clinical space, inventory, and equipment by reducing duplication and service fragmentation
- Minimize use of **physician and skilled staff** time for less skilled activities
- Reduce the provision of routine or uncomplicated services in **highly-resourced** facilities
- **Reduce cycle times** across the care cycle
- **Optimize total care cycle cost** versus minimizing cost of individual service
- Increase **cost awareness** in clinical teams

- Many cost reduction opportunities will actually **improve outcomes**

3. Reimburse through Bundled Prices for Care Cycles



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

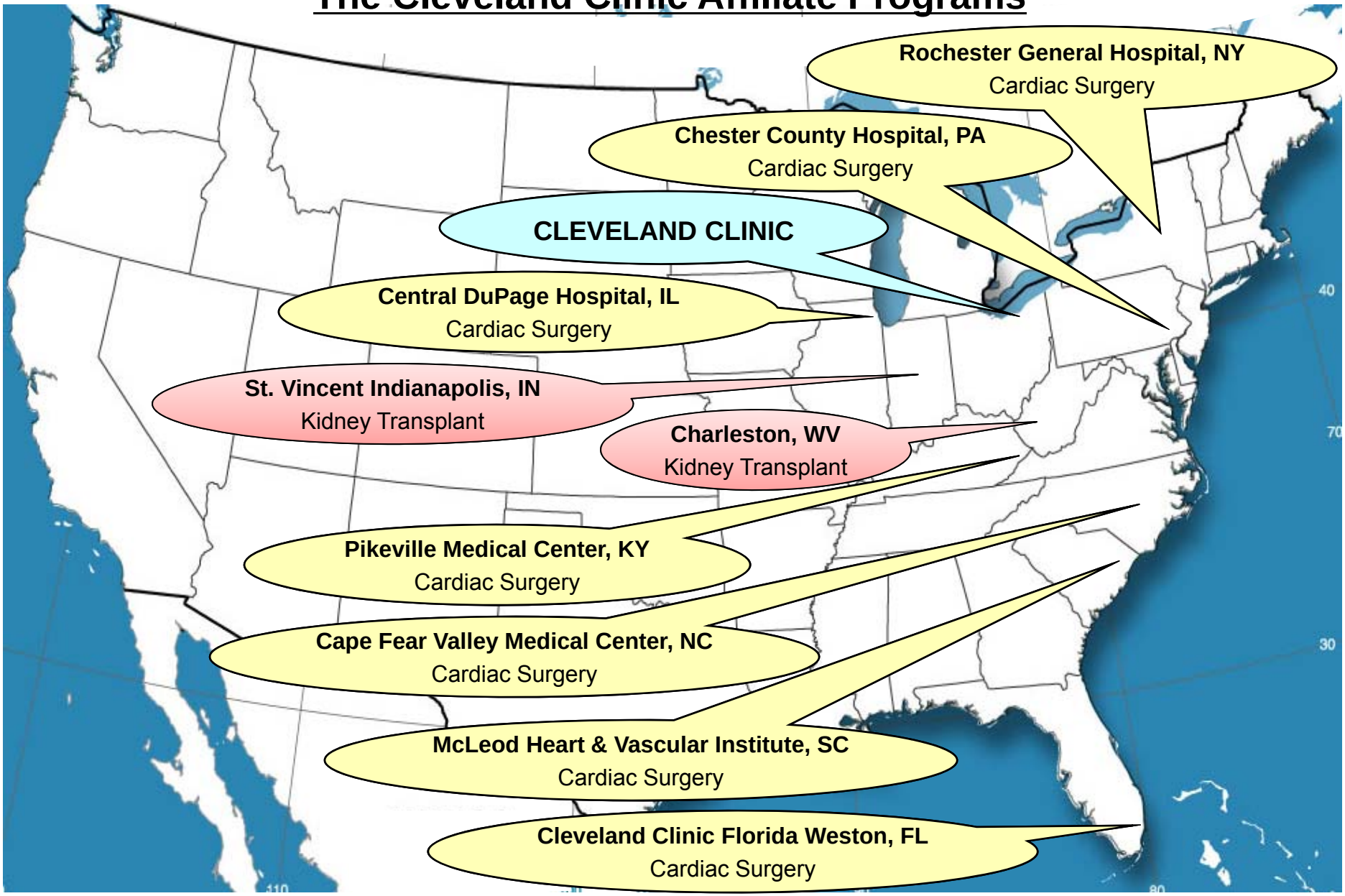
- The Stockholm bundled price for a knee or hip replacement is about **US $8,000**

4. Integrate Care Delivery Systems
Four Levels of Provider System Integration

1. **Define overall scope of services** where the provider can achieve high value
2. **Concentrate volume in fewer locations** in the conditions that providers treat
3. Choose the **right location** for each service based on medical condition, acuity level, resource intensity, cost level and need for convenience
   - E.g., shift routine surgeries out of tertiary hospitals to smaller, more specialized facilities
4. Integrate care **across locations**

5. Expand Geographic Reach

The Cleveland Clinic Affiliate Programs

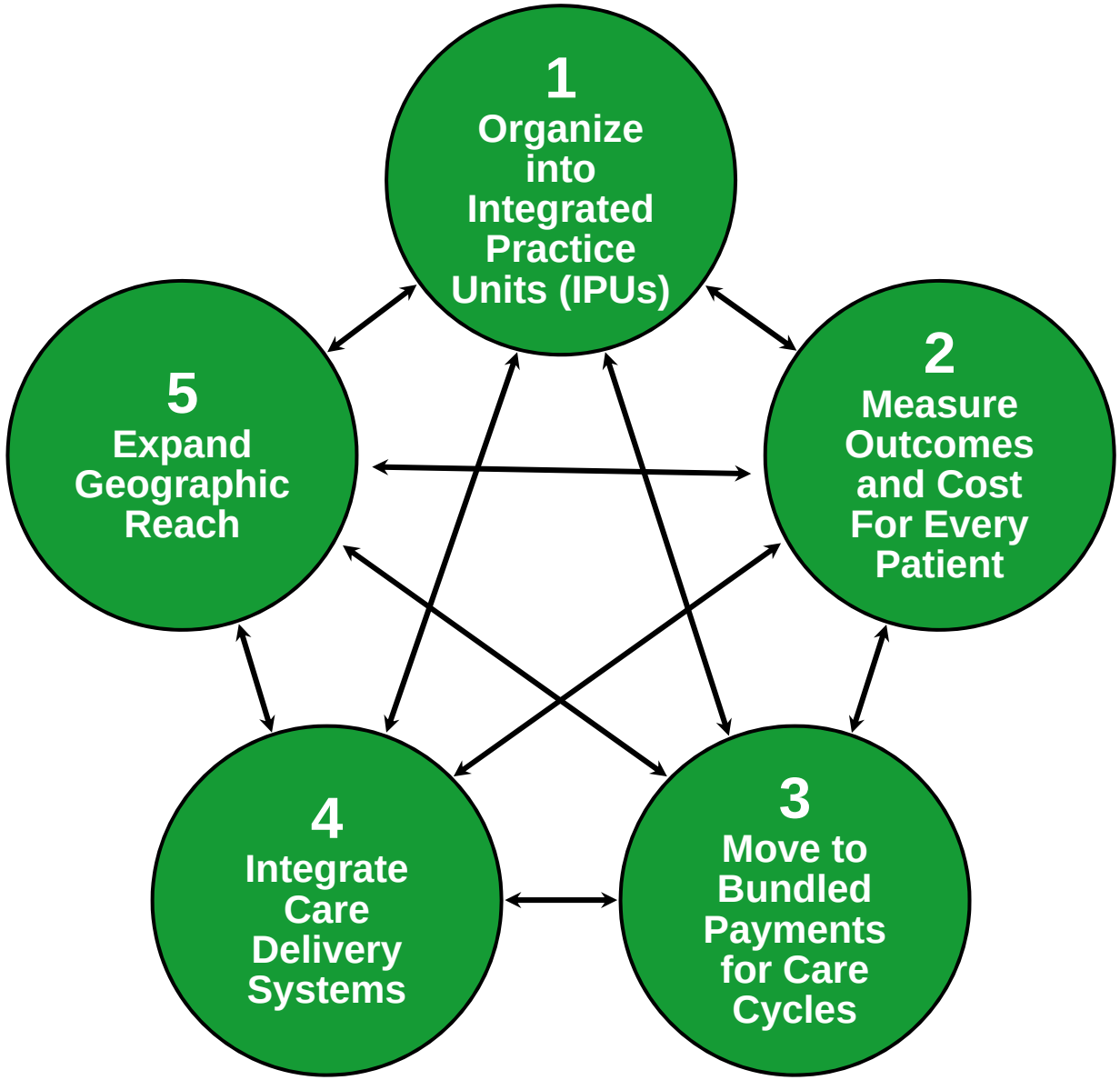


6. Build an Enabling Information Technology Platform

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



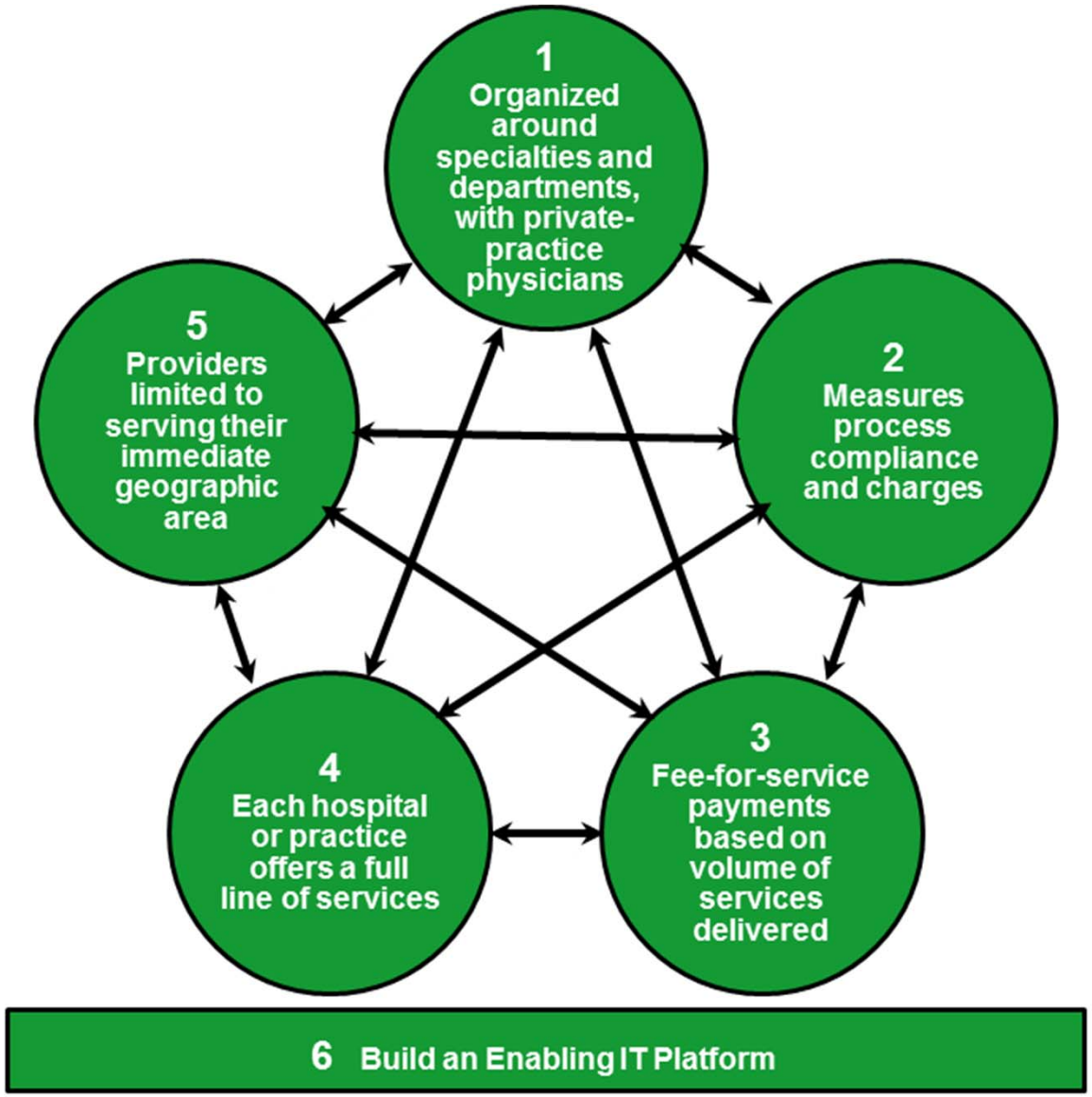
Why Is This So Hard?
(And What Do We Do About It?)

“Magic Bullets” Have Had Limited Impact

- Examples:
  - Evidence-based medicine/clinical effectiveness research/guidelines
  - Eliminating fraud
  - Eliminating errors
  - Adding layers (care coordination, prior authorization)
  - Turning patients into consumers
  - Electronic health records
  - New low cost models of primary care
  - Capitation

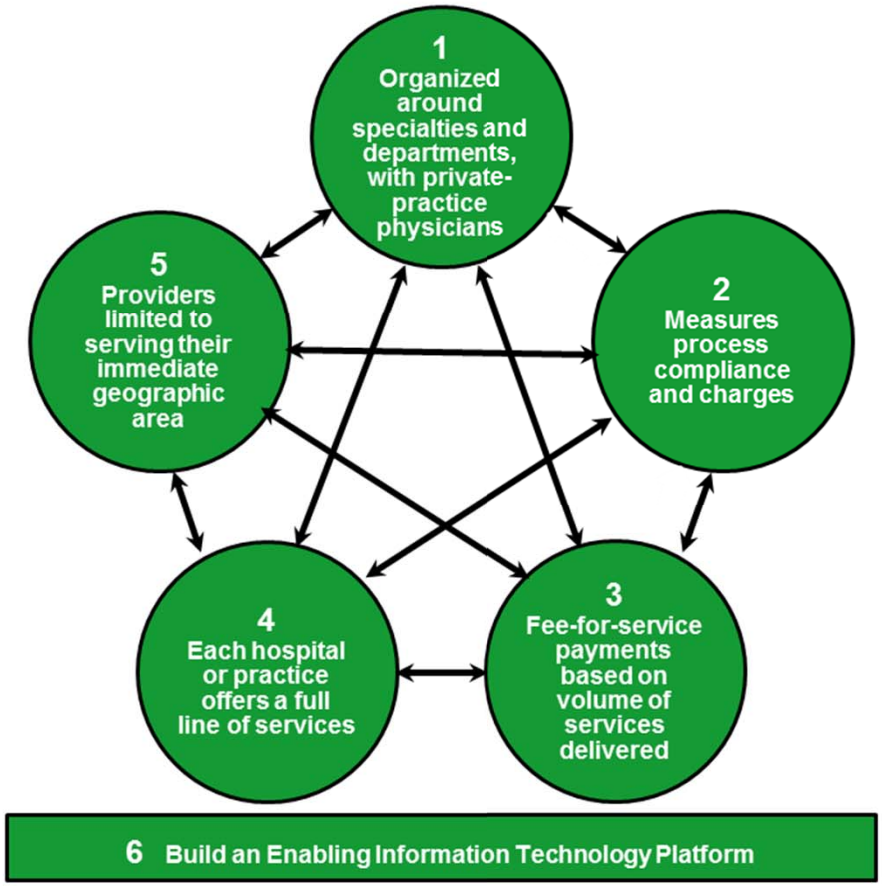
Why We Are Stuck

Legacy System

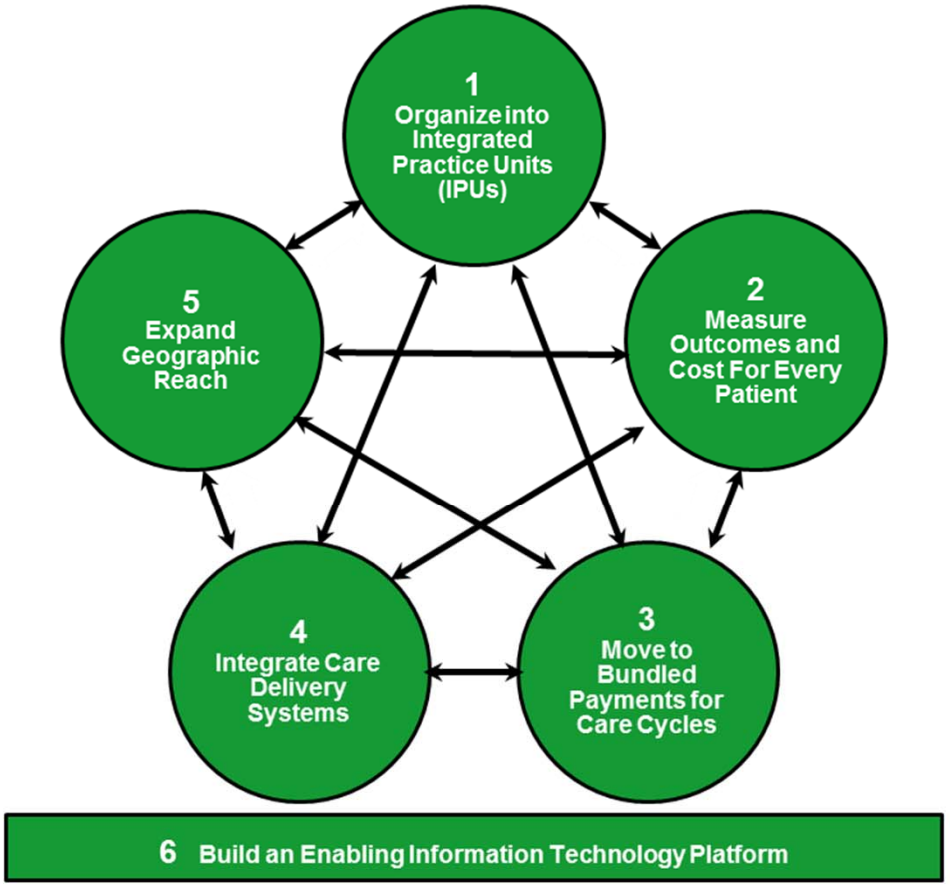


Getting Unstuck

Legacy System



A Mutually Reinforcing Strategic Agenda



This Won't Be Easy …

Common Reactions

- "How can we create real teams if our physicians are not our employees?"
  - "… or even if they are employees, but are paid by RVU?"
- "We can't ask anyone to stop doing anything as long as we all have our own bottom lines."

… But We Have to Get Going

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  - "… or even if they are employees, but are paid by RVU?"
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First Steps

- Measure what matters to patients – benchmark and report
- Use narrative (patient stories) to create organizational shared purpose
- Create financial and nonfinancial incentives for improvement of value