



Costos evidentes y ventajas ocultas de la calidad



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El costo evidente y las ventajas ocultas de la calidad



Los **costos**
constituyen una
caja negra tanto
para los
prestadores como
para los pagadores

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Hay un costo evidente
Fallas percibidas

Hay costos ocultos de evitar
las malas cosas

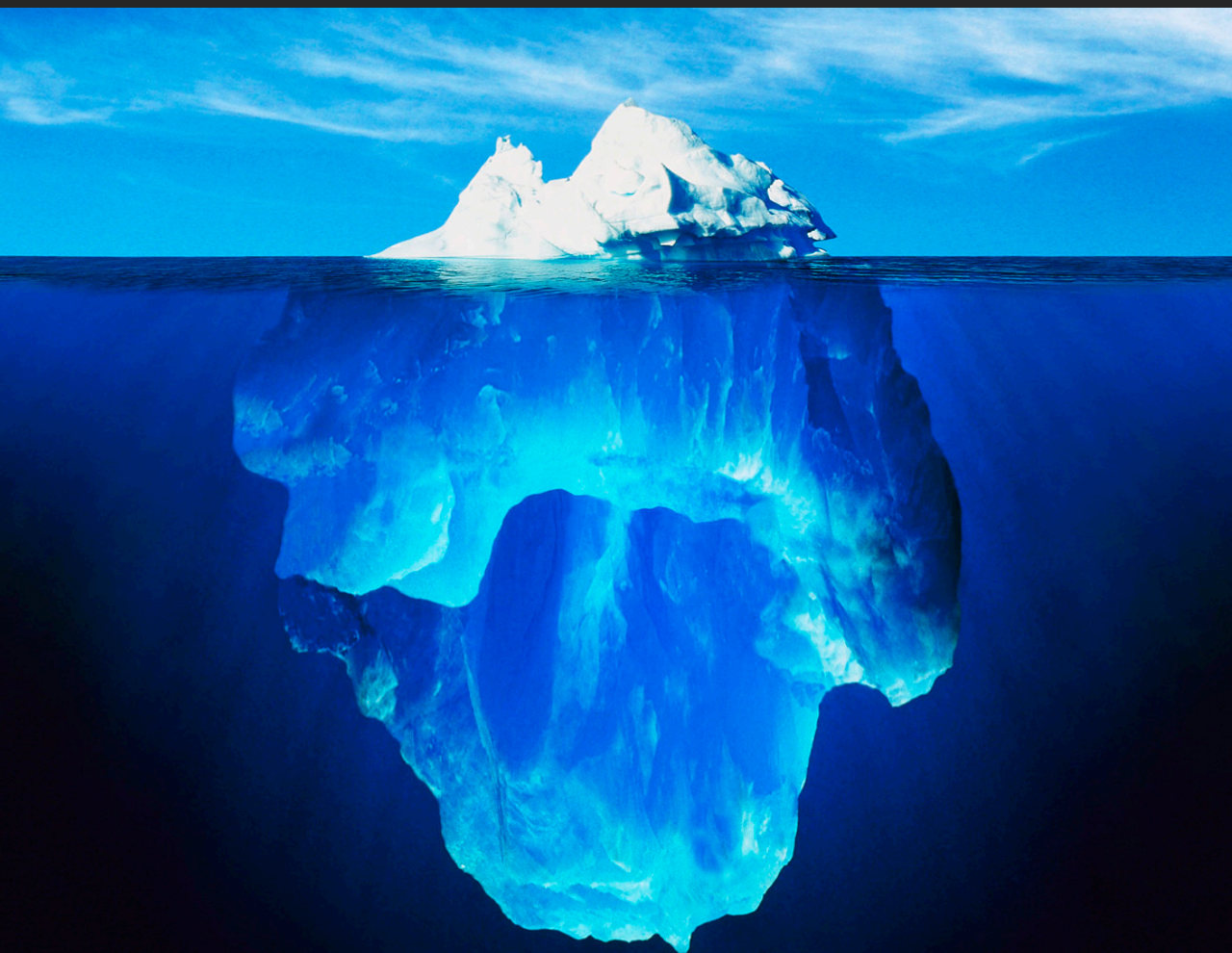
**Pero nadie mide con certeza el
costo de la mejor calidad**

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Mamparas con parlantes: 650.000

Office pre medicación: 6.000.000

Bala Neumática Farmacia: 4.000.000

Botón pánico baños: 750.000

Paneles dashboard P-S-I: 5.000.000

REUSO.....



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SPC SOFTWARE

HOME / TRAINING & CERTIFICATION / PROCESS EXCELLENCE BOOKS / THE HANDBOOK FOR QUALITY MANAGEMENT: SECOND EDITION / EXCERPTS FROM THE HANDBOOK

Excerpts from The Handbook for Quality Management | Table of Contents

Excerpts from The Handbook for Quality Management

Preface

Thank you for your interest in McGraw Hill's Handbook for Quality Management.

The original version of the text, first released in 1996 by Quality Publishing, was written exclusively by Tom Pyzdek. I had the pleasure of editing a revision released in 2000, which included Six Sigma and Lean method chapters (written by myself), as well as Bill Dettmer's Constraint Management material which is repeated in this edition. The early editions sold several thousand copies by the end of 2000, establishing the Handbook as an essential desktop reference for the quality professional.

The earlier versions relied heavily on the American Society for Quality (ASQ) body of knowledge for quality managers, even to the extent that the chapter headings and sub-headings matched those in the body of knowledge. Although this may have helped those seeking to check off items they learned, it tended to disrupt the flow of the topics. A main objective of this edition was the reorganization of the material into more naturally flowing discussions of the concepts and methods essential to quality management and operational excellence.

The essential body of knowledge for achieving operational excellence is heavily influenced by the works of Deming and Juran, most of which date from the period of 1950 through the mid 1980's. These authors spent their careers advocating a scientific approach to quality, displacing the widely-held notion that quality assurance inspections prevalent in the post-war era were sufficient or even credible approaches to achieving quality.

**Calidad: hacer las cosas bien y
*evitar hacer las cosas mal***

**El costo de la calidad se ha
centrado en *el 2do término*
(prevención, evaluación y fallos)**

No mide costo de hacerlo bien



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Annals of Internal Medicine®

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< PREV ARTICLE | THIS ISSUE | NEXT ARTICLE >

REVIEWS | 1 JANUARY 2013

The Association Between Health Care Quality and Cost: A Systematic Review

Peter S. Hussey, PhD; Samuel Wertheimer, MPH; Ateev Mehrotra, MD, MPH

Article, Author, and Disclosure Information

FULL TEXT



MORE ▾

Abstract

Background: Although there is broad policy consensus that both cost containment and quality improvement are critical, the association between costs and quality is poorly understood.

Purpose: To systematically review evidence of the association between health care quality and cost.

Data Sources: Electronic literature search of PubMed, EconLit, and EMBASE databases for U.S.-based studies published between 1990 and 2012.

Study Selection: Title, abstract, and full-text review to identify relevant studies.

Data Extraction: Two reviewers independently abstracted data with differences reconciled by consensus. Studies were categorized by level of analysis, type of quality measure, type of cost measure, and method of addressing confounders.

5441 / 61

**Costo: diferentes implicancias
(staff enfermería vs. Facturas)**

34% asociación positiva

Estandarizado x riesgo: 78%

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The Dartmouth Atlas of Health Care

The Center for the
Evaluative Clinical Sciences
Dartmouth Medical School

1996

**Gasto Medicare 3 patologías
Cadera – Ca. Colon - IAM**

Variabilidad 60%

Sin correlación en mortalidad

Podría reducir el Gasto un 30%

No se estandarizó por riesgo

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the NATIONAL BUREAU of ECONOMIC RESEARCH

Do High-Cost Hospitals Deliver Better Care? Evidence from Ambulance Referral Patterns

Joseph J. Doyle, Jr., John A. Graves, Jonathan Gruber, Samuel Kleiner

NBER Working Paper No. 17936

Issued in March 2012

NBER Program(s): Aging, Health Care, Health Economics

Endogenous patient sorting across hospitals can confound performance comparisons. This paper provides a new lens to compare hospital performance for emergency patients: plausibly exogenous variation in ambulance-company assignment. Ambulances are effectively randomly assigned to patients in the same area based on rotational dispatch mechanisms. Using Medicare data from 2002-2008, we show that ambulance company assignment importantly affects hospital choice for patients in the same zip code. Using data for New York state from 2000-2006 that matches exact patient addresses to hospital discharge records, we show that patients who live very near each other but on either side of ambulance-dispatch boundaries go to different types of hospitals. Both strategies show that higher-cost hospitals have significantly lower one-year mortality rates compared to lower-cost hospitals. We find that common indicators of hospital quality, such as indicators for "appropriate care" for heart attacks, are generally not associated with better patient outcomes. On the other hand, we find that measures of "leading edge" hospitals, such as teaching hospitals and hospitals that quickly adopt the latest technologies, are associated with better outcomes, but have little impact on the estimated mortality-hospital cost relationship. We also find that hospital procedure intensity is a key determinant of the mortality-cost relationship, suggesting that treatment intensity, and not differences in quality reflected in prices, drives much of our findings. The evidence also suggests that there are diminishing returns to hospital spending and treatment intensity.

Sistema de ambulancias

Centros Alto costo

Correlaciona con mortalidad

20 - 30% menor mortalidad

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Ageing and Health

#yearsahead

Populations are getting older



Percentage aged
60 years or older:

- 30% or more
- 10 to <30%
- <10%

2015

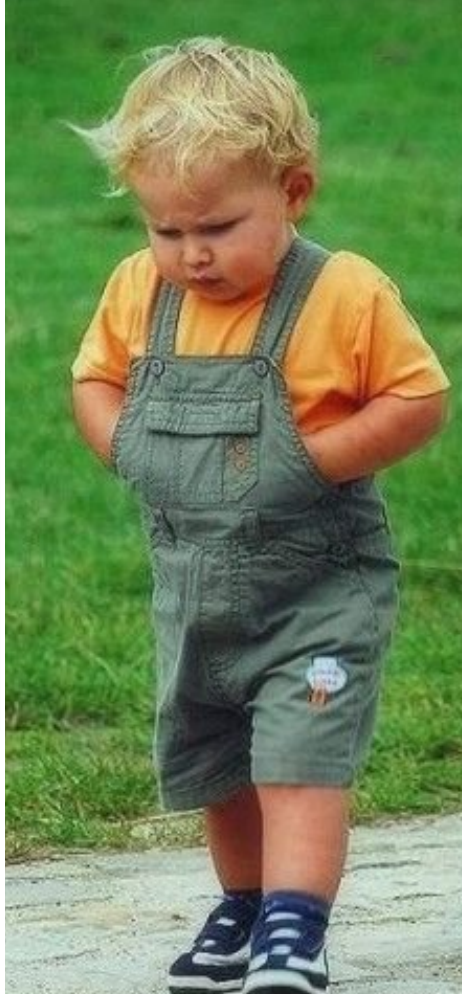
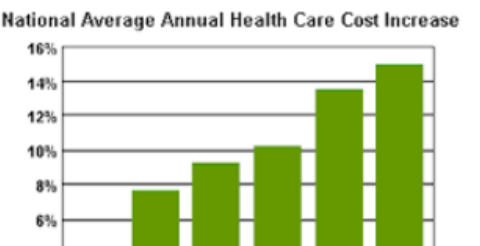
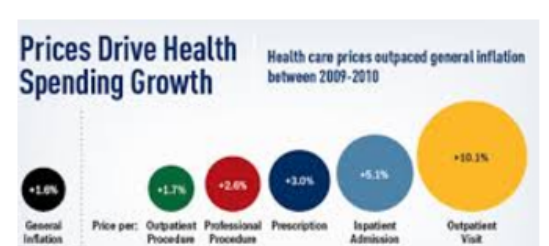
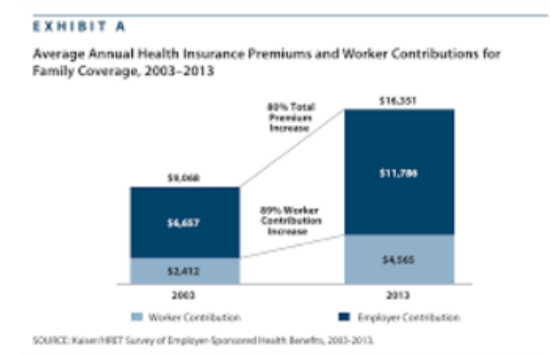
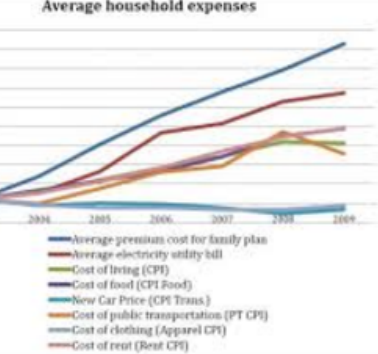
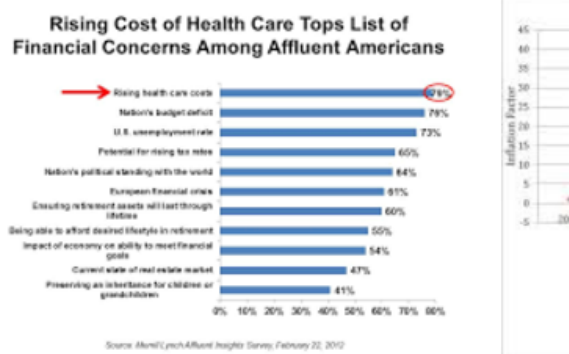
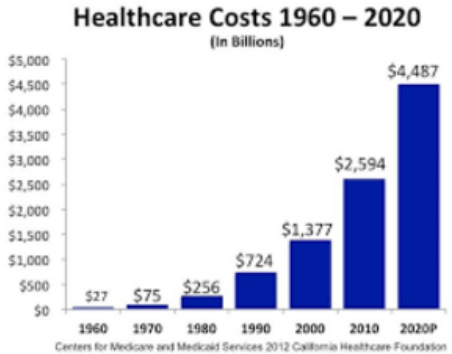
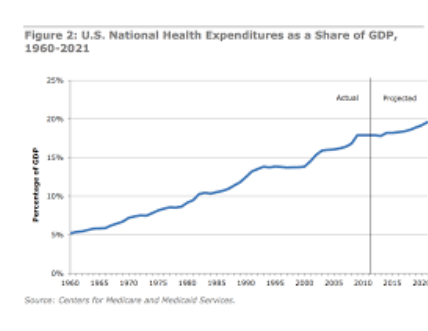
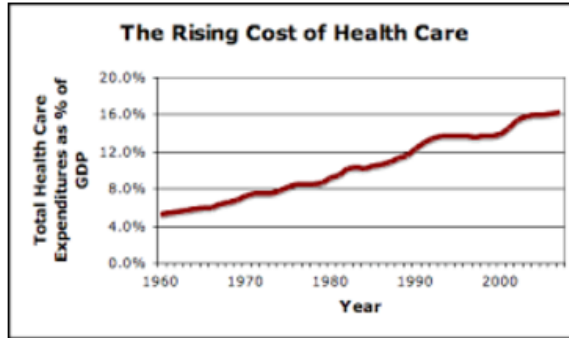
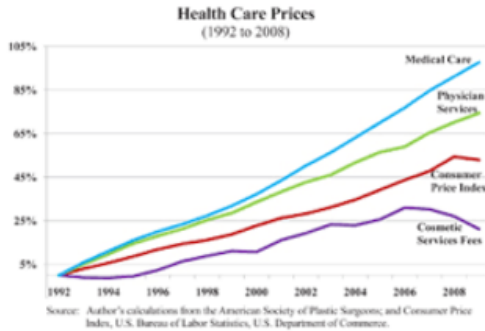


World Health
Organization



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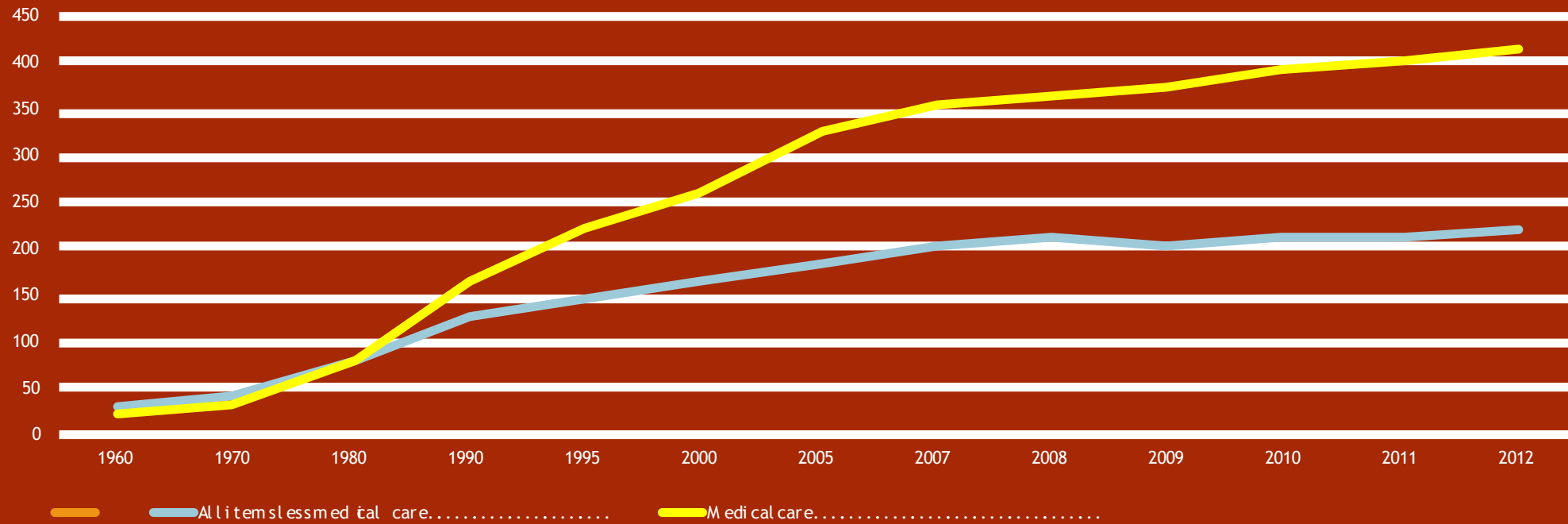


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Inflación general vs. Inflación de Salud



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	2008	2009	2010	2011	2012	2013	2014	2015	2016 ⁽¹⁾	2017 ⁽²⁾
VALOR BRUTO DE PRODUCCIÓN A PRECIOS BÁSICOS	1.906.269	2.043.466	2.727.713	3.579.679	4.297.499	5.424.021	7.403.186	9.501.705	13.107.167	16.752.145
Servicios auxiliares a la actividad financiera	5.696	6.447	8.286	11.343	14.378	18.395	24.297	31.950	43.803	59.664
ACTIVIDADES INMOBILIARIAS, EMPRESARIALES Y DE ALQUILER										
Servicios inmobiliarios con bienes propios y arrendados						9.493	586.648	790.329	1.063.726	1.448.203
Resto						2.517	155.271	205.877	281.992	390.538
ADMINISTRACIÓN PÚBLICA Y DEFENSA; PLANES DE SEGURIDAD SOCIAL										
ENSEÑANZA										
Enseñanza Pública	43.529	54.143	66.158	92.123	117.657	147.987	197.807	281.368	376.058	484.847
Enseñanza Privada	17.440	22.163	28.200	38.334	49.366	63.118	86.727	122.322	170.763	225.066
SERVICIOS SOCIALES Y DE SALUD	60.256	81.032	103.769	145.175	191.549	249.431	340.346	464.786	659.817	853.115
Salud pública	18.622	24.049	29.735	40.091	50.781	66.111	90.093	125.256	165.717	216.135
Salud Privada	41.634	56.983	74.033	105.083	140.768	183.320	250.253	339.530	494.100	636.980
OTRAS ACTIVIDADES DE SERVICIOS COMUNITARIAS, SOCIALES Y PERSONALES	55.618	66.657	84.972	110.557	140.575	178.444	235.668	315.352	430.023	562.732
Eliminación de desperdicios y aguas residuales, saneamiento y servicios similares	6.299	7.930	9.967	12.738	16.385	22.050	28.466	38.463	55.666	75.988
Asociaciones	19.190	24.033	32.513	44.151	58.555	75.445	101.752	138.669	187.710	247.505
Servicios culturales y deportivos. Otras actividades	30.129	34.694	42.492	53.667	65.635	80.949	105.450	138.220	186.647	239.299
HOGARES PRIVADOS CON SERVICIO DOMÉSTICO	7.307	9.166	11.199	14.653	19.636	25.960	33.886	44.540	58.837	74.889

853.115/16.752.145
5,2% PBI

Informe de avance del nivel de actividad
Primer trimestre de 2018

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Heart, Lung and Circulation (2014) 25, 807–810
1443-9506/04/\$36.00
<http://dx.doi.org/10.1016/j.hlc.2014.03.027>

ORIGINAL ARTICLE

Cost Benefit for Assessment of Intermediate Coronary Stenosis with Fractional Flow Reserve in Public and Private Sectors in Australia



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R. Bhindi, MBBS PhD FRACP ^b, G.A. Figtree, MBBS PhD FRACP ^b,
G.I.C. Nelson, MBBS FRACP PhD ^b,
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^aRoyal North Shore Hospital
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Background Fractional Flow Reserve (FFR) is a proven technology for guiding percutaneous coronary intervention (PCI), but is not reimbursed despite the fact that it is frequently used to defer PCI.

Methods Costs incurred with use of FFR were compared in both the public and private sectors with the costs that would have been incurred if the technology was not available using consecutive cases over a two year period in a public teaching hospital and its co-located private hospital.

Results FFR was performed on 143 lesions in 120 patients. FFR was < 0.80 in 37 lesions in 34 patients and 25 underwent PCI while 11 had CABG. It was estimated that without FFR 78 lesions in 70 patients would have had PCI with 17 patients having CABG with 35 additional functional tests. Despite a cost of \$A1200 per wire, FFR actually saved money. Mean savings in the public sector were \$1200 per patient while in the private sector the savings were \$5000 per patient.

Conclusions FFR use saves money for the Federal Government in the public sector and for the Private Health Funds in the private sector. These financial benefits are seen in addition to the improved outcomes seen with this technology.

Keywords Coronary intervention • Fractional flow reserve • Cost effectiveness • Revascularisation • Coronary artery bypass grafting

Introduction

Fractional Flow Reserve (FFR) (where the functional significance of an infarct-related coronary stenosis is assessed by

modern interventional cardiology. When the FFR shows the stenosis is not haemodynamically significant, percutaneous coronary intervention (PCI) results in an excess of adverse outcomes [1], while when the stenosis is haemodynamically

Murphy et al, Sydney University. 2014
2 años de uso FFR. 120 pac
FFR vs no FFR

Ahorro de A\$ 1.200 en sector público
Ahorro A\$ 5.000 en sector privado 20

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ORIGINAL RESEARCH ARTICLE

Clinical Outcomes and Cost-Effectiveness of Fractional Flow Reserve–Guided Percutaneous Coronary Intervention in Patients With Stable Coronary Artery Disease

Three-Year Follow-Up of the FAME 2 Trial (Fractional Flow Reserve Versus Angiography for Multivessel Evaluation)

BACKGROUND: Previous studies found that percutaneous coronary intervention (PCI) does not improve outcome compared with medical therapy (MT) in patients with stable coronary artery disease, but PCI was guided by angiography alone. FAME 2 trial (Fractional Flow Reserve Versus Angiography for Multivessel Evaluation) compared PCI guided by fractional flow reserve with best MT in patients with stable coronary artery disease to assess clinical outcomes and cost-effectiveness.

METHODS: A total of 888 patients with stable single-vessel or multivessel coronary artery disease with reduced fractional flow reserve were randomly assigned to PCI plus MT (n=447) or MT alone (n=441). Major adverse cardiac events included death, myocardial infarction, and urgent revascularization. Costs were calculated on the basis of resource use and Medicare reimbursement rates. Changes in quality-adjusted life-years were assessed with utilities determined by the European Quality of Life–5 Dimensions health survey at baseline and over follow-up.

RESULTS: Major adverse cardiac events at 3 years were significantly lower in the PCI group compared with the MT group (10.1% versus 22.0%;

William F. Fearon, MD*
Takeshi Nishi, MD*
Bernard De Bruyne, MD,
PhD
Derek B. Boothroyd, PhD
Emanuele Barbato, MD,
PhD
Pim Tonino, MD, PhD
Peter Jüni, MD
Nico H.J. Pijls, MD, PhD
Mark A. Hlatky, MD
for the FAME 2 Trial Inves-
tigators

Fearon et al, Stanford University, 2108
3 años de seguimiento
PCI vs Trat. Médico

Costos superior en agudo
Costos iguales a 3 años
MACE 50%
Revascularización 1/4
Mortalidad 20%

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Curar pocas veces, aliviar a menudo, consolar siempre

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Muchas Gracias

