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When doing the right thing hurts your financials.

Hospital management in between the patient and regulation.

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Case 1 –24/7 SRT-Service for Stroke

- Stent-retriever thrombectomy (SRT) is a highly effective treatment for ischemic stroke (good life vs. death/handicap)
- Roughly 7-10% of stroke admissions are eligible for SRT
- About 250-300 strokes eligible in Vienna (2 mio. population)

Case 1 – 24/7 SRT-Service: Problem

- Receiving SRT-treatment in Vienna was a matter of luck with about a 50 % chance → pretty **bad outcome**!
- SRT paid by health insurance (~ € 10.000/pat.) → **good value**
- Need for additional staff, but hospitals´ budget is capped
- Annual disability pension paid by pension insurance, permanent care by pension insurance and family, hospitalization and drugs by health insurance, lost income by the patient →**bad value**

Case 1 – 24/7 SRT-Service: Solution

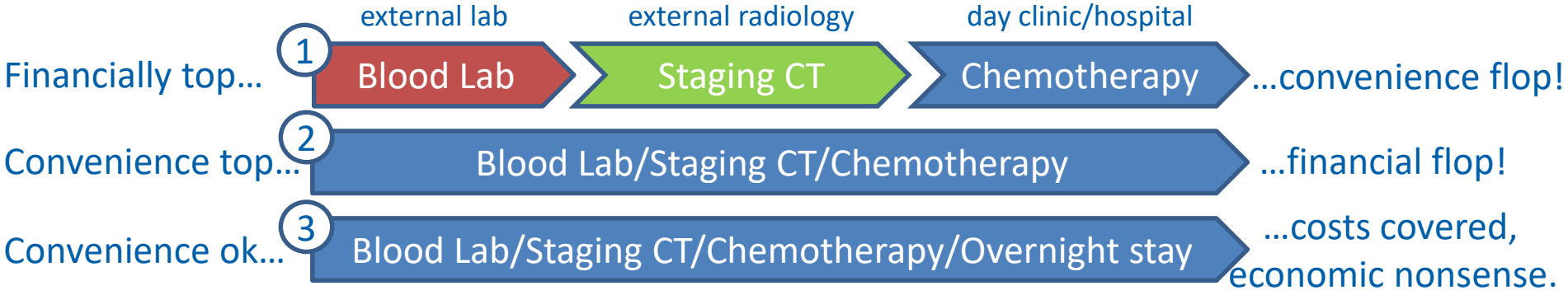
- In 2017, Vienna introduced a coordinated 24/7 SRT service

Results:

- In 2018 83 % more SRTs in our hospital (yoy) → 38 more patients by year end (forecast 84 vs. 46); ~ +130 patients in Vienna → **good outcome!**
- Additional cost for health insurance ~ € 1,3 mio.
- Saved cost for pension insurance ~ € 2,6 mio. annually, low or no hospitalization cost, low drug cost, no family expenses, low or no income loss for the patients → **good value!**

Why did it take years to implement a 24/7 service?

Case 2 – Chemo: patient interest vs. wrong incentives



While option 2 is best for patients and most cost effective, option 1 would be most attractive for service providers. Most popular is option 3, which is worst for tax payers.

Learnings

- Payers/Authorities need to understand the value chain
- Same service or outcome needs same compensation
- The point of service must not create conflicts of interest
- Outcome perspective and cost perspective are equally important to understand the value for the patient
- Efficiency is not the enemy but the best friend of good service and outcome!

From learnings to action: the Value Framework

1. Define outcome goals
2. Understand Patient Process (cross service providers)
3. Measure costs and value contribution of each process step
4. Convert data to decision relevant information
5. Change culture (especially in non-profit organisations/systems):
   - Align goals of players in the system
   - Understand that efficiency is key to creating good outcomes
   - Close loopholes for “systems arbitrage”

Contact

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Bous Track – Prostatectomy: robotic vs. laparoscopic

Prostatectomy - Total Costs in €			
	DaVinci	laparoscopic	open
Costs of surgery	3.644	2.197	1.182
Wards related costs	4.306	7.344	7.925
Costs per stay	**7.950**	**9.541**	**9.106**
NET MARGIN			
without 1 day ICU	**-120**	**-1.711**	**-1.277**
with 1 day ICU	**1.143**	**-448**	**-13**

- Caveat!: Ø LOS 6,24 (robotic) vs. 10,64 (lap.)
- Break even at Δ LOS of 2,1 days
- Realistic Δ LOS of 1 day leads to € 757 advantage for laparoscopic
- Wrong DRG incentive for 1 day ICU stay

Prostatectomy – Cost Analysis

Prostatectomy - Costs of Surgery			
	DaVinci	laparoscopic	open
personnel costs	879	1.362	829
material costs	1.540	815	342
costs of instruments	1.226	21	11
Costs of surgery	**3.644**	**2.197**	1.182
DRG related profit/loss	**-418**	**1.029**	2.044

Prostatectomy - Ward Costs			
	DaVinci	laparoscopic	open
Ø lenght of stay	6,24	10,64	11,48
Ward - primary costs/day	224	224	224
Ward - allocated urology costs	103	103	103
Ward - allocated costs	363	71	71
Ward - Costs per day	***690***	***690***	***690***
Ward - Costs of stay	**4.306**	**7.344**	**7.925**
DRG relatd profit/loss	**298**	**-2.740**	-1.749

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	DaVinci	laparoscopic	open
Costs of surgery	3.644	2.197	1.182
Wards related costs	4.306	7.344	7.925
Costs per stay	**7.950**	**9.541**	9.106
NET MARGIN			
without 1 day ICU	**-120**	**-1.711**	-1.277
with 1 day ICU	**1.143**	**-448**	-13

Remarkable:

- Break even at Δ LOS of 2,1 days
- Watch ICU effect! Wrong DRG incentive!