Value Based Health Care Delivery
The Strategic Agenda

Prof. Michael E. Porter
Harvard Business School

Strategy for Health Care Delivery
Leadership Workshop
January 11, 2009

Value-Based Health Care Delivery
Executive Education Course

- The Leadership Workshop on Strategy for Health Care Delivery is an intensive, two day workshop on the principles of **value-based health care delivery**, examining organizations working to **implement** those principles in practice.

Participants

71 Leaders from Health Care Organizations Worldwide

- 37 Hospital/Provider Organization CEO's and Senior Executives
- 10 Chief Medical/Clinical Officers
- 2 Chief Nursing Officers
- 7 Health Plan CEO's and Senior Executives
- 4 Educators
- 9 Government Officials
- 2 Health Care Philanthropists/ Board Members

Countries

- United States (48)
- Canada (13)
- Finland (4)
- Sweden (3)
- Germany (2)
- Taiwan (1)

Faculty

- **Michael E. Porter**, Harvard Business School, Course Head
- **Elizabeth Olmsted Teisberg**, University of Virginia, Darden Graduate School of Business Administration
- **Robert Huckman**, Harvard Business School
- **Sachin Jain**, Research Fellow, Institute for Strategy and Competitiveness
- **Scott Wallace,** Batten Fellow, University of Virginia, Darden Graduate School of Business

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 value**
  - Ownership of entities is secondary (e.g. non-profit vs. for profit vs. government)
- How to create 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 delivered with 19th century organization structures, management practices, and pricing models

  - Process improvements and safety initiatives are beneficial but **not sufficient**

Harnessing Competition on Value

- Competition is a powerful force to encourage **restructuring of care** and **continuous improvement in value**
  - Competition for patients
  - Competition for health plan subscribers
- Today's competition in health care **is not aligned with value**

Financial success of system participants	≠	Patient success

- Creating **competition to improve value** is a central challenge in health care reform

Zero-Sum Competition in U.S. Health Care

Bad Competition

- Competition to **shift costs** or **capture more revenue**
- Competition to **increase bargaining power** and secure discounts or price premiums
- Competition to **capture patients** and **restrict choice**
- Competition to **restrict services** in order to maximize revenue per visit or reduce costs

Zero or Negative Sum

Good Competition

- Competition to **increase value for patients**

Positive Sum

Principles of Value-Based Health Care Delivery

1. Set the goal as **value for patients**
   - Not volume
   - Not access
   - Not equity
   - Not cost reduction
   - Not "profit" in the current scheme

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

- Outcomes are the **full set of health outcomes** achieved by the patient
- Costs are the **total costs**, including costs not necessarily borne within the health care system

Principles of Value-Based Health Care Delivery

1. Set the goal as **value for patients**
2. The best way to **contain cost** is to **improve quality**, where quality is health **outcomes**

- Prevention of disease	- Fewer complications
- Early detection	- Fewer mistakes and repeats in treatment
- Right diagnosis	
- Early and timely treatment	- Faster recovery
- Right treatment to the right patients	- More complete recovery
	- Less disability
- Treatment earlier in the causal chain of disease	- Fewer relapses or acute episodes
- Rapid care delivery process with fewer delays	- Slower disease progression
	- Less need for long term care
- Less invasive treatment methods	- Less care induced illness

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

Principles of Value-Based Health Care Delivery

1. Set the goal as **value for patients**
2. The best way to **contain cost** is to **improve quality**, where quality is health **outcomes**
3. To maximize value health care delivery must be organized around **medical conditions** over the **full cycle of care**

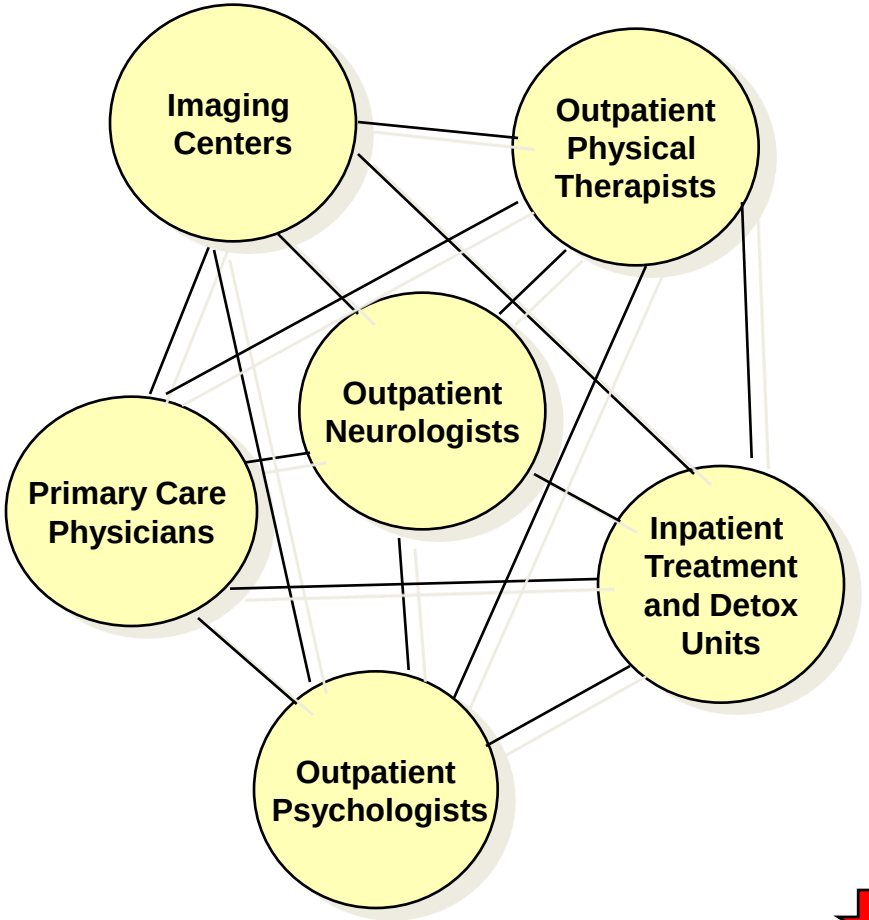
- A medical condition is **an interrelated set of patient medical circumstances best addressed in an integrated way**
  - Defined from the **patient's** perspective
  - **Includes** the most common co-occurring conditions
  - Involving **multiple** specialties and services

- The medical condition is the **unit of value creation** in health care delivery

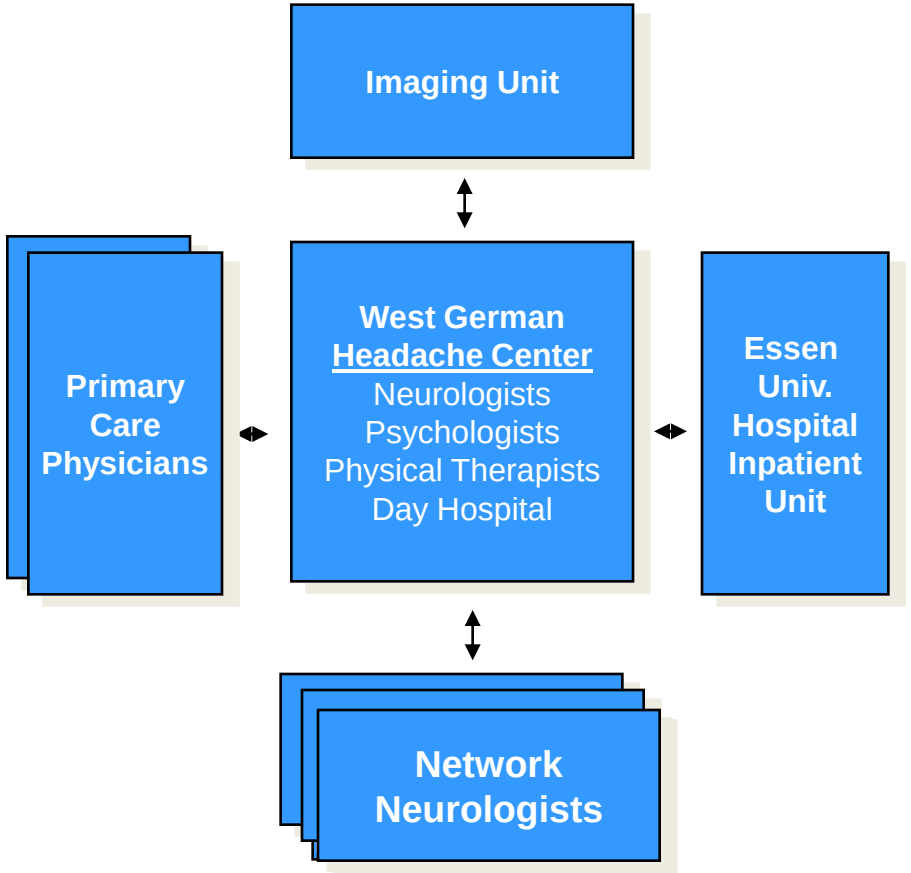
Restructuring Care Delivery

Migraine Care in Germany

Existing Model: Organize by Specialty and Discrete Services



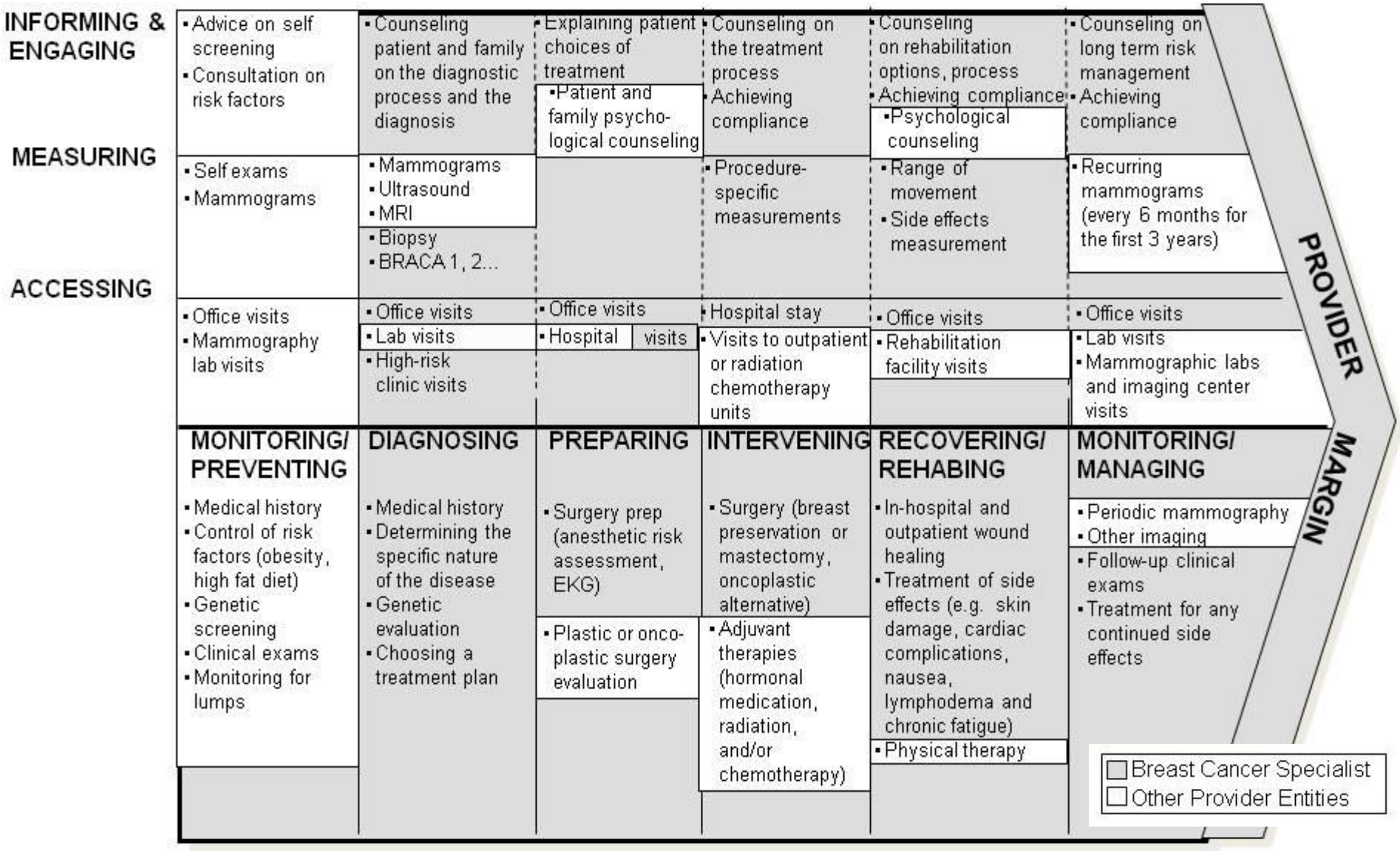
New Model: Organize into Integrated Practice Units (IPUs)



- The health plan was crucial to this transformation

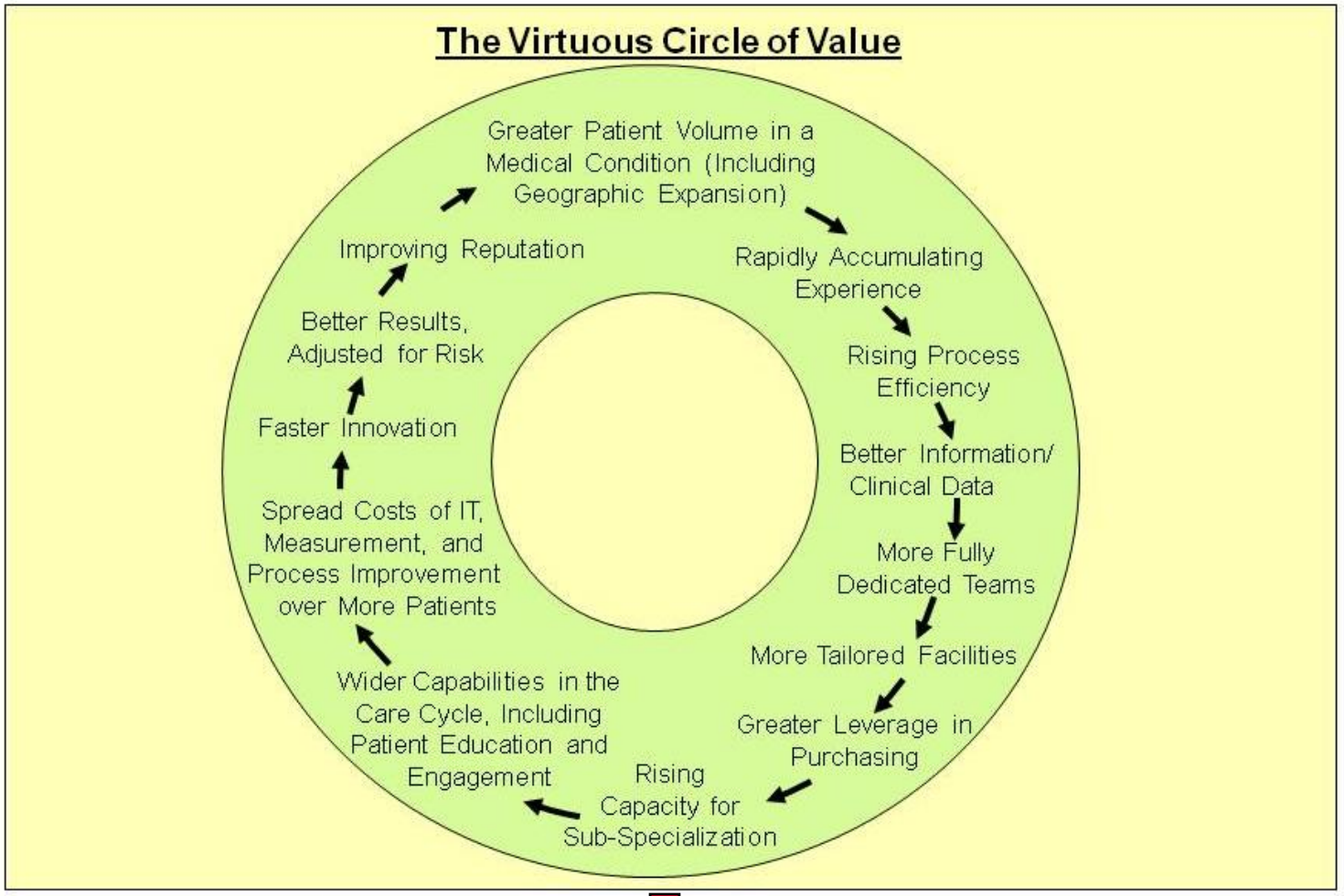
Source: Porter, Michael E., Clemens Guth, and Elisa Dannemiller, *The West German Headache Center: Integrated Migraine Care*, Harvard Business School Case 9-707-559, September 13, 2007

The Cycle of Care
Breast Cancer



Principles of Value-Based Health Care Delivery

4. Value is enhanced by increasing provider **experience**, **scale**, and **learning** at the **medical condition level**



- The virtuous cycle **extends across geography** when care for a medical condition is integrated across locations

Fragmentation of Hospital Services
Sweden

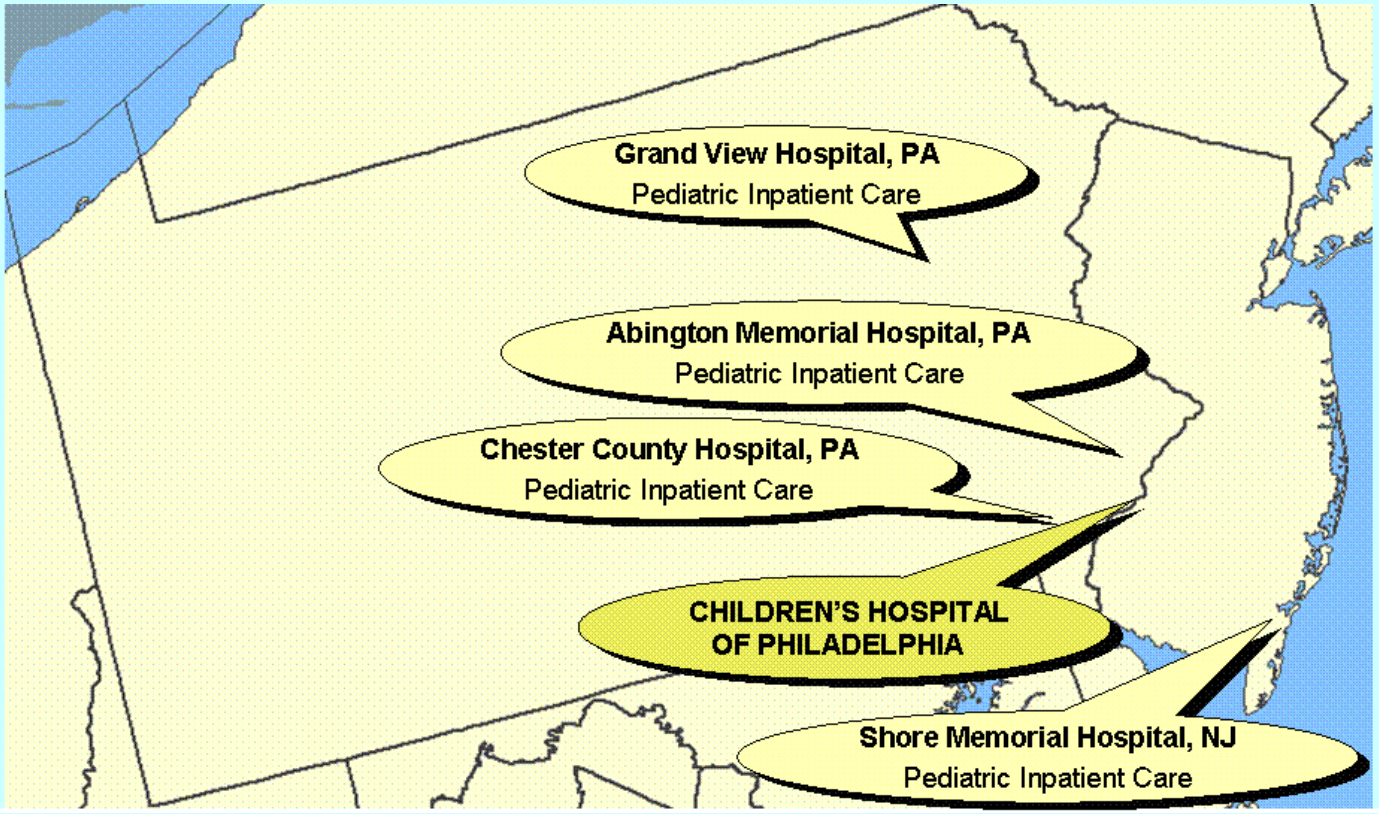
Procedure	Number of hospitals performing the treatment (of 116)	Average number of procedures per provider per year	Average number of procedures per provider per month
Heart transplants	3	13	1.1
Cardiac valve procedures with cardiac catheter	5	11	0.9
Coronary bypass with cardiac catheter	6	56	4.7
Cleft lip and palate repair	8	67	5.6
Splenectomy, Age >7	39	4	0.3
Total Mastectomy (without complications)	66	45	3.8
Iguinal & femoral hernia procedures, Age >17 (without complications)	67	47	3.9

Source: Compiled from The National Board of Health and Welfare Statistical Databases – DRG Statistics, Accessed September 27, 2007.

Principles of Value-Based Health Care Delivery

5. Integrate health care delivery **across facilities** and **across regions**, rather than duplicate services in stand-alone units

Children's Hospital of Philadelphia (CHOP) Affiliations



- Excellent providers can manage care delivery **across multiple geographies**

Principles of Value-Based Health Care Delivery

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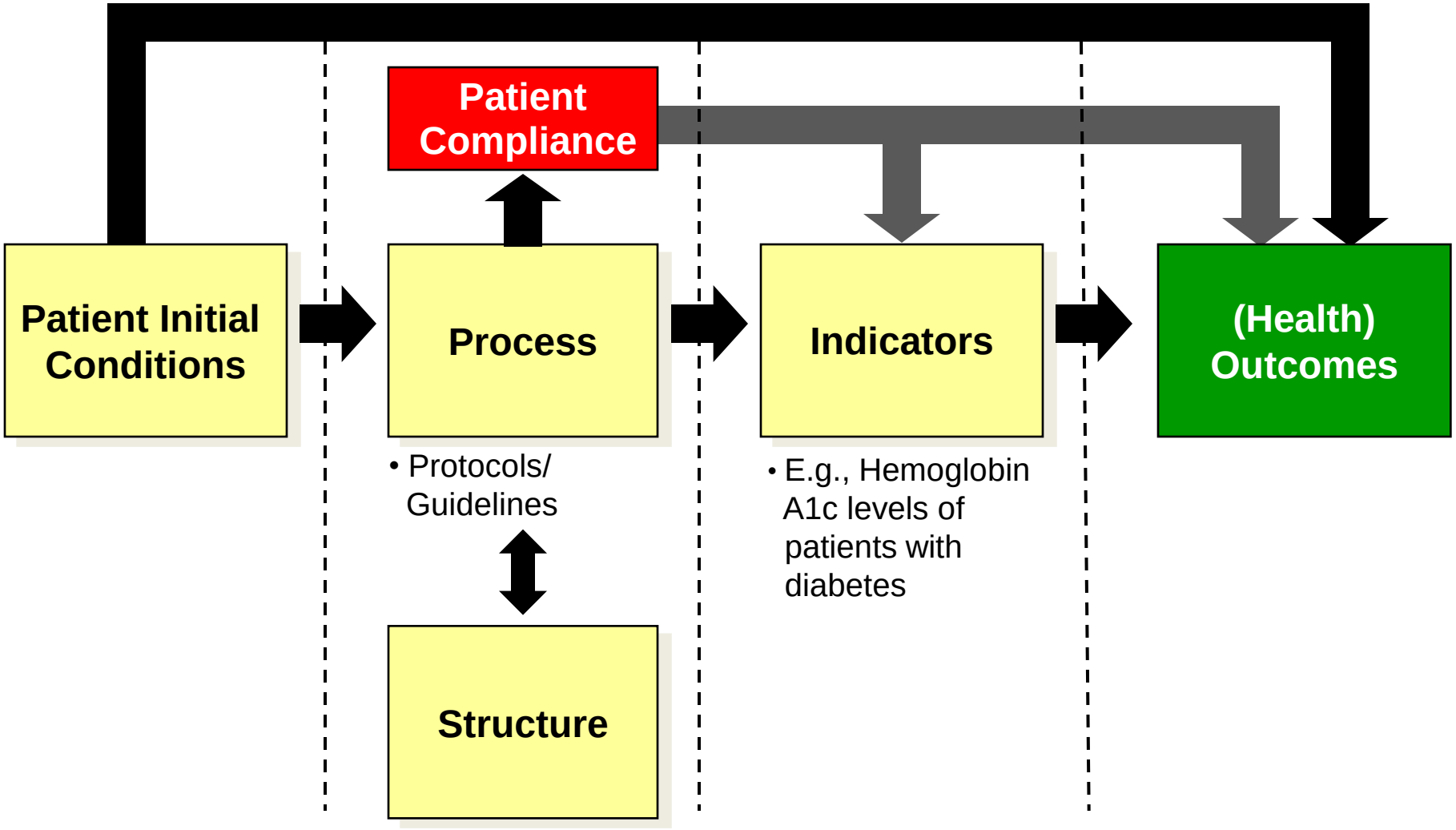
2. The best way to **contain cost** is to **improve quality**, where quality is health **outcomes**
3. To maximize value, health care delivery must be organized around **medical conditions** over the **full cycle of care**
4. Drive value improvement by increasing provider **experience**, **scale**, and **learning** at the **medical condition level**
5. Value requires integrating health care delivery **across facilities** and **across regions**, rather than duplicating services in stand-alone units
6. Value must be **measured** and ultimately **reported** by every provider for each medical condition
   - Results should be measured at **the level at which value is created**

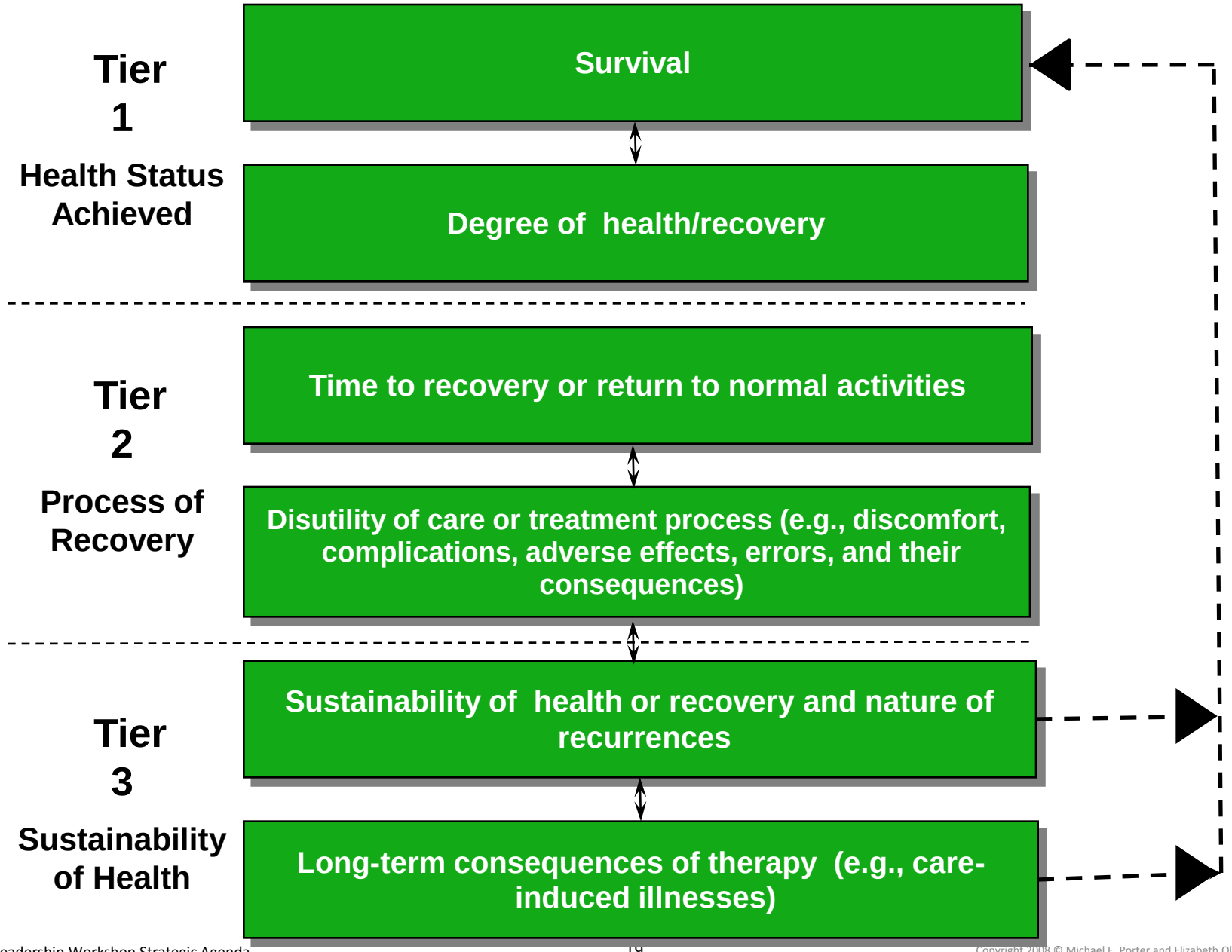
- **For** medical conditions over the cycle of care
  - Not for interventions or short episodes
  - Not for practices, departments, clinics, or hospitals
  - Not separately for types of service (e.g. inpatient, outpatient, tests, rehabilitation)

Measuring Value in Health Care



- Value is co-produced by clinicians and the patient

The Outcome Measures Hierarchy



Principles of Value-Based Health Care Delivery

1. Set the goal as **value for patients**, not containing costs
2. The best way to **contain cost** is to **improve quality**, where quality is health **outcomes**
3. Reorganize health care delivery around **medical conditions** over the **full cycle of care**
4. Drive value improvement by **increasing** provider **experience**, **scale**, and **learning** at the **medical condition level**
5. Value requires integrating health care delivery **across facilities** and **across regions**, rather than duplicating services in stand-alone units
6. Value must be **measured** and ultimately **reported** by every provider for each medical condition
7. Reimbursement must be aligned with **value** and reward **innovation**

- Bundled reimbursement for **care cycles**, not payment for discrete treatments or services
  - Most DRG systems are **too narrow**
  - Adjusted for **patient complexity**
- Reimbursement for **overall management of chronic conditions**
- Reimbursement for **prevention** and **screening**, not just treatment

- **Providers** and **health plans** must be proactive in driving new reimbursement models, not wait for sgovernment

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8. Information technology can enable **restructuring of care delivery** and **measuring results**, but is not a solution by itself

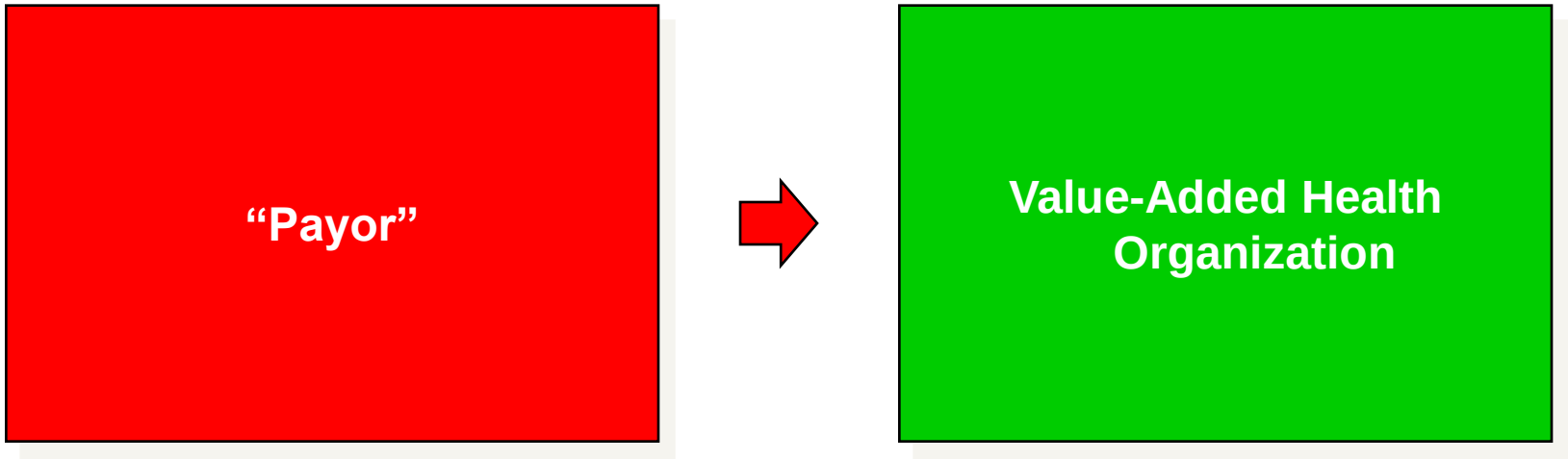
- Common data definitions
- Precise interoperability standards
- Patient-centered data warehouse
- Include all types of data (e.g. notes, images)
- Cover the full care cycle, including referring entities
- Accessible to all involved parties
- Templates for medical conditions

Value-Based Health Care Delivery:
The Strategic Agenda

1. **Integrated Practice Units**
   - **Partnerships** with other organizations involved in the care cycle, including primary care
2. **Outcomes and Cost Measurement**
3. **New Reimbursement Models**
4. **Provider System Integration**
   - Specialization of services **within** units
   - Integration of care **across** units
5. **Growth Models**
   - Enhancing value through expanding **across geography**

- How can **health plans**, **employers**, and **government** best encourage and enable these changes?

Value-Based Healthcare Delivery: Implications for Health Plans



Value-Based Health Care Delivery: Implications for Employers

- Set the goal of **employee health**
- Assist employees in **healthy living** and **active participation in their own care**
- Provide for convenient and high value **prevention, screening,** and **disease management** services
  - On site clinics
- Set **new expectations for health plans**
  - Plans should contract for **integrated care**, not discrete services
  - Plans should assist subscribers in **accessing excellent providers** for their medical condition
  - Plans should contract for care **cycles rather** than discrete services
  - Plans should **measure** and **improve** member health results, and expect providers to do the same
- Provide for **health plan continuity** for employees, rather than plan churning
- Find ways to **expand insurance coverage** and advocate **reform of the insurance system**

- Measure and hold employee benefit staff accountable for the company's **health value received**

Value-Based Healthcare Delivery: Implications for Consumers

- Participate actively in **managing personal health**
- **Comply** with treatment and preventative practices
- Expect **relevant information** and **seek advice**
- Make choices of treatments and providers based on **outcomes** and **value**, not convenience or amenities
- Work with a health plan on **long-term health management**
  - Shifting plans frequently is not in the consumer's interest

- But "consumer-driven health care" is the **wrong metaphor** for reforming the system

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**
- Create mandatory IT standards including **data architecture and definitions**, **interoperability standards**, and **deadlines for system implementation**
- Remove obstacles to the **restructuring of health care delivery** around the integrated care of medical conditions
- **Open up competition** among providers and across geography
- Shift reimbursement systems to **bundled prices for cycles of care** instead of payments for discrete treatments or services
- Encourage greater **responsibility of individuals** for their health and their health care

Schedule

Sunday, January 11	Monday, January 12	Tuesday, January 13
		Session 4: Participant Breakout Groups and Plenary Session (8:30 - 11:45am) *All Program Faculty*
	Session 2: (9:00 - 10:30am) Case: The Joslin Diabetes Center *Faculty: Elizabeth Teisberg*	
	Break (10:30 - 10:45am)	
	Case Protagonist and Topic Lecture (10:45am - 12:30pm) Guest: Ranch Kimball, CEO, Joslin Diabetes Center	Lunch (11:45am - 12:45pm)
	Group Photo (12:30 - 12:45pm)	
	Lunch (12:45 - 1:30pm)	**Session 5:** (12:45 - 2:15pm) Case: The U. of Texas MD Anderson Cancer Center: Interdisciplinary Cancer Care *Faculty: Elizabeth Teisberg*
	Session 3: (1:30 - 3:00pm) Case: Cleveland Clinic: Growth Strategy 2008 *Faculty: Michael Porter*	Break (2:15 - 2:30pm)
	Break (3:00 - 3:15pm)	**Protagonist Video Topic Lecture** (2:30 - 3:15pm) MD Anderson video
	Case Protagonist and Topic Lecture (3:15 - 5:00pm) Guest: Toby Cosgrove, CEO, Cleveland Clinic	**Q&A and Wrap Up** (3:15 - 4:00pm)
Introduction (4:30 - 5:00pm) *Faculty: Michael Porter*		
Session 1: (5:00 - 6:15pm) Case: ThedaCare: System Strategy *Faculty: Michael Porter*		
Case Protagonist (6:15 - 6:45pm) Guest: John Toussaint, former CEO, ThedaCare	**Reception and Dinner** Williams Room, Spangler Hall (6:15pm)	
Buffet Dinner Kresge Hall (7:00pm)		

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Workshop Goals