Operating in the Dark
The Role of Journalists and other non-clinicians

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Canadian Scandal: Health Care Still Operating in the Dark

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Inspiring Minds

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- Canadian Institute for Health Information, CIHI Physician Advisory Committee
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- Health Policy Fellow, Atlantic Institute for Market Studies
  - Publications: Operating in the Dark; Public Health, State Secret; Definitely Not the Romanow Report

Key Factors

- Who are the constituencies?
- Are their interests aligned or opposed? What are their interests ?
- Are professional and financial interests aligned?
- What are the key concepts that every one should know who has an interest in health care? Role of Journalists? Informaticians working together?
- What do we know about health care?

Compliance?

- What would you think if you had the same condition as your doctors, but the doctors treated themselves differently?
- What do you and your audience need to know to make choices?
- Flu Immunizations? Use of Antidepressants? Cholesterol lowering drugs?

Confusion may hurt flu vaccine rollout, health officials fear

Many may decide not to get immunized for H1N1 virus amid conflicting data

Oct 04, 2009 04:30 AM

Comments on this story (5)

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STAFF REPORTER

RICK EGLINTON/TORONTO STAR FILE PHOTO

"People have to get their own information and make their own decision," says Dr. Barbara Yaffe of Toronto Public Health.

There is much ado about the flu. Or to be more exact, about how not to get the flu.

The good news is that the province has a three-pronged immunization plan ready to roll out during the fall flu season for both the H1N1 and the seasonal flu virus.

But the plan – seasonal shots to seniors, then rolling out swine flu vaccine for everyone in mid-November and then resuming seasonal flu shots in December or January – is already marred by

Treatment For Hodgkin's Disease How to decide?

- Choices were
  - Radiation,
  - Chemotherapy
  - Radiation plus Chemotherapy

Can patients make the choice? Physicians? What to people and communities need to know to express their preferences?

The ChronicleHerald.ca
EDITORIALS

Health care workers need shot in arm

Mon. Oct 5 - 4:45 AM

HEALTH CARE workers who shrug off the annual flu shot for no good reason are playing a dangerous game. Not only are they increasing the chances that they will get sick, which affects staffing levels and ultimately patient care, but they are also directly increasing the risk to patients, many of whom could easily succumb to an opportunistic infection. Obviously, the stakes for elderly and frail patients are much higher — life and death — than they are for their care providers.

There are other consequences. The lower the compliance rate among health care workers, the greater the likelihood their employers will contemplate mandatory flu-shot policies. Enforced, blanket immunization would be a non-issue if health workers forgoing the flu shot were the exception rather than the rule.

Sadly, that is not the case. After a meeting of the legislature's public accounts committee last year, Dr. Robert Strang, the province's chief public health officer, said that on average half of Nova Scotia's health workers don't bother with a flu shot. In the province's largest health distict, Capital Health, only one-third of employees participated in flu-shot clinics during the 2007-08 flu season. (Those numbers are roughly in line with the compliance rate among Nova Scotia Nurses' Union members.)

H1N1

- Dr. Barbara Yaffe Toronto Star October 4
- “People have to get their own information and make their own decision” Daughters story”

Purposes of Health Care

- People and communities seek health care in order to
  - Improve comfort
  - Improve function
  - Increase life span
  - Acquire information about ones health

Are the goals of health care measureable?

- Comfort
  - Subjective, do you feel better? Has your pain decreased?
  - CIHI Board chair does not believe this is valuable?
- Function
  - Measurable
    - How much more can you do? Does your knee have a full range of movement? Are you able to work?

APACHE II Score for ICU Mortality

Does the patient have a history of chronic organ insufficiency or immunocompromise?

- ☐ Yes, and is s/p emergency surgery.
- ☐ Yes, but is not s/p operation.
- ☐ Yes, and is s/p elective surgery.
- ☐ No.

Does the patient have acute renal failure?

- ☐ Yes.

Age _____ years old

Temperature (Rectal, Celsius) _____ ° C

pH (Arterial) _____

Heart Rate _____ bpm

Respiratory Rate (either ventilated or spontaneous) _____ bpm

TIME TO FAILURE-INDUSTRIAL MODEL

- Dr. Ken Rockwood and Arnold Mitniski at Dalhousie – time to failure using industrial model
- "Mortality in older subjects results from a combination of biological, functional, psychological, pathological, and environmental factors, tools that effectively identify patients with low life expectancy should take a multidimensional approach."

- *Rejuvenation Res.* 2008 February; 11(1): 151–161.

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NIHMSID: NIHMS45525

Development and Validation of a Multidimensional Prognostic Index for One-Year Mortality from Comprehensive Geriatric Assessment in Hospitalized Older Patients

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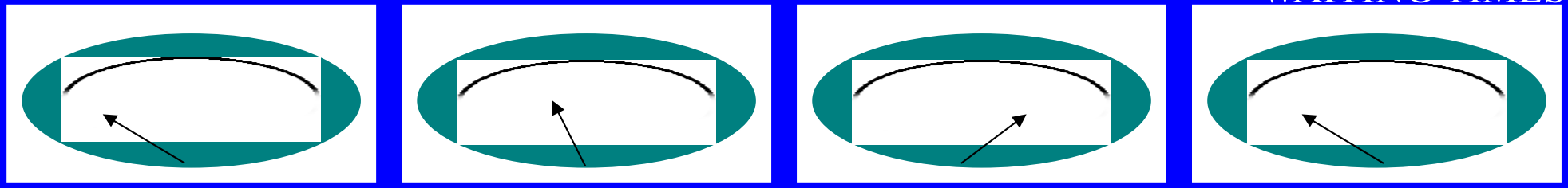
Abstract

Our objective was to construct and validate a Multidimensional Prognostic Index (MPI) for 1-year mortality

COMFORT FUNCTION SEVERITY ACCESS/ WAITING TIMES



VALUE = COST FOR A BENEFIT

BENEFITS = CHANGES IN

-COMFORT, FUNCTION,

LIKLIHOOD OF DEATH

.COSTS= FINANCIAL/HUMAN

WAIT TIME, FATE OF WAITING PATIENTS

DALHOUSIE University

Benefits and Harms of Care

- Few treatments help everyone
- Most treatments hurt someone
- THE KEY CONCEPT IN TREATMENT IS
- Numbers Needed to Treat and
- Numbers Needed to Harm (NNT-NNH)

NNT

- Would you take a drug if there was 1 chance in 100 that if you took it for 5 years you might not get a heart attack or stroke?
- What if there was 1 chance in 23,000?

Lipitor, cholesterol lowering

- According to the manufacturer if 100 people at high risk take Lipitor 2 will have a heart attack or stroke. If they take a placebo (pretend pill) 3 people will have a heart attack or stroke.
- This is a 33% reduction in the risk of stroke or heart attack
- But only 1 fewer stroke or heart attack if 100 people take it for 5 years.

Celexa

- According to the manufacturer
- 9 depressed people have to take the drug for one to benefit. But about 1 person in four will suffer from side effects such as weight and appetite change, change in libido, and there is some thought that antidepressant drugs might be associated with an increase in suicide.
- WHAT DOES INFORMED CONSENT MEAN IN THIS CONTEXT?

Efficiency

- Costs = financial and personal
- FOR A
- Benefit = changes in comfort, function, life span and new knowledge about a condition

- EFFICIENCY = COST/BENEFITS

For Journalists and Informaticians

- Gather information about how many people are helped or harmed by a proposed intervention?
- What are the characteristics of people who are helped? Harmed? Does the intervention improve comfort/function or life span?
- What are the financial and personal risks/costs associated with the treatment?

Evaluating Health Programs

- Efficiency = cost for a benefit
- Reducing costs just means paying less
- In health care saving money means either paying people less or firing people.
- Saving money doesn't mean much unless there is some information about what is achieved.
- Spending money doesn't tell you about value withou information about benefits and harms

- Can you think of other ways to save money when the bulk of payment –over 70% is on wages?

YOU CAN'T MANAGE WHAT YOU DON'T MEASURE

- HEALTH SYSTEM MISTAKES
- WAITING TIMES
- OUTCOMES
- EFFECTIVENESS AND EFFICIENCY OF PROGRAMS

Gathering Information about how Health Care Functions

- Canadian Institute for Health Information
  - Source of Macleans reports
  - Over 2 Billion Dollars of Canadian Resources
  - QUANGO
  - QUASI AUTONOMOUS NON GOVERNMENAL ORGANIZATION
  - Private not for profit?
  - Reviews chart of every patient admitted to hospital

CIHI

- Information about activity and results but not outcomes sent to CIHI with offices in Ottawa and Toronto
- Discharge Abstract Data Base provides information about length of stay by diagnosis
  - No adjustment for severity
  - Some people with pneumonia very sick, others not so

Camp Hill Medical Centre (CHMC)

Comparison lengths of stay / All patient services - CHMC
Pre and post complexity study area / April 1 to September 30, 1993

The following is camp Hill Medical Centre data used by CIHI for their complexity project. It does not reflect all discharges for all services. For example ENT, Psychiatry and Opthalmology.

Service	Total Cases	Total Matched Cases	% Matched Cases	CHMC Mean	Pre-Complexity Data: Dbase Mean	Pre-Complexity Data: Days ov/und Dbase	Post Complexity Data: Dbase Mean	Post Complexity Data: Days ov/und Dbase
10 General Medicine	1812	1320	72.8%	*8.5	6.1	2.4	8.3	0.2
30 General Surgery	963	812	84.3%	*7.8	6.8	1.0	9.4	-1.5
39 Urology	440	395	89.8%	5.5	5.4	0.1	6.8	-1.3
***31 Cardiovascular Surgery**	**431**	**370**	**85.8%**	**9.5**	**8.8**	**0.7**	**13.2**	**-3.7**
55 Gynecology	365	344	94.2%	*6.3	5.4	0.9	5.9	0.4
34 Orthopedics	356	328	92.1%	7.3	7.3	0.0	10.3	-3.0
01 Family Practice	150	111	74.0%	*10.2	7.0	3.2	9.9	0.3
60 ENT	102	89	87.3%	5.6	6.0	-0.4	7.3	-1.7
62 Opthalmology	53	50	94.3%	*4.8	7.9	-3.1	11.0	-5.2
Miscellaneous	134	126	n/a	n/a	n/a	n/a	n/a	n/a
Hospital Totals	**4806**	**3895**	**81.0%**	***7.9**	**6.5**	**1.4**	**8.9**	**-1.0**

**Statistical significance is determined by comparing the distribution of matched cases rather than placing emphasis on the average. Data will be identified as significant if it contains an abnormally high proportion of cases either in the lower or upper quartiles. The emphasis is placed on skewed distribution of cases.*

Source: Complexity Project, CIHI / Provided by: Maureen Aucoin, Health Records

Outcomes

- CIHI does not capture information about the outcomes of care except for a project in rehabilitation medicine
- Capital Health = about $1 Billion
- What did we get? How many people, better, worse or about the same

Changes in Comfort, Function, Life Expectancy Not Known

MARCH 16, 2000

[redacted]

Health Card No: [redacted]

MSI Service Audit

As part of the operation of the MSI Program, a designated number of services submitted to MSI by physicians and other providers are audited. This is a routine audit and services are selected on a random basis. The purpose of the audit is to verify that the information reported on services is accurate.

A service paid by MSI on your behalf has been selected for audit. The details are shown below. If you received the service and the information shown below is correct, please sign the letter. If the information is incorrect, write your comments on the back of the letter. Please return the letter in the enclosed confidential envelope.

If you have any questions please contact PAT ROBERTS, 496-7116 OR TOLL FREE AT 1-800-563-8880.

PROVIDER: [redacted]
PATIENT:

Service Date	Type of Service	MSI Payment*
FEB 7, 2000	OFFICE VISIT	$ 20.24

LEAGUE TABLES

ANNUAL LEAGUE TABLES:LONGITUDINAL STUDY BMJ JUNE 1998

- ***"ANY ACTION PROMPTED BY ANNUAL LEAGUE TABLES WOULD HAVE BEEN EQUALLY LIKELY TO HAVE BEEN BENEFICIAL, DETRIMENTAL OR IRRELEVANT"***

AUDITOR GENERAL

"In relation to the Canada Health Act, I observed that Health Canada does not have the information it needs to effectively monitor and report on compliance. So, within those areas of federal responsibility it is clear that better quality information is required."

(Dennis Desautels, Jan. 2000 response to OID)

Mount Sinai Example
The Role of Coding

- Department of Medicine accrued about $8,000,000 more with shift to concurrent coding. They looked better, but no changes in administrative or clinical behavior.
- Other organizations looked comparatively worse
- When someone has numerous problems which one is ‘MOST RESPONSIBLE’

CIHI Remark
Coding Remains a problem

Effective immediately, we are removing Complexity Overlay from our Case Mix Groups, Resource Intensity Weights and efficiency reports. The need to differentiate complex patients in efficiency measures such as length of stay comparisons remains. We feel, however, it is necessary to remove this tool from use until after its re-development based on ICD-10-CA/CCI data.

QUALITY AND SAFETY IN HEALTH CARE

An international peer review journal for health professionals in quality improvement and patient safety

Quality and Safety in Health Care 2008;**17**:234-235; doi:10.1136/qshc.2008.029595

EDITORIAL

Editorial

Healthcare system error: beyond apology

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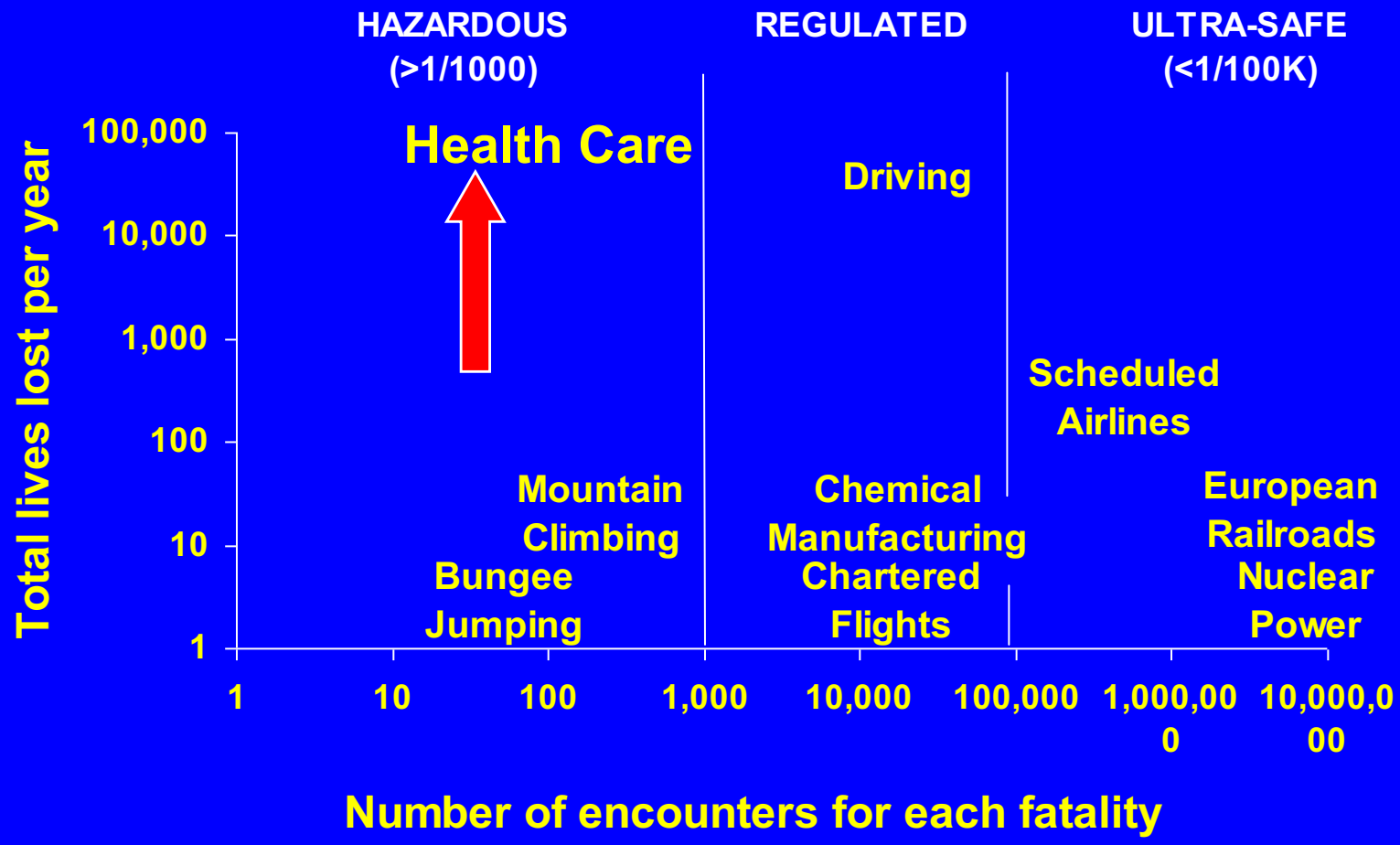
The first 150 words of the full text of this article appear below.

When a healthcare professional commits an error that results in an adverse patient outcome, it is increasingly considered appropriate that an apology should be made to the harmed person.[1] [2] Such an apology benefits both the health professional and the patient, and serves to address the considerable emotional burden that accompanies this wrenching aspect of practice ***(see page 249)***.[1] The process of apology invariably calls for candid self-reflection and, in the best of circumstances, leads to better and safer care. It emphasises that healthcare is at its heart a social process that contains predictable human emotions that contribute to its value but can

How Hazardous Is Health Care?



Leape et.al.

Are Treatments Safe?
Canadian Adverse Events Study 2004

- In Canada, Baker et al. suggest hospitals are not safe
  - Baker et al. estimate that 3 in 200 patients admitted to Canadian Hospitals are killed because of preventable adverse events.
- Adverse events 7.5/100 admissions
- Preventable 37.5% 2.8/100 admissions
- Deaths 21% **1.5/100** admissions

Baker GR, Norton PF, Flintoft V et al.: The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada. CMAJ 2004; 170(11): 1678-86

Are We Better or Worse?

- Government, as evaluator and regulator, their normal role would not tolerate this level of preventable death, discomfort and disability.
- Unfortunately, in this case the regulator is the monopolist. The hand they slap is their own!

Issues related to Quality of Care

- Effectiveness
  - Outcomes
  - Health System Error
- Efficiency
  - Cost for a benefit
  - 811 Number
  - Role of patient preferences?
- Stewardship
  - Error Tolerance
  - Health care an unregulated monopoly

Paradox of ethics review

Efficiency

- Visit to family physician office COST?
- Call to 811 number-nurse line COST?
- It has been reported that visits to the Capital Health ERs has increased dramatically.
- Marked increase in Code SENSELESS (census) meaning the ER is not available, and patients diverted elsewhere

Unnecessary Work
Do We Need More Doctors?

- Chest surgery story
  - 1 or 2 days per week for surgery at most
  - Block is lack of access to Operating room despite long waits. Would more surgeons doing research or on the golf course help this problem?

- Family Medicine
  - Simple visits-blood pressure checks, refills of drugs that are frequently used, going to doctors office for laboratory tests

Unnecessary Work

- Urologists in Toronto have made results of PSA tests available to patients over the web, at a secure web site so they don't have to meet patients after each periodic test, and so that patients don't need to find parking space.
- In Halifax you cannot get results from the lab. The lab won't send you result even if you and your doctor ask them to.
- THE RESULT IS INCREASE IN PREVENTABLE HARM FROM LOST REPORT.

President Obama and Saving Money

- Saving Money means spending less
- Salaries are the largest part of health budgets
- Saving money (spending less) means firing people
- Who would be fired?
- What are the constituencies in health care

Constituencies have **Professional and Financial Interests**

- Clinicians- individual care, increase revenue
  - Doctors, nurses, pharmacists, physiotherapy and more
- Health services administrators-populations, spend less
  - Hospitals, clinics,
- Governance-influences goals and policy-
  - Government, insurance companies

Role of profit? Large salaries (700,000 to 1.5 million) influence our ability to provide care?

What does “not for profit” mean?

Constituencies

- Employers
- Workers compensation board- get people back to work- priority care for their people
- Patients- spend more, better care
- Relatives-spend more better care
- Healthy tax payers-spend less, save money
- Can you suggest other constituencies?

Health Care Controversies

- Goal
  - Excellent care for all, rich and poor alike
  - Agreement by left, right and centre
- Controversy is over the means not the ends

CANADIAN HEALTH CARE CONFLICT OF INTEREST

- GOVERNMENT'S ROLE
  - REGULATOR AND EVALUATOR
- AIRLINE INDUSTRY
  - GOVERNMENT INSISTS THAT DANGEROUS PROBLEMS ARE RESOLVED
- HEALTH CARE
  - GOVERNMENT IS THE REGULATOR AND ADMINISTRATOR
  - HEALTH CARE IN CANADA, AN UNREGULATED MONOPOLY

A Working Health System

- Social Capital should **not** be the currency of health care
- Single tier for quality not necessarily for price
- Currently government prefers some people to others and makes it difficult for people to get the same services as their neighbors

Felderhoff cooperative

- One practice with primary care nurses and IT paid for by government
- Neighboring practice 4,000 patients and one doctor, no additional government support
- Dr. Felderhoff suggested that people pay to support equal services
- Government in a snit!

Shedding Light on Health Care! 9 suggestions for journalists

1. **Encourage independent evaluation – strengthen government's role as regulator**

2. **Encourage valid and reliable information and methods, not the methodological "rot" as reported recently in an article in *The Economist***

3. **Insist that health systems provide information about the results of care -- numbers needed to treat and numbers needed to harm -- so that patients, governments and administrators can use appropriate information to guide care.**

A Light on Health Care! Nine Things You Can Do

4. **Encourage doctors and health organizations to provide accurate information about the consequences of waiting**

5. **Insist that health organizations tell people the waiting time for services**

6. **Discourage the services by unregulated monopolies**

A Light on Health Care! Nine Things You Can Do

7. **Encourage service delivery by the public or private sector, whoever does it best**

8. **Insist on competition with adaptation to the current environment, and variations on service delivery as a means for continuous improvement**

9. **Support health insurance with a deductible as recommended by Tommy Douglas, Senator Kirby and others. Wealthy would pay more directly for care**