A health care system to meet our needs

Health Reform: Improving Patient Care

A/PROFESSOR J CLOSE, CO-CHAIR, REDUCING UNWARRANTED CLINICAL VARIATION TASKFORCE

PRIORITIES FOR ‘UNWARRANTED CLINICAL VARIATION’ IN THE NEXT YEAR
UNWARRANTED CLINICAL VARIATION

Clinical Variation - Is everywhere, occurs across all disciplines and practices & arises for a range of valid reasons.

UNWARRANTED CLINICAL VARIATION (UCV):
• most definitions include something like: variation that cannot be explained by the condition or the preference of the patient; it is variation that can only be explained by differences in health system performance (ACQSHC)
• not a new concept
• can reduce safety, quality, performance effectiveness and efficiency outcomes
• is not related to a patient’s clinical status but is embodied in health system performance and clinical practices
UNWARRANTED CLINICAL VARIATION

ACI Reducing UCV Taskforce (formed in OCT 2012):

• Comprises clinicians from many disciplines, data experts (including the BHI and the Sax Institute), the Ministry (including the Chief Nursing and Midwifery Officer), CEC, Cancer Institute & two Chief Executives of LHDs.
• The purpose of the Taskforce is to work with clinicians, managers and other stakeholders oversee the development of a system-wide Strategy to Reduce Unwarranted Clinical Variation.

4 Key Areas Identified and being progressed:
• Stroke & AMI- BHI: Clinical variation and 30 day mortality rates
• Fractured Neck of Femur
• Low volume, complex cancer surgeries: Pancreas & Oesophagus
THE IMPORTANCE OF CREDIBLE DATA

Denial

Bargaining

Anger

Depression

Acceptance
UNWARRANTED CLINICAL VARIATION

OESOPHAGUS CANCER SURGERIES
Mean procedure volume in NSW, 2005-2008

<table>
<thead>
<tr>
<th>Average annual volume</th>
<th>Procedures (n)</th>
<th>Facilities (n)</th>
<th>30-day mortality (%)</th>
<th>90-day mortality (%)</th>
<th>1 year conditional survival</th>
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<tbody>
<tr>
<td>0-3</td>
<td>20</td>
<td>19</td>
<td>4.6</td>
<td>9.4</td>
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<tr>
<td>&gt;3-6</td>
<td>32</td>
<td>8</td>
<td>3.2</td>
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<td>72.8</td>
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<tr>
<td>&gt;6</td>
<td>41</td>
<td>5</td>
<td>2.7</td>
<td>5.5</td>
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</table>
UNWARRANTED CLINICAL VARIATION

Source: BHI Healthcare in Focus 2012
Percentage of hip fracture procedures commenced within first two days†, by NSW hospital, July 2000 to June 2011. Adjusted for age, sex and comorbidity of patient‡.
Funnel plot for 30-day mortality rate following hip-fracture procedure.
NSW by facility, Jul 09 - Jun 11. Adjusted for patient comorbidity, age and sex.

30 DAY MORTALITY FOR HIP FRACTURE IN NSW

NSW average: 7.35%
UK Best Practice Tariff – Rewarding Good Practice

Payment per patient

Current price

Current tariff structure

Best practice tariff structure

Base tariff for each DRG

Additional payment for best practice

Reduction in base tariff for current compliance rate

2-part tariff for best practice
THE IMPACT OF QUALITY STANDARDS & A SYSTEM THAT MEASURES AND REWARDS PERFORMANCE

Binomial test p-value <0.001 for all trends; average mortality at 30 days fell from 9.4% to 8%.
Question 1

What incentives are there to better share clinical data?
Question 2

What opportunity does funding reform present?