Value in Canadian Healthcare

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Introduction

• I have been costing patients for nearly 30 years
• Across many countries and health systems
• What value can costing bring
• Why does costing generally fail to live up to its full potential
What is Patient Costing

• The UK Department of Health in 2009 indicated that Patient Costing was a move away from a top down allocation approach based on averages and apportionments to a more direct and sophisticated approach based on the actual consumption of resources (DH:2009)

• My simple definition
  Matching the work performed to the expenses incurred
Value of Patient Costing

• In order to cost, we need all the clinical & fin data
• Huge value beyond costs
  – Treatment protocols
  – Readmissions
  – HACs
• In essence, a measure of quality and outcomes
Costing - What could go wrong

- Governments lose sight of why they cost
- Costing becomes the deliverable
- They seek perfection in the costs
  - At the expense of all the other value that the data holds
- Data becomes untimely
  - Often released 6-12 months later
Important to understand

• Costing is not a deliverable
• Costing go live is purely a milestone
• As a result, need
  – Rapid implementation
  – Timely information
  – Transparency of the results
• We want people to have access to all the information quickly
How Much Direct Nursing Time Counts To The Patient Experience

The Interest

• Trying to understand patient experience is putting patient at the centred of care
• The patient experience is both qualitative and quantitative
The Learning

The Approach
• Capturing Patient Experience
• Measuring direct nursing time
• Involved experienced data analytics researchers

The Result
• Direct nursing time is only one component
• Frequency counts more than intensity
• Patient experience is multi-dimensional, complex and dynamic
Costing – international best practice

• Look at Quebec as an international best practice framework
• Growing concern about quality of care
• What is quality of care?
  – Access to care
  – Safe care
  – Cost of care
Challenges Facing Quebec’s Healthcare System

• Various Quebec reforms are still not resolving accessibility problems

• Healthcare is a repeated source of major pressure on public expenditure:
  – Increase as a proportion of spending on all government funded programs
Political Pressure in Quebec

- Population (2013)
  - 64% needs fundamental changes
  - 13% needs to be completely rebuilt

Overall opinion of the health care system by country and province, 2013 (as a percentage)

- Québec: 23% needs fundamental changes, 64% needs some changes, 13% needs to be completely rebuilt
- Ontario: 50% needs fundamental changes, 45% needs some changes, 5% needs to be completely rebuilt
- Alberta: 43% needs fundamental changes, 50% needs some changes, 8% needs to be completely rebuilt
- Canada: 42% needs fundamental changes, 51% needs some changes, 8% needs to be completely rebuilt
- United Kingdom: 63% needs fundamental changes, 33% needs some changes, 4% needs to be completely rebuilt
- Switzerland: 54% needs fundamental changes, 40% needs some changes, 7% needs to be completely rebuilt
- The Netherlands: 51% needs fundamental changes, 44% needs some changes, 5% needs to be completely rebuilt
- Australia: 48% needs fundamental changes, 43% needs some changes, 9% needs to be completely rebuilt
- New Zealand: 47% needs fundamental changes, 45% needs some changes, 8% needs to be completely rebuilt
- Norway: 46% needs fundamental changes, 42% needs some changes, 12% needs to be completely rebuilt
- Sweden: 44% needs fundamental changes, 46% needs some changes, 10% needs to be completely rebuilt
- Germany: 42% needs fundamental changes, 48% needs some changes, 10% needs to be completely rebuilt
- France: 40% needs fundamental changes, 49% needs some changes, 11% needs to be completely rebuilt
- United States: 25% needs fundamental changes, 48% needs some changes, 27% needs to be completely rebuilt

Integration

• Critical for timely information
• Approximately 700 interfaces generating 1300 extracts
• Standardise and normalise the data - ability to compare, benchmark
• Ensure the frequency of the data, either monthly, weekly or daily, is suitable to drive KPIs, benchmark portal, costing analysis and ABF
Methodology

- CDO - Headed by gov centre of excellence to support sites
- Needed to ensure the bottom doesn’t drop out
- Maintain all costing sites to a min standard

Provides IT solutions and costing methodology (PPM) + user autonomy (training) and support by CDO as an excellence center (training)
Provincial Deployment

• Encourage transparency
• Results available across the province
• Engage with sites on how to use the information
Clinical Champions

- Deliver daily/weekly/monthly performance indicators
- Support clinical engagement with a view to normalise clinical practice
- Deliver green/black belt training to clinical champions

Support organisation with the use of results to drive healthcare system transformation (clinical performance review, lean training, benchmarking portal, user community, etc.)
Buy-in from clinicians

Incident rates by hospital:

- Avoid the overused message of doing more with less
- Not focused on financial goals, e.g. costs, efficiency gains & performance
Incidents by Principal Type

Distribution of adverse events according to the 3 main types of events for episodes with DRG = COPD and by Hospital

- Hosp. 5: 65.5% (Medications), 14.5% (Falls), 9.1% (Treatments/Procedures)
- Hosp. 4: 40.4% (Medications), 28.1% (Falls), 9.0% (Treatments/Procedures)
- Hosp. 3: 51.2% (Medications), 31.7% (Falls), 7.3% (Treatments/Procedures)
- Hosp. 2: 53.6% (Medications), 39.3% (Falls), 0.0% (Treatments/Procedures)
- Hosp. 1: 46.4% (Medications), 33.9% (Falls), 7.1% (Treatments/Procedures)
Average Incident Costs

Average Costs of Episodes with DRG = COPD based on Hospital and presence of Adverse Events

Hosp. 1: Without event $6159, With event and consequence (A, B, C, D) $12611, With event and consequence (E1 et +) $19953
Hosp. 2: Without event $5077, With event and consequence (A, B, C, D) $9694, Without event $x
Hosp. 3: Without event $4317, With event and consequence (A, B, C, D) $6672, With event and consequence (E1 et +) $14652
Hosp. 4: Without event $5301, With event and consequence (A, B, C, D) $18823, With event and consequence (E1 et +) $22136
Hosp. 5: Without event $6856, With event and consequence (A, B, C, D) $11632, Without event $x
In Closing

- There is a chasm between the cost of operating an annual costing exercise and one that delivers better patient outcomes and true savings to the healthcare system.
- It is important to align desired outcomes with spend.