

Creating a Value-Based Health Care Organization: The Strategic Agenda

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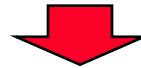
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This presentation draws on Redefining Health Care: Creating Value-Based Competition on Results (with Elizabeth O. Teisberg), Harvard Business School Press, May 2006; “A Strategy for Health Care Reform—Toward a Value-Based System,” *New England Journal 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

- 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

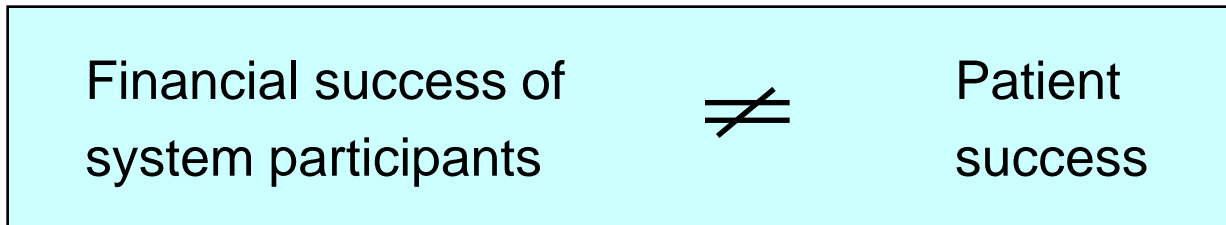
- Significant improvement in value will require **fundamental restructuring of health care delivery**, not incremental improvements

Today, 21st century medical technology is often delivered with 19th century organization structures, management practices, and pricing models

- Process improvements, lean production concepts, safety initiatives, care pathways, disease management and other **overlays** to the current structure are beneficial, but not sufficient
- Consumers **cannot fix the dysfunctional structure** of the current system

Creating Competition on Value

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



- Creating positive-sum **competition on value** is a central challenge in health care reform in every country

Principles of Value-Based Health Care Delivery

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

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

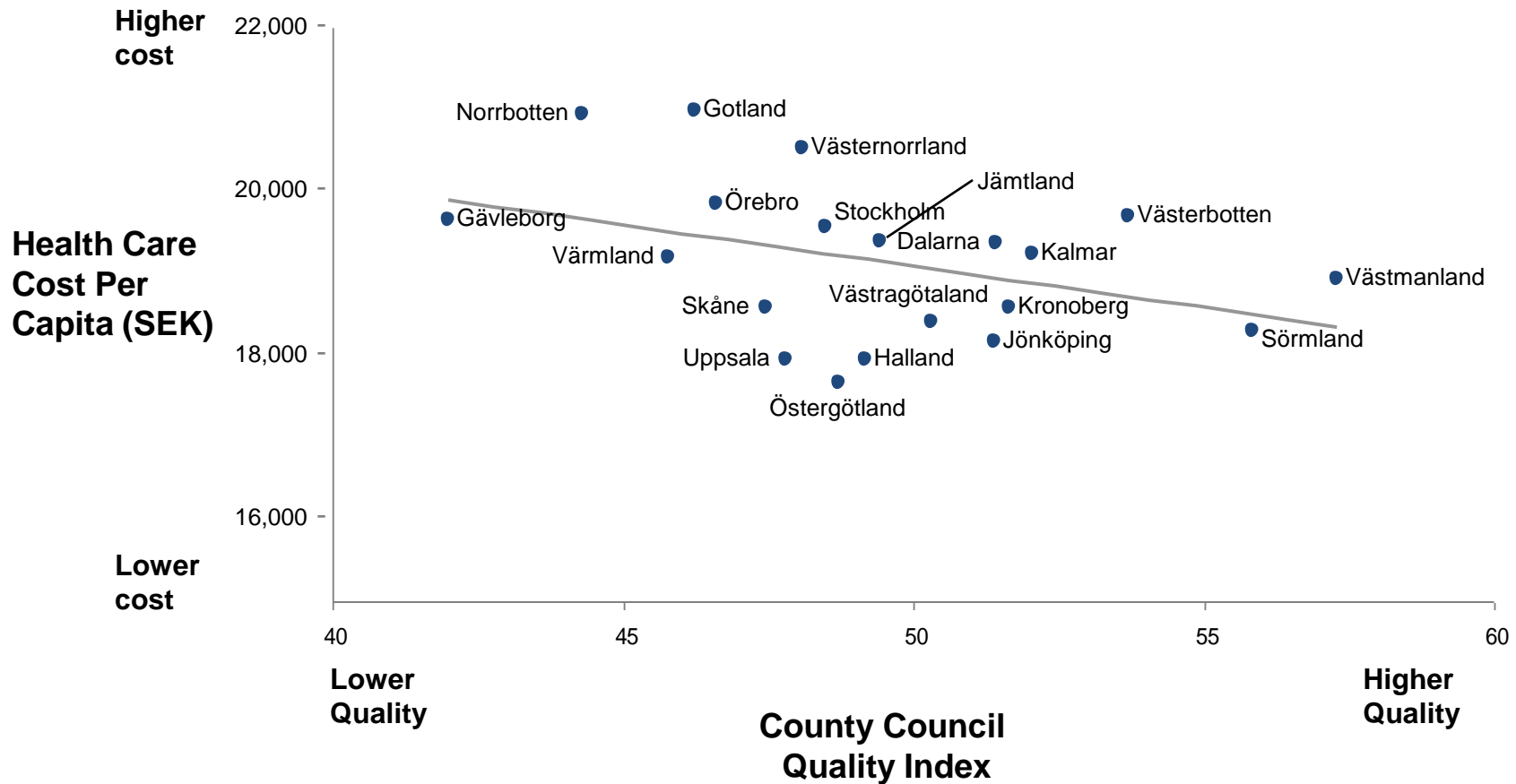
- Prevention of illness and recurrences
- Early detection
- Right diagnosis
- Right treatment to the right patient
- Early and timely treatment
- Treatment earlier in the causal chain of disease
- Rapid cycle time of diagnosis and treatment
- Less invasive treatment methods
- Fewer complications
- Fewer mistakes and repeats in treatment
- Faster recovery
- More complete recovery
- Less disability
- Fewer relapses or acute episodes
- Slower disease progression
- 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

Cost versus Quality, Sweden

Health Care Spending by County, 2008



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: Öppna jämförelser, Socialstyrelsen 2008; Sjukvårdsdata i fokus 2008; BCG analysis

Creating a Value-Based Health Care Delivery Organization

The Strategic Agenda

1. Organize into Integrated Practice Units Around Patient Medical Conditions (IPUs)
 - Including primary and preventive care for **distinct patient populations**
2. Measure Outcomes and Cost for Every Patient
3. Move to Bundled Prices for Care Cycles
4. Create an Integrated Health System
5. Grow and Affiliate to Drive Excellence
6. Develop an Enabling Information Technology Platform

1. Organize into Integrated Practice Units Around Patient Medical Conditions (IPUs)

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

Examples of Medical Conditions:

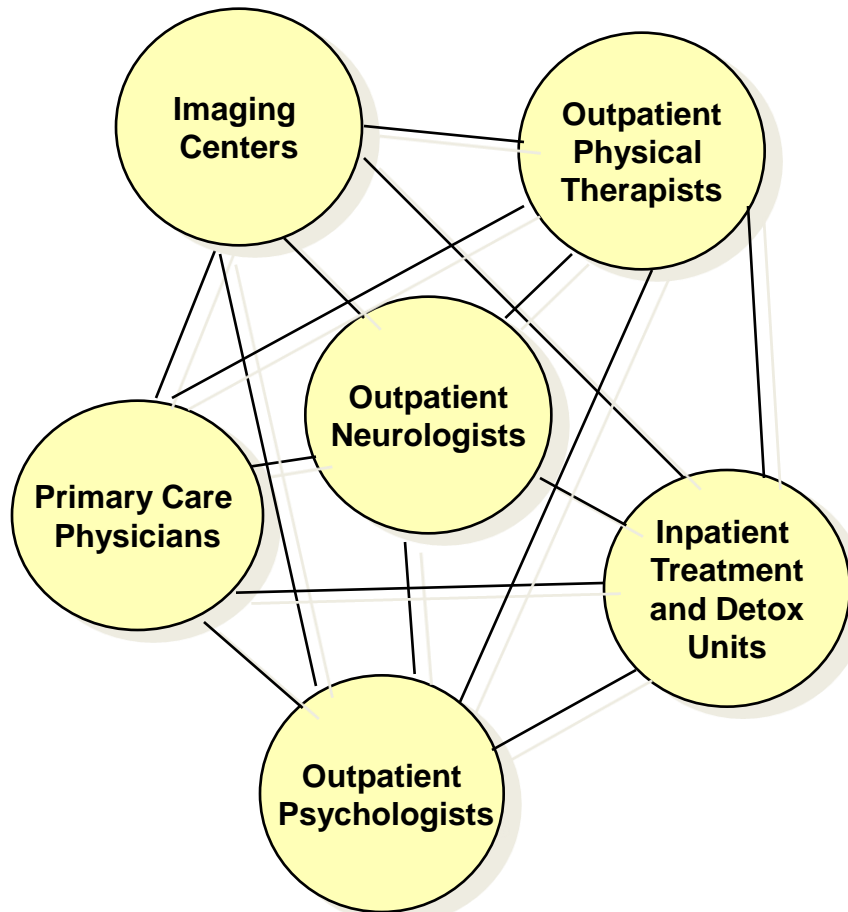
- Diabetes
- Asthma
- Multiple Sclerosis
- Breast Cancer

Organizing Around Patient Medical Conditions

Migraine Care in Germany

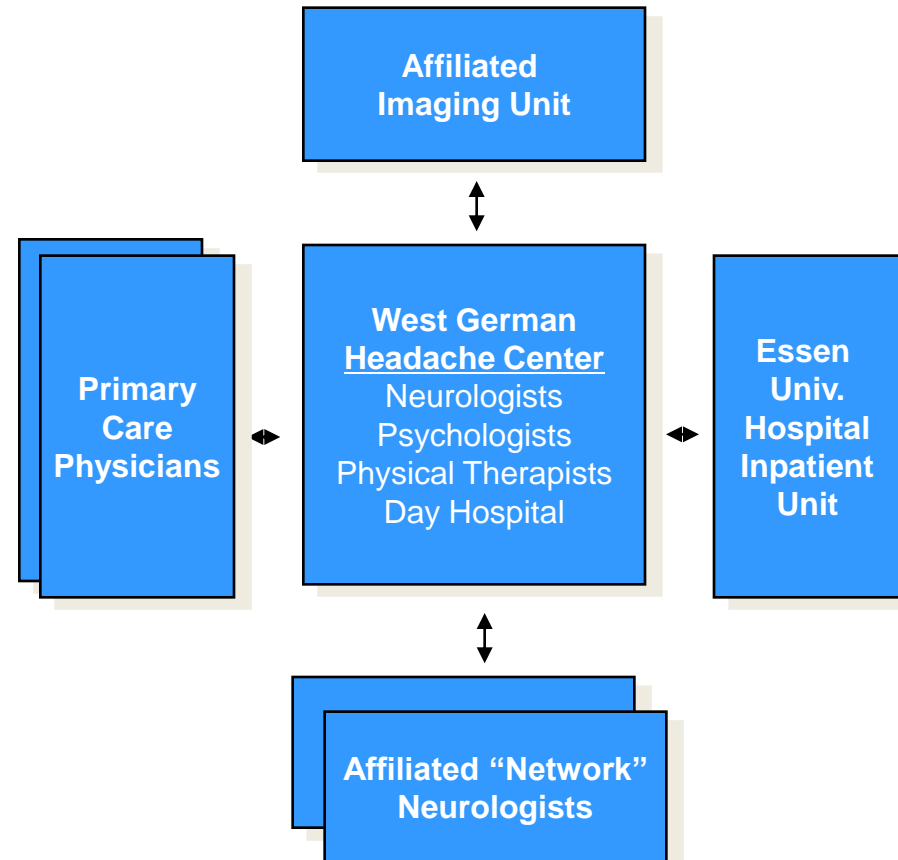
Existing Model:

Organize by Specialty and Discrete Services



New Model:

Organize into Integrated Practice Units (IPUs)



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

Integration Across the Care Cycle

Breast Cancer Care Delivery Value Chain

INFORMING AND ENGAGING	▪Advice on self screening ▪Consultations on risk factors	▪Counseling patient and family on the diagnostic process and the diagnosis	▪Explaining patient treatment options/shared decision making	▪Counseling on the treatment process ▪Education on managing side effects and avoiding complications of treatment ▪Achieving compliance	▪Counseling on rehabilitation options, process ▪Achieving compliance	▪Counseling on long term risk management ▪Achieving Compliance
			▪Patient and family psychological counseling		▪Psychological counseling	
MEASURING	▪Self exams ▪Mammograms	▪Mammograms ▪Ultrasound ▪MRI ▪Labs (CBC, Blood chems, etc.) ▪Biopsy ▪BRACA 1, 2... ▪CT ▪Bone Scans	▪Labs	▪Procedure-specific measurements	▪Range of movement ▪Side effects measurement	▪MRI, CT ▪Recurring mammograms (every six months for the first 3 years)
ACCESSING	▪Office visits ▪Mammography lab visits	▪Office visits	▪Office visits	▪Hospital stays	▪Office visits	▪Office visits
		▪Lab visits	▪Hospital visits ▪Lab visits	▪Visits to outpatient radiation or chemotherapy units ▪Pharmacy	▪Rehabilitation facility visits ▪Pharmacy	▪Lab visits ▪Mammographic labs and imaging center visits
		▪High risk clinic visits				
MONITORING/ PREVENTING		DIAGNOSING	PREPARING	INTERVENING	RECOVERING/ REHABING	MONITORING/ MANAGING
▪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)	▪Surgery (breast preservation or mastectomy, oncoplastic alternative)	▪In-hospital and outpatient wound healing ▪Treatment of side effects (e.g. skin damage, cardiac complications, nausea, lymphodema and chronic fatigue)	▪Periodic mammography ▪Other imaging
			▪Plastic or onco-plastic surgery evaluation ▪Neo-adjuvant chemotherapy	▪Adjuvant therapies (hormonal medication, radiation, and/or chemotherapy)	▪Physical therapy	▪Follow-up clinical exams ▪Treatment for any continued or later onset side effects or complications

☐ Breast Cancer Specialist
☐ Other Provider Entities

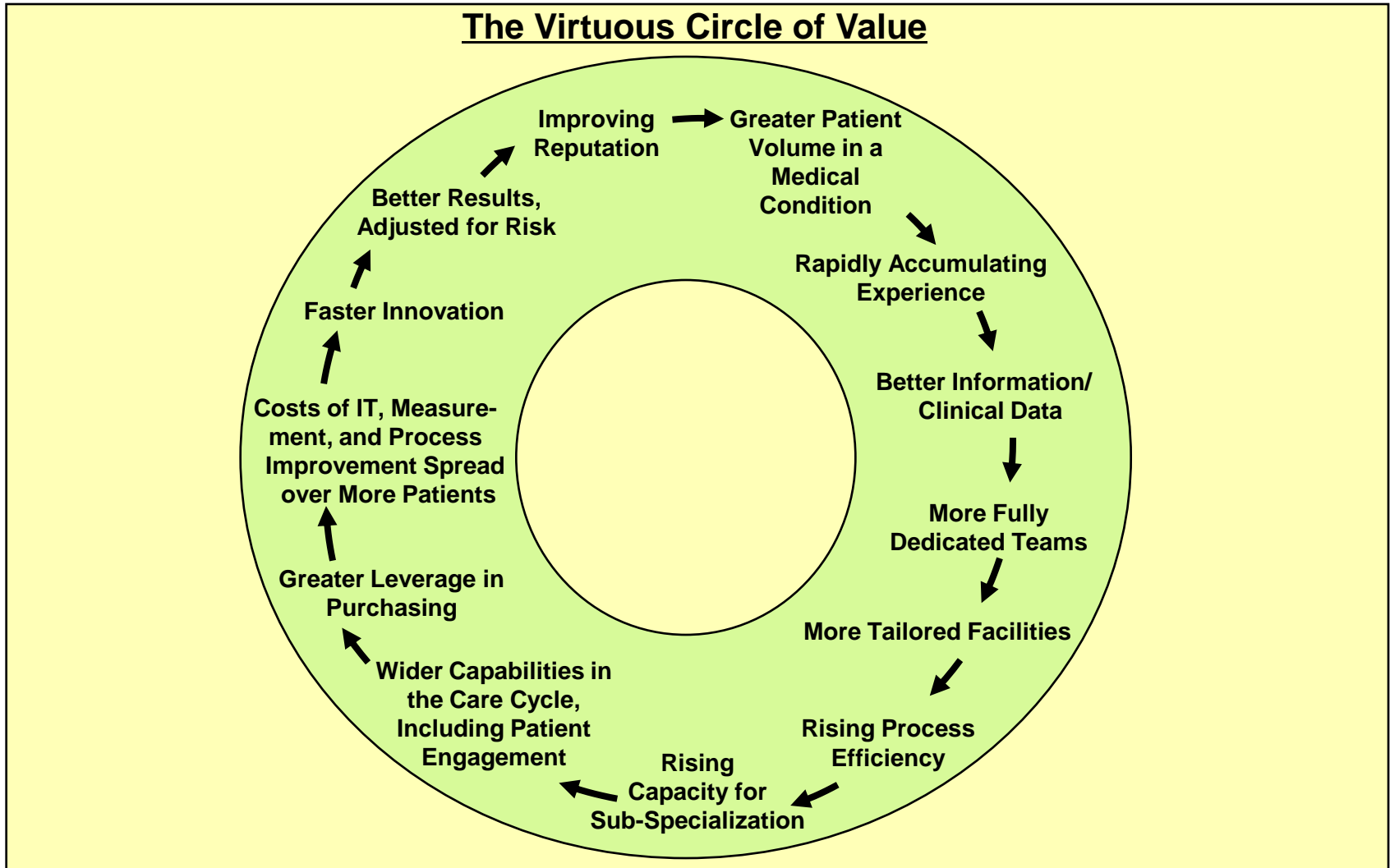
Integration Across the Care Cycle

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INFORMING AND ENGAGING	Advice on self screening Consultations on risk factors	Counseling patient and family on the diagnostic process and the diagnosis	Explaining patient treatment options/shared decision making Patient and family psychological counseling	Counseling on the treatment process Education on managing side effects and avoiding complications of treatment Achieving compliance	Counseling on rehabilitation options, process Achieving compliance Psychological counseling	Counseling on long term risk management Achieving Compliance
	Self exams Mammograms	<ul style="list-style-type: none"> Mammograms Ultrasounds MRI Labs (CBC, Blood chems, etc.) Biopsy BRACA 1, 2... CT Bone Scans 	Labs	Procedure-specific measurements	Range of movement Side effects measurement	MRI, CT Recurring mammograms (every six months for the first 3 years)
MEASURING	Office visits Mammography lab visits	Office visits	Office visits	Hospital stays	Office visits	Office visits
		Lab visits	Hospital visits Lab visits	Visits to outpatient radiation or chemotherapy units Pharmacy	Rehabilitation facility visits Pharmacy	Lab visits Mammographic labs and imaging center visits
ACCESSING		High risk clinic visits				
MONITORING/ PREVENTING	DIAGNOSING	PREPARING	INTERVENING	RECOVERING/ REHABING	MONITORING/MANAGING	
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)	Surgery (breast preservation or mastectomy, oncoplastic alternative)	In-hospital and outpatient wound healing Treatment of side effects (e.g. skin damage, cardiac complications, nausea, lymphodema and chronic fatigue)	Periodic mammography Other imaging	
		Plastic or onco-plastic surgery evaluation Neo-adjuvant chemotherapy	Adjuvant therapies (hormonal medication, radiation, and/or chemotherapy)	Physical therapy	Follow-up clinical exams Treatment for any continued or later onset side effects or complications	

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Volume in a Medical Condition Enables Value



- Volume and experience have an **even greater** impact on value in an IPU structure than in the current system

Fragmentation of Hospital Services

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.

What is Integrated Care?

Attributes of an Integrated Practice Unit (IPU):


1. Organized around the **patient's medical condition**
2. Provides the **full cycle of care** for the condition
 - Encompasses **inpatient, outpatient, and rehabilitative** care as well as **supporting services** (e.g. nutrition, social work, behavioral health)
 - Includes **patient education, engagement** and **follow-up**
3. Involves a **dedicated team** who devote a significant portion of their time to the condition
4. Where providers are part of a **common organizational unit**
5. **Co-located** in **dedicated facilities**
6. Utilizing a **single administrative** and **scheduling structure**
7. With a **physician team captain** and a **care manager** who oversee each patient's care process
8. Where the team **meets formally and informally** on a regular basis
9. And measures **processes** and **outcomes** as a **team**, not individually
10. And accepts **joint accountability** for outcomes and costs

What is Not Integrated Care?

Integrated care is **not the same as:**

- A clinical pathway
- Co-location per se
- Care delivered by the same organization
- A multispecialty group practice
- Freestanding focused factories
- An institute or center
- A Center of Excellence
- Medical homes
- Accountable care organizations
- A health plan/provider system (e.g. Kaiser Permanente)

Integrated Models of Primary Care

- Organized around **specific patient populations** (e.g. healthy adults, frail elderly, type II diabetics) rather than attempting to be all things to all patients
 - **Defined service bundles** covering appropriate prevention, screening, diagnosis, wellness and health maintenance
 - Services are provided by **multidisciplinary teams**, including ancillary health professionals and support staff in **dedicated facilities**
 - **Alliances with specialty IPUs** covering the prevalent medical conditions represented in the patient population
 - Delivered not only in traditional settings but at the **workplace**, **community organizations**, and in **other locations** that offer regular patient contact and the ability to develop a group culture of wellness
- 
- Today's primary care is **fragmented** and attempts to address **overly broad needs** with limited resources

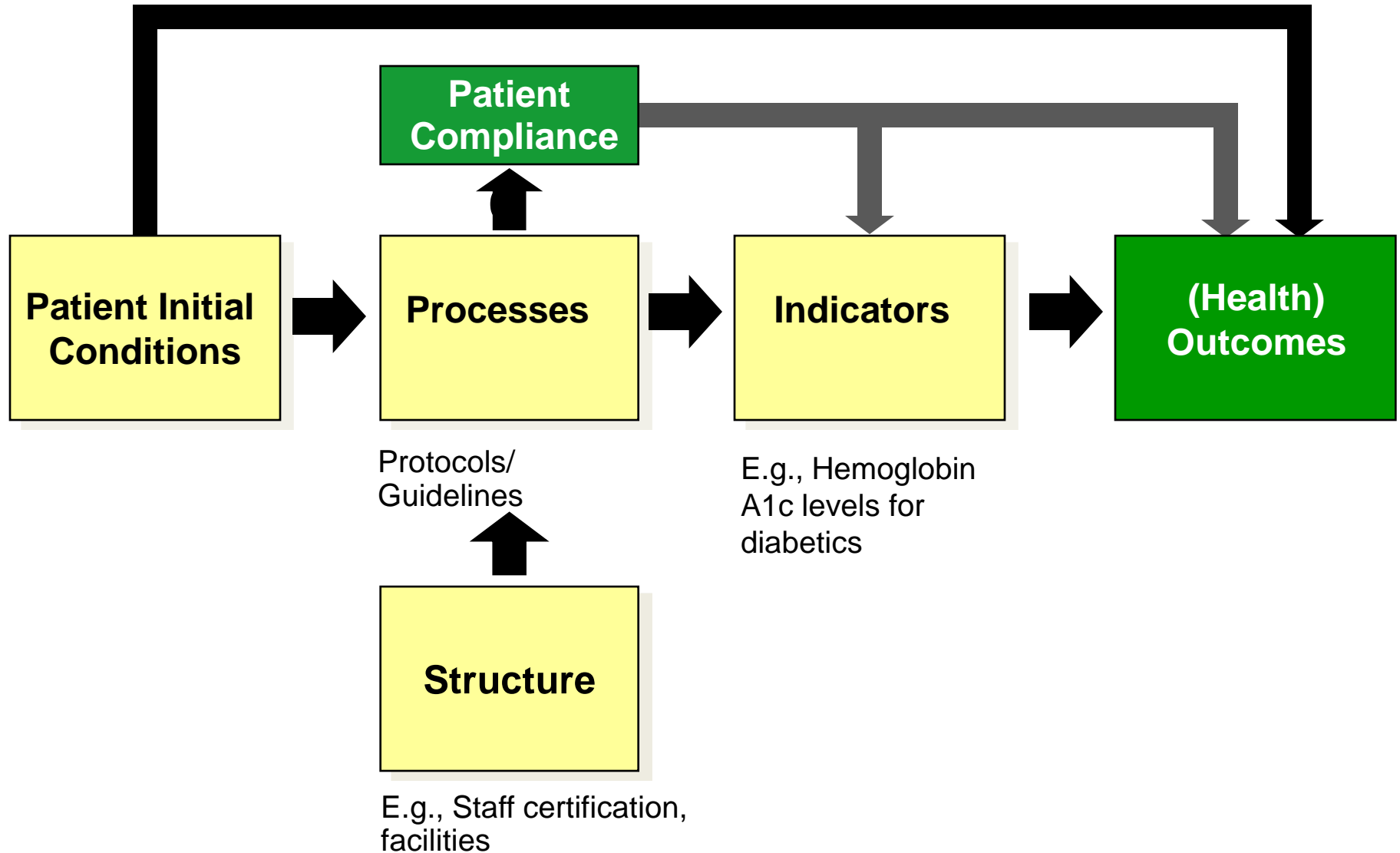
2. Measure Outcomes and Cost for Every Patient

- **For** medical conditions
- **Real time** and “**on-line**” in care delivery, not just retrospectively or in clinical studies
- **Not** for interventions or short episodes
- **Not** separately for types of service (e.g. inpatient, outpatient, tests, rehabilitation)
- **Not** for practices, departments, clinics, or entire hospitals

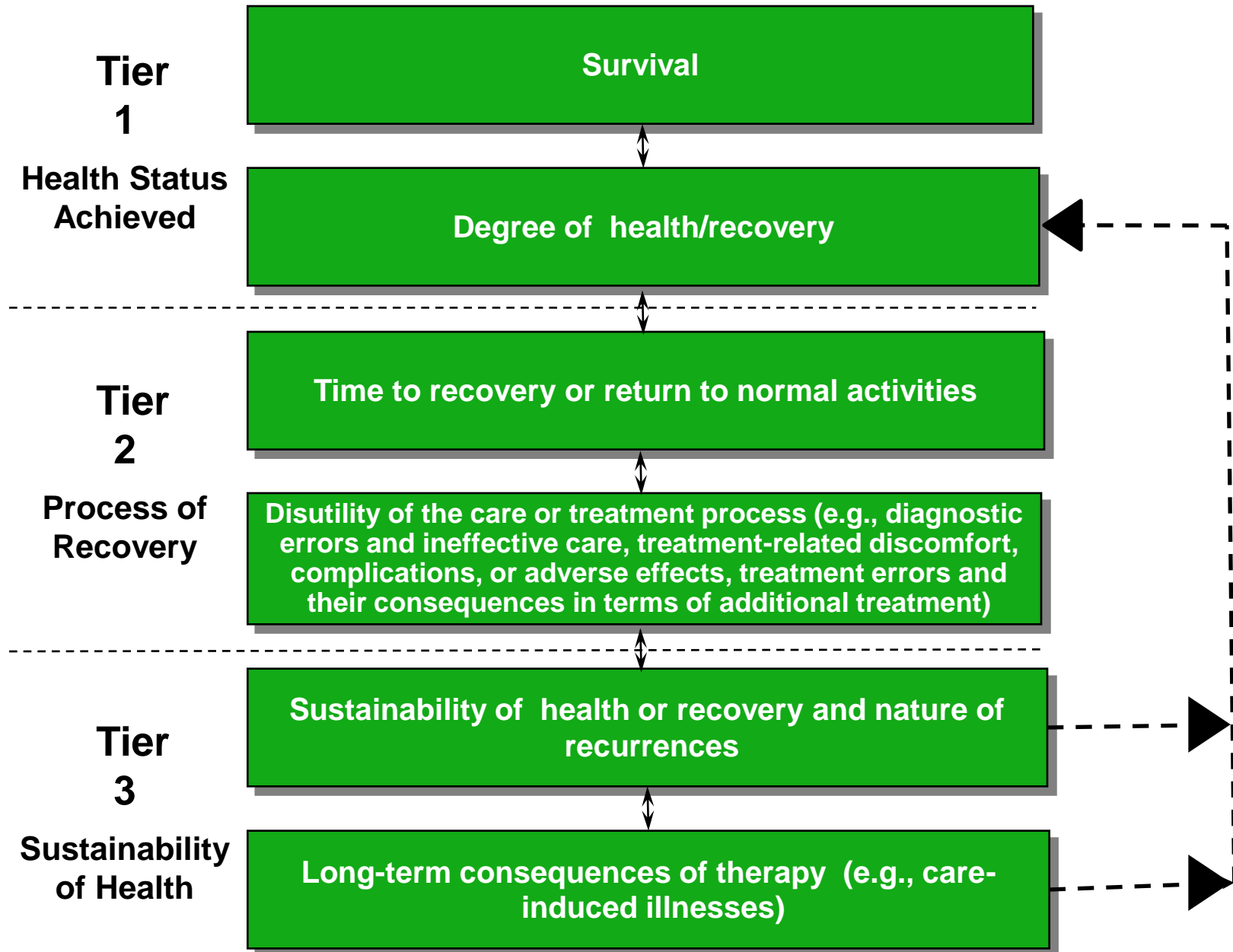


Measuring and reporting **volume** by medical condition

Measuring Value



The Outcome Measures Hierarchy



The Outcome Measures Hierarchy

Breast Cancer

Survival

- Survival rate
(One year, three year, five year, longer)

Degree of recovery / health

- Degree of remission
- Functional status
- Breast conservation
- Depression

Time to recovery or return to normal activities

- Time to remission
- Time to functional status

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)

- Nosocomial infection
- Nausea/vomiting
- Febrile neutropenia
- Suspension of therapy
- Failed therapies
- Limitation of motion
- Depression

Sustainability of recovery or health over time

- Cancer recurrence
- Sustainability of functional status

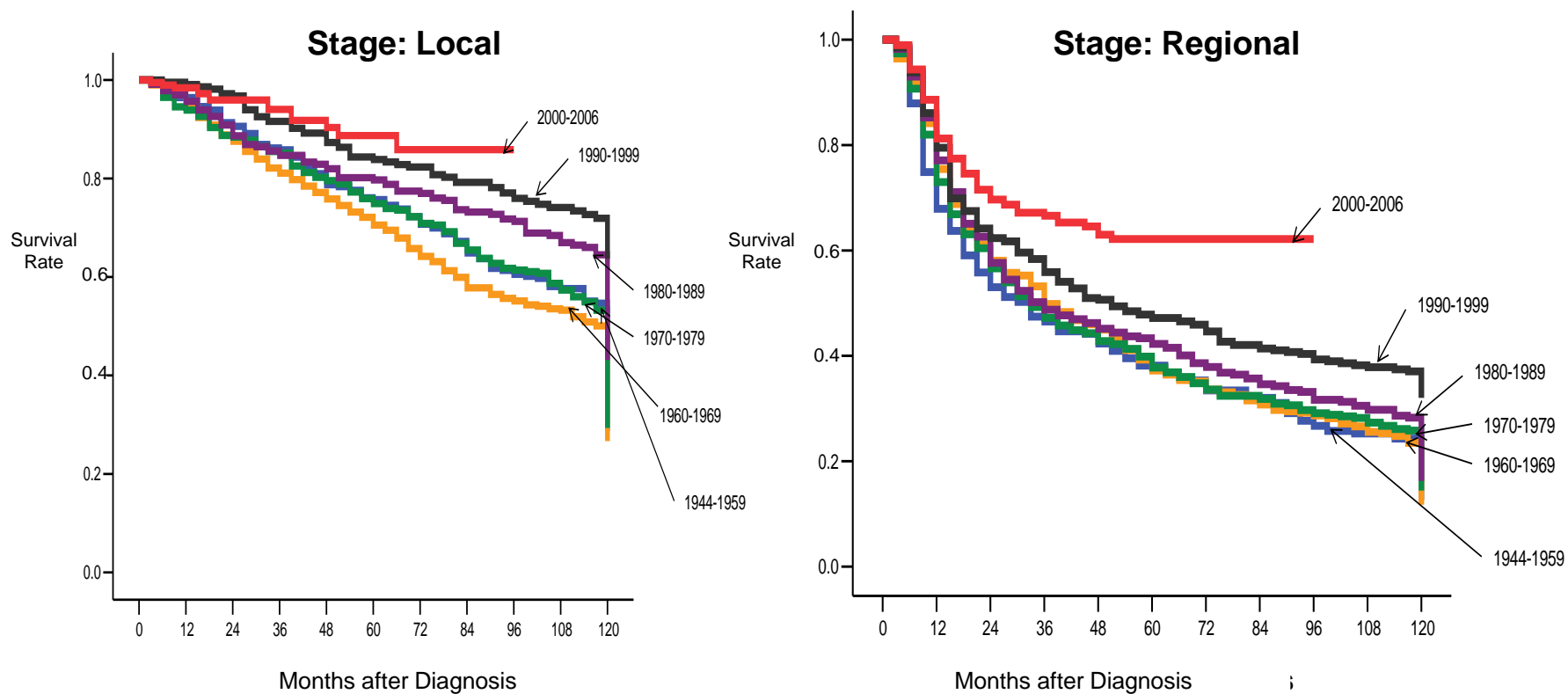
Long-term consequences of therapy (e.g., care-induced illnesses)

- Incidence of secondary cancers
- Brachial plexopathy
- Fertility/pregnancy complications
- Premature osteoporosis

Initial Conditions/Risk Factors

- Stage upon diagnosis
- Type of cancer (infiltrating ductal carcinoma, tubular, medullary, lobular, etc.)
- Estrogen and progesterone receptor status (positive or negative)
- Sites of metastases
- Previous treatments
- Age
- Menopausal status
- General health, including co-morbidities
- Psychological and social factors

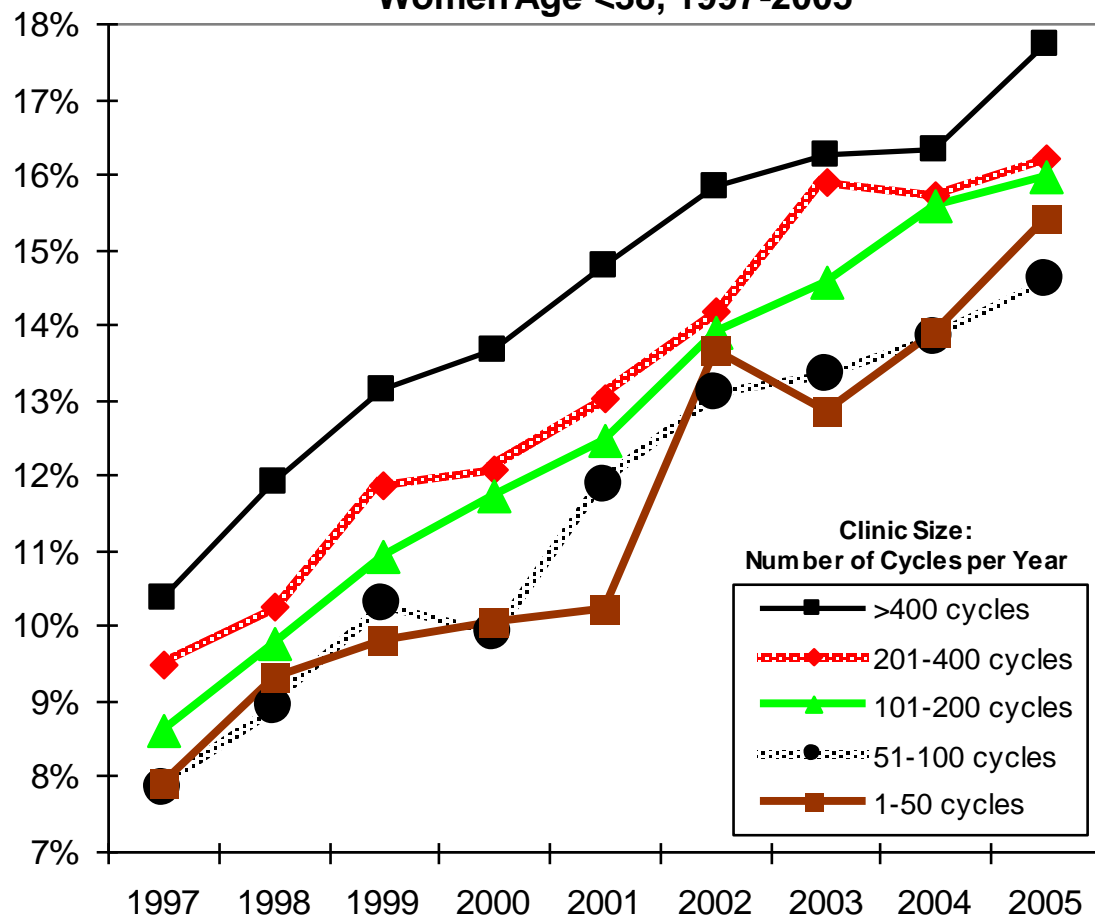
MD Anderson Oral Cavity Cancer Survival by Registration Year



Source: MD Anderson Cancer Center

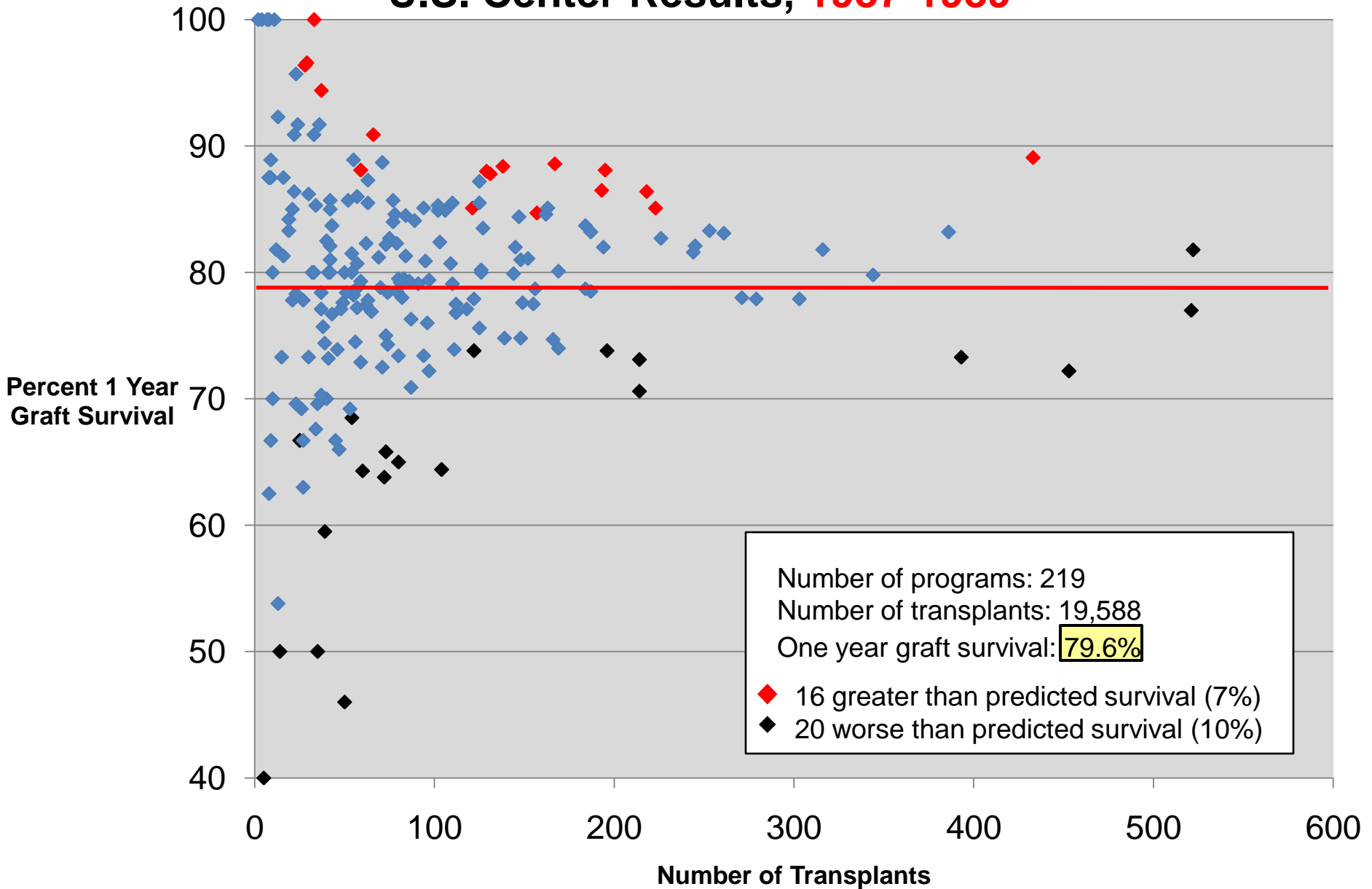
In-vitro Fertilization Success Rates Over Time

Percent Live Births per Fresh, Non-Donor Embryo Transferred by Clinic Size
Women Age <38, 1997-2005

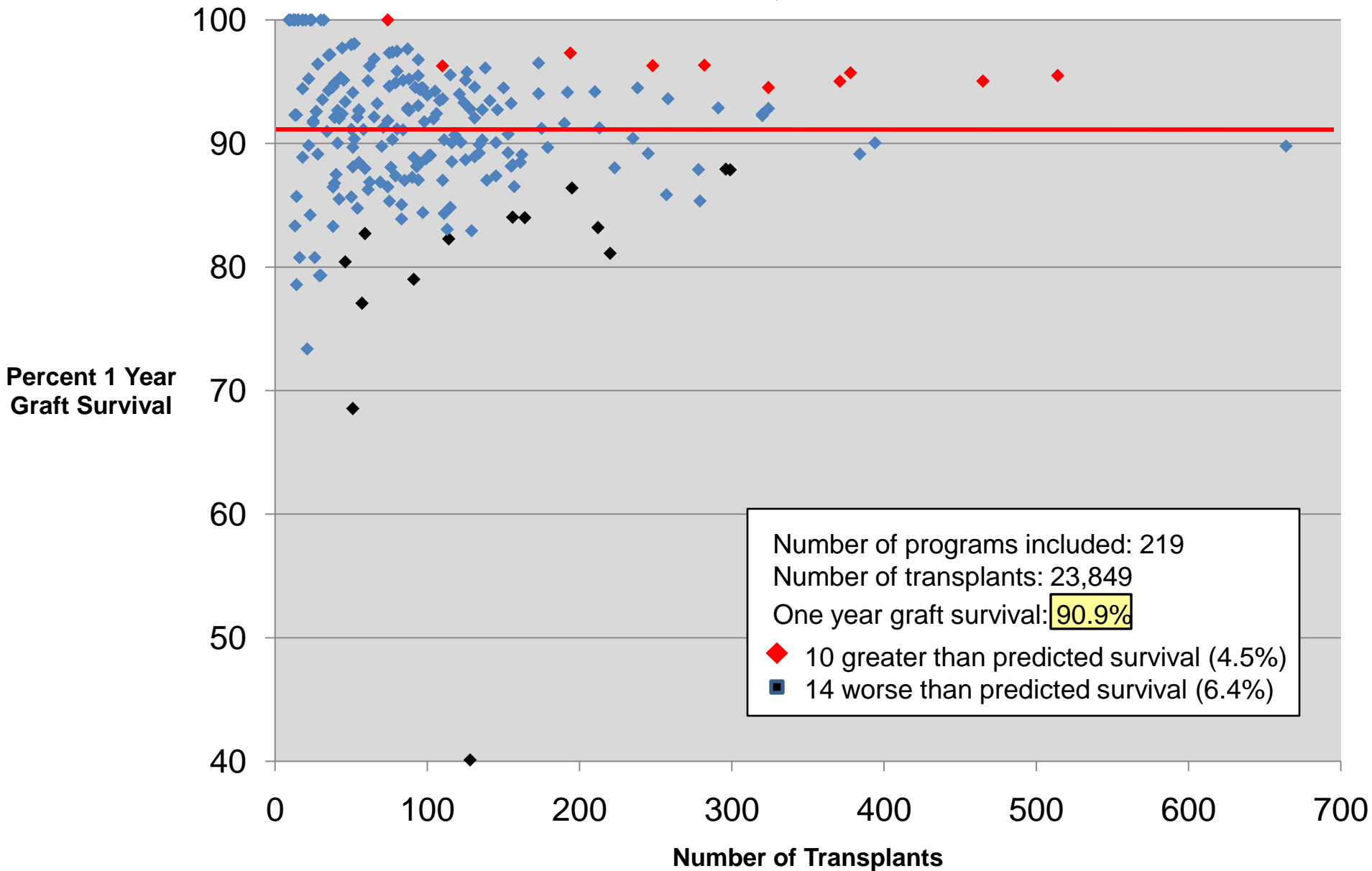


Source: Michael Porter, Saquib Rahim, Benjamin Tsai, *Invitro Fertilization: Outcomes Measurement*. Harvard Business School Press, 2008

Adult Kidney Transplant Outcomes, U.S. Center Results, 1987-1989

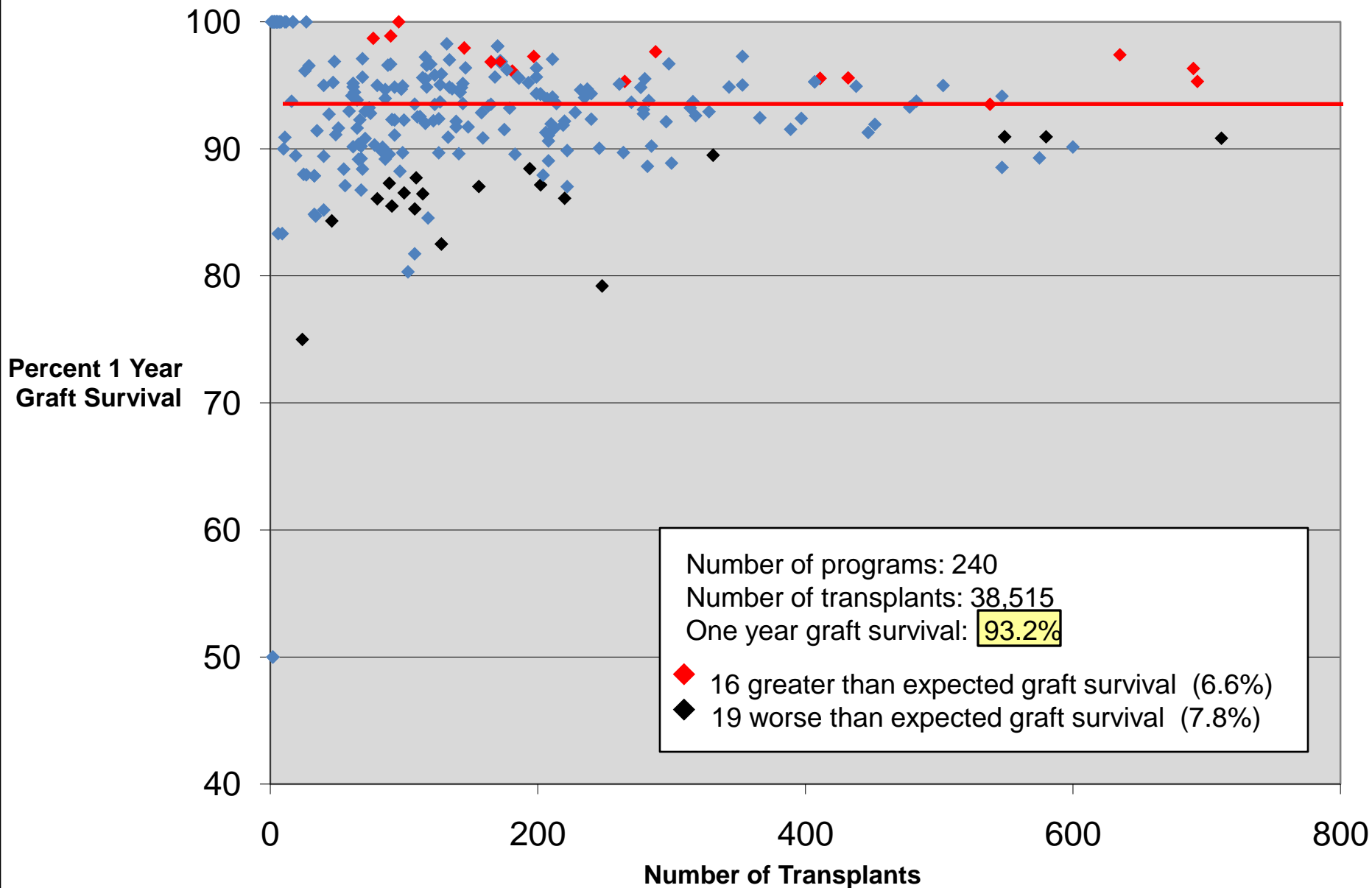


Adult Kidney Transplant Outcomes, U.S. Center Results, 1998-2000



Adult Kidney Transplant Outcomes

U.S. Center Results, 2005-2007



Swedish National Quality Registers, 2007*

Respiratory Diseases

- Respiratory Failure Register (Swedevox)
- Swedish Quality Register of Otorhinolaryngology

Childhood and Adolescence

- The Swedish Childhood Diabetes Registry (SWEDIABKIDS)
- Childhood Obesity Registry in Sweden (BORIS)
- Perinatal Quality Registry/Neonatology (PNQn)
- National Registry of Suspected/Confirmed Sexual Abuse in Children and Adolescents (SÖK)

Circulatory Diseases

- Swedish Coronary Angiography and Angioplasty Registry (SCAAR)
- Registry on Cardiac Intensive Care (RIKS-HIA)
- Registry on Secondary Prevention in Cardiac Intensive Care (SEPHIA)
- Swedish Heart Surgery Registry
- Grown-Up Congenital Heart Disease Registry (GUCH)
- National Registry on Out-of-Hospital Cardiac Arrest
- Heart Failure Registry (RiksSvikt)
- National Catheter Ablation Registry
- Vascular Registry in Sweden (Swedvasc)

- National Quality Registry for Stroke (Riks-Stroke)
- National Registry of Atrial Fibrillation and Anticoagulation (Auricula)

Endocrine Diseases

- National Diabetes Registry (NDR)
- Swedish Obesity Surgery Registry (SOREg)
- Scandinavian Quality Register for Thyroid and Parathyroid Surgery

Gastrointestinal Disorders

- Swedish Hernia Registry
- Swedish Quality Registry on Gallstone Surgery (GallRiks)
- Swedish Quality Registry for Vertical Hernia

Musculoskeletal Diseases

- Swedish Shoulder Arthroplasty Registry
- National Hip Fracture Registry (RIKSHÖFT)
- Swedish National Hip Arthroplasty Register
- Swedish Knee Arthroplasty Register
- Swedish Rheumatoid Arthritis Registry
- National Pain Rehabilitation Registry
- Follow-Up in Back Surgery
- Swedish Cruciate Ligament Registry – X-Base
- Swedish National Elbow Arthroplasty Register (SAAR)

* Registers Receiving Funding from the Executive Committee for National Quality Registries in 2007

Creating an Outcome Measurement System

Schön Kliniken

1. Define medical conditions to measure

- Identified medical conditions

2. Develop outcome dimensions, measures, and risk adjustments

- Measures developed by convening groups of involved physicians and members of Schön's quality improvement team
- Five metrics per medical condition

3. Data collection infrastructure

- Physicians and nurses enter data during the patient's stay
- Data can be extracted from the EMR reducing the burden of capture
- Long term follow-up still done manually

4. Incentives and mechanisms for data reporting

- Reporting of all metrics is mandated for all physician groups
- Involvement in the metrics development process increases physician buy-in

5. Compliance and accuracy validation

- Validates accuracy through trend analysis

6. Outcome reporting

- Capture outcome data for 70% of patients
- Report results internally at the individual physician level
- Annual quality report (27 process and outcome measures)

7. Process for outcome improvement

- Physicians trust metrics and are convinced of their value in driving improvement
- Link physician pay to quality of care delivered

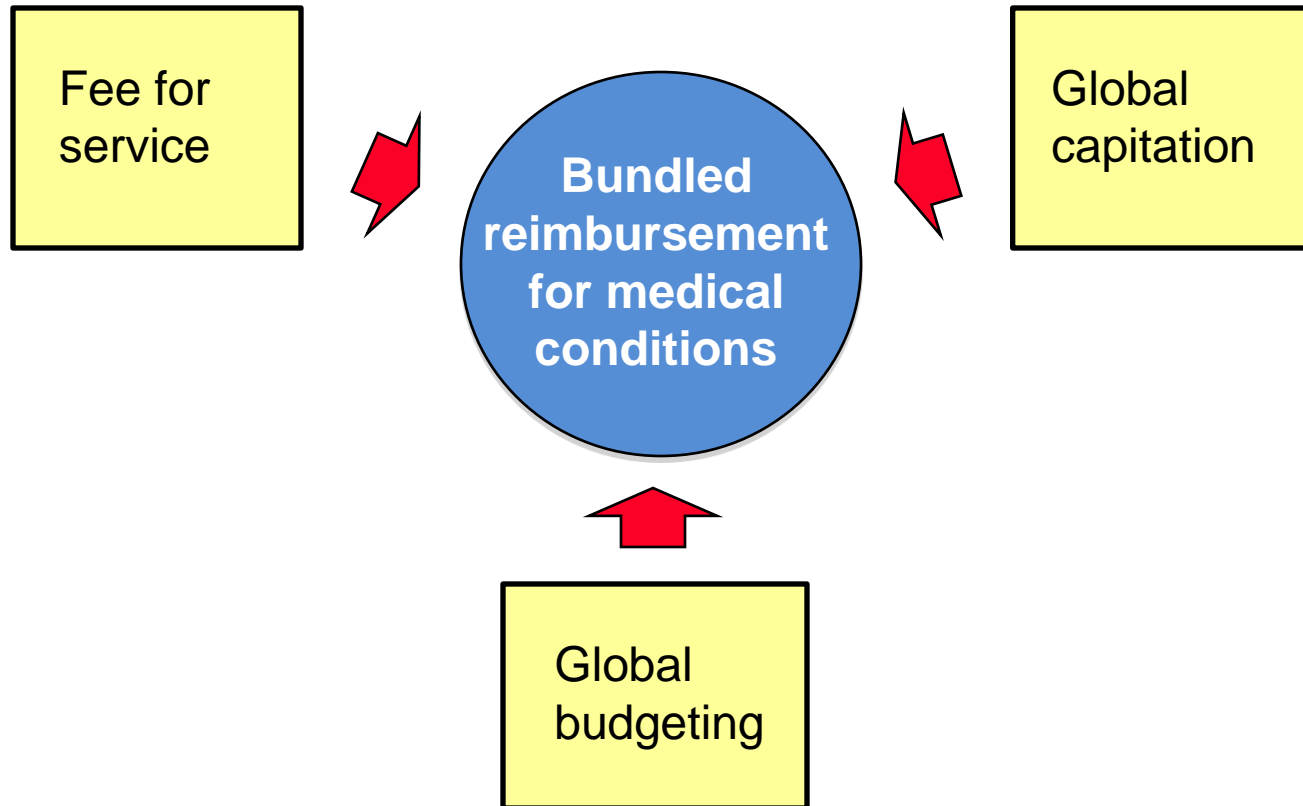
Cost Analysis Principles

- Cost should be aggregated at the **medical condition level** (which includes common co-occurring conditions and complications), not for services or entire facilities
- Cost should be aggregated **for each patient** across the **full cycle of care**
- The cost of each activity or input attributed to a patient should reflect **that patient's use of resources** (e.g. time, staff, facilities, service), not average allocations or allocations based on charges
- The only way to properly measure cost per patient is to track the **time** or **shared resource capacity** devoted to each patient by physicians, staff, facilities, support services, and other shared costs



- **Time-Driven Activity Based Costing**
 - Chart the CDVC
 - Assess **capacity cost** of each shared resource involved in the care process
 - Assess **actual capacity use** in transactions with each patient
 - Enable **aggregation** by patient, by medical condition, etc.
- Cost measurement should be accompanied by **outcome measurement**

3. Move to Bundled Prices for Care Cycles



What is a Bundled Payment?

- A **total package price** for the care cycle for a medical condition
 - Including time-based bundled reimbursement for **managing chronic conditions** and for **primary/preventive** service bundles
 - Including responsibility for **avoidable complications**
- The bundled price should be **severity adjusted**

What is Not a Bundled Payment

- Price for a **short** episode (e.g. inpatient only, procedure only)
- **Separate** payments for physicians and facilities
- “**Medical Home**” payment for care coordination
- **Pay-for-performance** bonuses



- DRGs can be a **starting point** for bundled payment models

Bundled Payment in Practice

Hip and Knee Replacement in Stockholm, Sweden

- **Components** of the bundle

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

- 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** but all providers are involved



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

Creating a Bundled Pricing System

- Defining the Bundle
 - **Scope** of the medical condition
 - **Range of services** included
 - **Complications** and **comorbidities** included/excluded
 - **Duration** of care cycle/time period
 - Must be long enough to minimize the risk of cost shifting
 - **Flexibility** on methods/process of care essential
- Pricing the Bundle: Key Choices
 - Price relative to **sum of current costs**
 - Extent of **incentive** to improve value by reducing avoidable complications, improving efficiency, etc.
 - Extent of “**guarantees**” by providers
 - Extent of **severity/risk** adjustments
 - Mechanism for handling **unanticipated** complications and **outliers**
- Implementing the Bundle
 - Internal **distribution of payment** among providers (dividing the pie)
 - Degree of risk sharing by specialty
 - **Claims** management process and infrastructure
 - **Outcome measurement** is essential to measure success and minimize incentives to limit value-enhancing services

4. Integrate Care Delivery Across Separate Facilities

Traditional Motivations for Health Systems

- Expand geographic coverage
- Increase patient volume
- Expand coverage of the care cycle
- Gather volume for high acuity facilities
- Reduce crowding

Levels of System Integration

- Determine the **scope of service lines**
- **Rationalize service lines/ IPU**s across facilities to improve volume, avoid duplication, and concentrate excellence
- **Offer specific services** at the **appropriate facility**
 - E.g. acuity level, cost level, need for convenience
 - Patient referrals across units
- **Clinically integrate care across facilities**, within an IPU structure
 - **Expand** and **integrate** the care cycle
 - Better connect **preventive/primary care** units to specialty IPUs

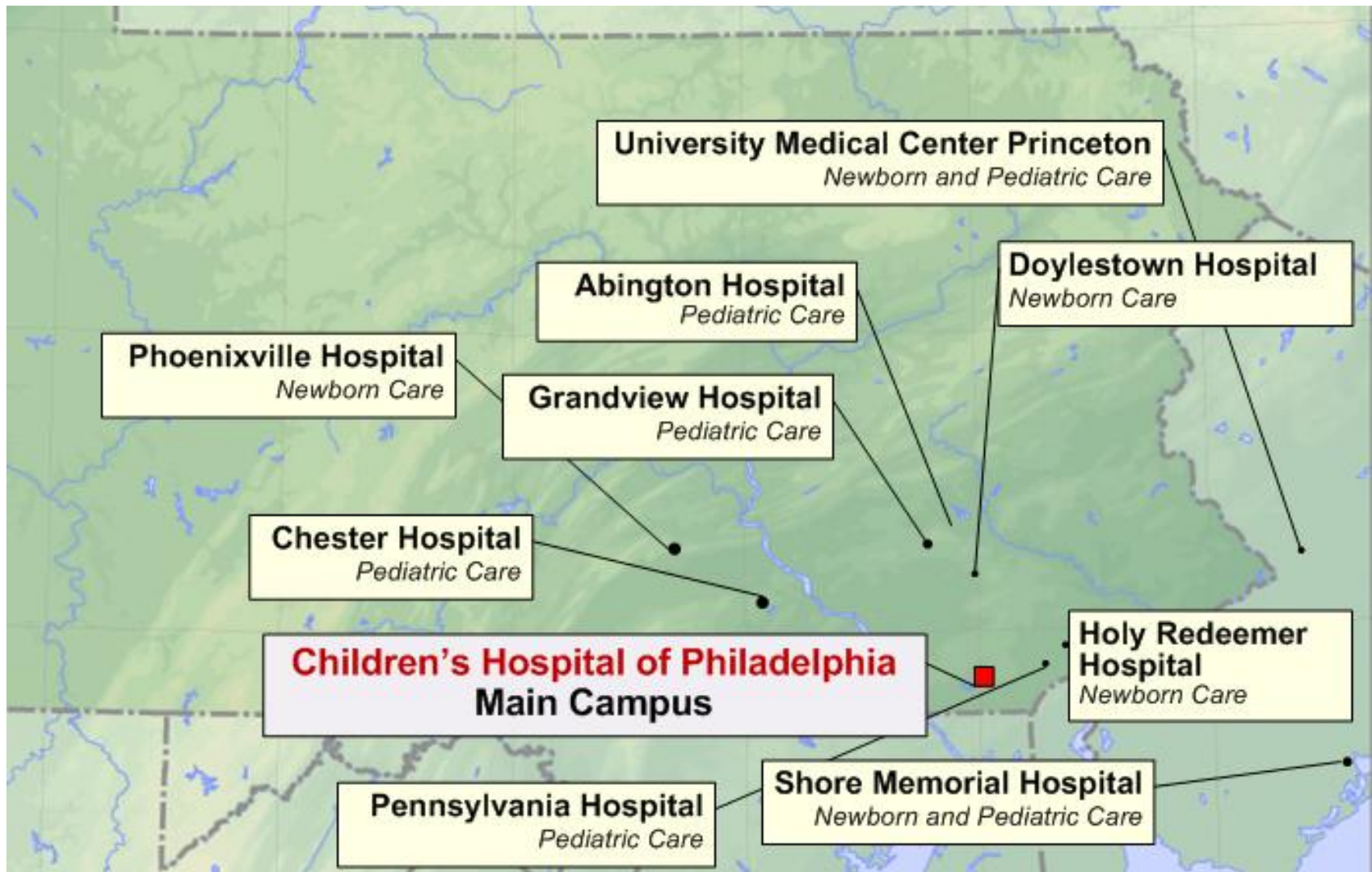


- There is a major opportunity to improve value through **moving care out** of heavily resourced, tertiary and quaternary facilities

Provider System Integration

Children's Hospital of Philadelphia (CHOP)

Hospital Affiliates



Enabling System Integration

Practice Structure

- **IPU structure**
 - First step is to increase **consistency** of protocols/processes across sites
 - **“Virtual” IPU**s even if providers practice at different locations
 - **Case management structure** spanning units where appropriate

Scheduling

- Common or federated **patient scheduling service** across units

Physician Organization

- **Employed** physicians
- Formal **affiliations** with independent physicians
 - Support service as an inducement for affiliation (E.g. IT, back office)
- **Rotation** of staff across locations

Common Systems

- **Common EMR platform** which aggregates information across units
- Common **outcome and process measurement** systems

Cost Measurement

- Ability to accurately accumulate **cost per patient** across the entire care cycle
- Ability to measure **cost by location** for each service/activity

Culture

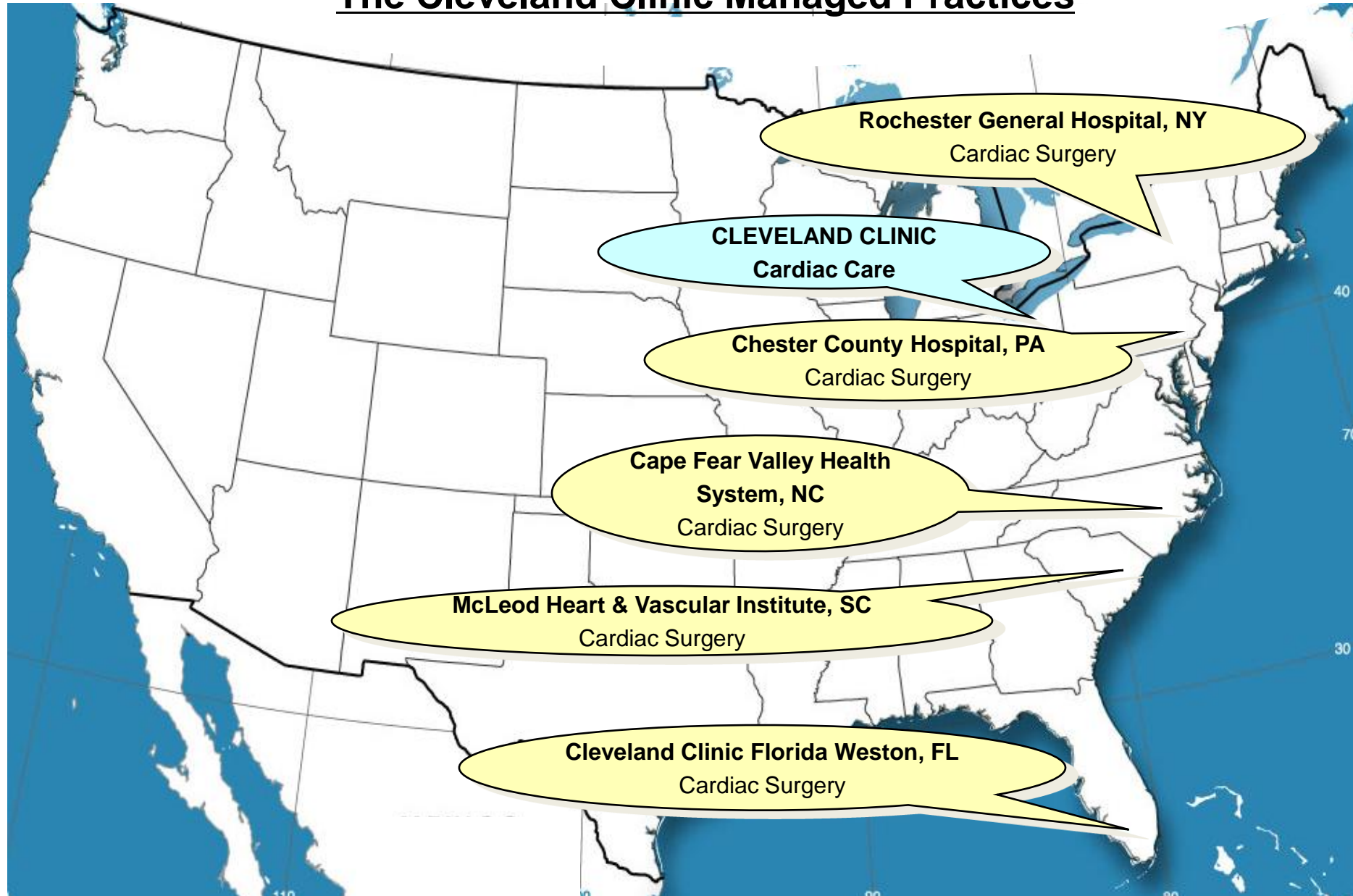
- Management practices that foster **affiliation with the organization**, developing **personal relationships**, and **regular contact** among dispersed staff

5. Expand Excellent IPUs Across Geography

- Grow in ways that improve **value**, not just increase volume
- Grow **areas of excellence** and **leverage across locations**, rather than adding broad line, stand-alone units
- **Affiliate with excellent providers** in medical conditions where there is insufficient volume or expertise to achieve superior value

Expanding Excellent IPU's Across Geography

The Cleveland Clinic Managed Practices



Models of Geographic Expansion

Affiliations

**Affiliation
Agreements
with
Independent
Provider
Organizations**

**Second
Opinions and
Telemedicine**

Dispersed Services

**Dispersed
Diagnostic
Centers**

**Convenience
Sensitive
Service
Locations in the
Community**

**Complex IPU
Components
(e.g. surgery)
in Additional
Locations**

New Hubs

**Specialty
Hospitals as
Referral Hubs
in Additional
Locations**

**New Broader-
Line Hospital
Hubs**

6. Create 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 over time
- Data encompasses the **full care cycle**, including referring entities
- Allowing access and communication among **all involved parties**, including patients
- **“Structured”** data vs. free text
- **Templates** for medical conditions to enhance the user interface
- Architecture that allows **easy extraction of outcome, process, and cost measures**
- Interoperability standards enabling communication among **different provider systems**

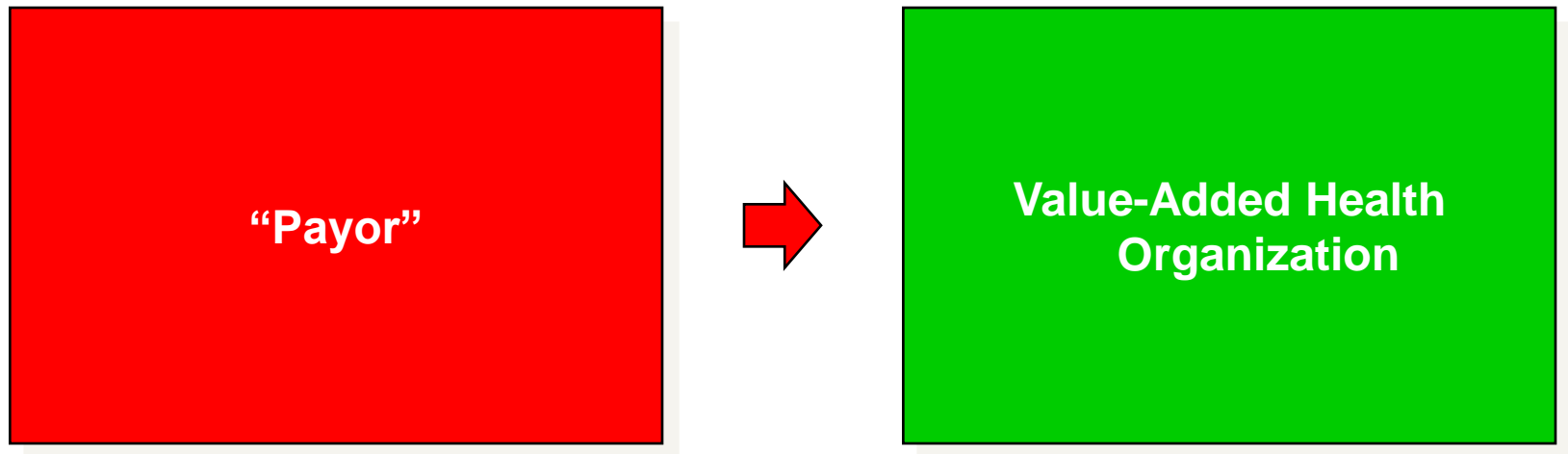
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Value-Based Healthcare Delivery:

Implications for Contracting Parties/Health Plans



- Providers can lead in developing new relationships with health plans through their role in **providing health benefits for their own employees**

Value-Based Health Care: The Role of Employers

- Employer interests are **more closely aligned with patient interests** than any other system participant
 - Employers need healthy, high performing employees
 - Employers bear the costs of chronic health problems and poor quality care
 - The cost of poor health is 2 to 7 times more than the cost of health benefits
 - Absenteeism
 - Presenteeism
 - Employers are **uniquely positioned** to improve employee health
 - Daily interactions with employees
 - On-site clinics for quick diagnosis and treatment, prevention, and screening
 - Group culture of wellness
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- Providers should establish **direct relationships with employers** to enable value based approaches

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**
- Shift reimbursement systems to **bundled prices for cycles of care** instead of payments for discrete treatments or services
- Remove obstacles to the **restructuring of health care delivery** around the integrated care of medical conditions
- **Open up competition** among providers and across geography
- Set policies that encourage greater **responsibility of individuals** for their health and their health care
- Mandate **EMR adoption** that enables integrated care and supports outcome measurement
 - National **standards** for data definitions, communication, and aggregation
 - **Software as a service** model for smaller providers