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When doing the right thing hurts your financials

Hospital management in between the patient and regulation.

On a Monday morning in November 2015, Carl, 42 years old, suffered an acute ischemic stroke while having breakfast in his Vienna suburban home. The ambulance arrived within 15 minutes, and only 60 minutes later, the CT scan confirmed that his stroke could be treated with a stent retriever thrombectomy (SRT). The medical team could not find a hospital with that service on duty.

Carl survived, but is severely handicapped, in need of 24 hour care. He will never again have a normal life. Carl´s family receives approximately USD 25,000 annual support for his treatment from the statutory insurance. Over his reduced life expectancy of maybe 20 years, these payments will sum up to USD 500.000. High costs for the system, and that is not considering all costs for medical treatment, family time spent for his care and lost income.

An SRT at an approximate cost of USD 12,000 would likely have had Carl leave the hospital after a couple of days fully recovered with low or even no health consequences.

In Vienna, with a population of 2 million people, 200 to 300 strokes are eligible for SRT annually.

In Carl´s case, we face a bad patient outcome at high cost—an undesirable result.

ALIGNING PATIENTS AND PAYERS GOALS: THE EASY CASE

In early 2017, the government of Vienna decided to setup a 24/365 SRT-service. Although the service went fully operational only in the second half of 2017, we saw an increase in SRT therapy of 50% in 2017 compared to pre 24/365 times. In the first half of 2018 alone, so far we have documented 83% more cases, which means that in our hospital, Brothers of St. John of God Vienna,, 49 people have been saved by SRT-therapy, which is 22 more than in all of 2016! The implementation of a round the clock SRT-service is a straightforward case, medically as well as economically, that does not need a lot of calculation. Yet it took years to implement the service. How do hospitals, politics and society deal with less obvious cases?

ALIGNING PATIENTS AND PAYERS GOALS: THE DIFFICULT CASE

Robotic surgery is an example for a less straightforward case. A robot is an expensive device, which naturally increases costs in the operation room when using it. Literature on comparing traditional laparoscopic surgery and robot assisted surgery is ambiguous. So why did our hospital after six years of experience with more than a thousand prostatectomies buy a second robot and decide to expand robotic operations to four disciplines (urology, gynecology, general surgery and ENT)?

The decision process was twofold.

First, we compared costs of traditional laparoscopy with robotic surgery based on a simplified process costing model. The model included costs occurring in the hospital, from admission to discharge of the patient. Differences between the methods were recorded during and after surgery. While costs of the surgery where higher when using the robot, post-surgery costs were in favour of the robot. The total cost of robotic operations was about equal to traditional laparoscopic surgery.

Second, we looked at the patient outcome which based on our data was better when using robotic surgery, specifically resulting from shorter hospital stays.

We decided to expand robotic surgery since costs were manageable and outcomes improved.

WHEN REGULATION JUMPS IN: THE WEIRD CASES

The SRT service and robotic surgery cases were relatively straight forward. But what, if stakeholders have to meet contradictory goals?

Take the example of cancer patients, receiving chemotherapy and regular staging CTs. In the Austrian system, this seemingly simple process leads to major issues which result in suboptimal service for the patient for the following reasons.

Chemotherapy, by regulation, has to be carried out in a hospital. If the chemo-patient arrives at the hospital with a blood analysis from an external lab, the external lab gets paid for it. If, however, the hospital performs the analysis itself, there is no extra payment for the hospital lab. Similarly, if the hospital decides to perform a staging CT, the hospital day clinic does not get paid for the CT. Yet, if the patient stays overnight, the hospital is paid for the CT by medical insurance.

Optimizing the process for the patient leads to not getting paid for the hospital. Optimizing costs and revenue in the value chain unnecessarily complicates the patients´ lives.

Similar cases exist in many jurisdictions and regulatory environments.

THE WAY FORWARD: CULTURE, DATA AND EDUCATED DECISIONS

To avoid all undesired consequences of such cases, a culture change in healthcare has to occur, at an individual as well as systemic level. Efficiency is not the enemy but the friend of good service and outcomes.

Everyone in hospitals needs to understand that limited resources need to be focussed on the best patient outcome. Everyone in regulation and politics needs to understand that it is better for everyone to optimize the healthcare ecosystem than let people pursue contradictory goals.

In order to do that, we need higher quality data to perform the required analyses to underpin decisions. Only transparent and easily communicable results will allow everyone in the system, from nurses and doctors to regulators and policymakers, to act in the best interest of patients.

A focus on value-based healthcare, balancing costs and patient outcomes, will support this transformation.

Helmut Kern will be talking about doing the right thing when it hurts your financials at 4:5pm on Wednesday 10 October 2018 during day 1 of the World Hospital Congress.

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