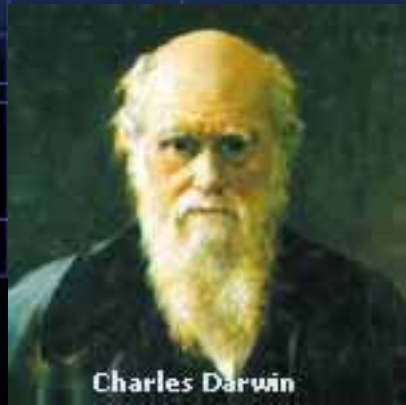


# Clinical Prioritisation for a Hospital

SPNHIA Workshop  
October 2007



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**"Oh, we tried a nurturing corporate culture,  
but we found the law-of-the-jungle mentality  
is what keeps our competitive edge.."**

# Background - I

- The ADHB Clinical Practice Committee (CPC) was set up in response to managerial restructuring and the ongoing frustration that clinicians had in being held accountable for productivity without control over resources (space, FTE and capital items)
- The model used was from the Mayo Clinic where a clinician body examines service restructuring and new technology requests
- The ADHB CPC therefore antedated the Service Planning and New Health Intervention Assessment (SPNHIA) initiative.

# Background - II

- Once the SPNHIA framework was published, every effort was made to ensure that the ADHB CPC conformed to the 'local' category of SPNHIA structure
- The focus has been on being 'the DHB-level gatekeeper on service change and new health interventions' – Page 10
- More recently we have been conforming to the horizon scanning component of the local structure requirement. We have used the material produced by the Health Policy Advisory Committee on Technology in Australia

# Tools of the trade - I

- It was clear from the outset that the majority of the work was going to be the evaluation of innovative or augmented treatments and that these would be quite diverse
- We therefore needed some very clear 'ground rules' regarding the assessment of such technologies/treatments that allowed comparison for the sake of prioritisation

# Example scoring tool

## Indicative Scores

### Quality of Evidence

	A	B	C	D
Submission indicates that, for the diagnostic group in question, procedure costs will be reduced with either an improvement or no change in outcomes (cost neutrality point expected <b>within first 12 months</b> )	100	90	40	30
Submission indicates that, for the diagnostic group in question, procedure costs will be reduced with either an improvement or no change in outcomes (cost neutrality point expected <b>within first 2 years</b> )	90	80	35	25
Submission indicates that, for the diagnostic group in question, procedure costs will be reduced with either an improvement or no change in outcomes (cost neutrality point expected <b>within first 3 years</b> )	60	50	30	20
Submission indicates that, for the diagnostic group in question, procedure costs will remain neutral but outcomes will improve	60	50	30	20
Submission indicates that, for the diagnostic group in question, procedure costs will be increased but patients will likely experience significantly improved overall survival rates	40	30	20	10
Submission indicates that, for the diagnostic group in question, procedure costs will be increased but patients will likely experience significantly reduced morbidity rates	20	15	10	5

# Modifiers

- These were based on priorities established by the ADHB (ADHB Strategic Plan) and by the Ministry of Health
- Points were given for specified disease entities, categories of patient and policy adherence (e.g. improving access, improving the knowledge regarding resource utilisation for high cost therapies)
- Points were also given for cost-effectiveness. Up until now this has been only in terms of life-years. As of this week we are moving to cost utility analysis (incremental cost per QALY).

# Tools of the trade - II

- Members of the CPC must be capable of critical evaluation of medical literature
- Submissions are made through a purpose built website with the assistance of our CPC manager (includes literature searches, advice about costing formats etc)
- Submitters appear in person before the committee, speak to the subject and answer questions from CPC members
- 2 members of the 12 person committee are asked to be primary reviewers – all score



# Clinical Practice Committee

[Click here](#)

*(All Medical Practitioners will...) "accept a responsibility for assisting in the allocation of limited resources to maximise medical benefit across the community"*

(a Principle of Ethical Behaviour, New Zealand Medical Association, Code of Ethics, 2004).

# Mission Statement

**"Using the combined expertise of its members, the Clinical Practice Committee will use an open, fair and transparent process to assess submissions with resource implications".**

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# Submissions to date - I

- ABO Incompatible Live Donor Kidney Transplantation
- Creation of a sustainable Hospital Palliative Care Team (HPCT) for ADHB
- Rituximab for severe systemic lupus erythematosus
- Home humidification for head and neck surgery and radiotherapy
- Testing for Long QT syndrome (LQTS) in young sudden death victims
- Service Interface Behaviour
- CT PET scans - criteria (patient selection) for referral to Australia
- Increase in Cytogenetic testing
- Palivizumab to Prevent RSV Infection in Paediatrics with Broncho-Pulmonary Dysplasia
- Hyperbaric Oxygen Therapy

# Submissions to date - II

- Left Ventricular Assist Devices: A bridge to transplantation and recovery
- Pre-filled, pre-labelled Midazolam Syringes for anaesthesia Levels 4, 8 and 9 ACH
- Basiliximab induction therapy in renal transplantation.
- ABO Incompatible Live Donor Kidney Transplantation: re-submission
- Medical Termination of First Trimester Pregnancy
- Photodynamic Therapy for unresectable cholangiocarcinomas
- Bariatric Surgery
- ICDs for primary prevention of sudden cardiac death
- Vagal Nerve Stimulation (VNS) for epilepsy
- Deep Brain Stimulation (DBS) for Parkinson's disease

# Outcomes

- The CPC is advisory to ADHB management (direct report to deputy CMO, quarterly to the CEO)
- Cost saving or cost neutral innovations that score well – adoption recommended
- Innovations that would incur added costs and that score poorly – adoption not recommended (or disinvestment recommended)
- Innovations that score well but would incur added costs have almost always had regional or national implications – these have ‘gone to the next step’

# The next step - I

- In the SPNHIA framework, the next step for technologies such as: LVADs as a bridge to heart transplantation; Implantable defibrillators for heart failure patients; Photodynamic therapy for cholangiocarcinoma; Vagal nerve stimulation for intractable epilepsy and Deep brain stimulation for movement disorders is the 'Regional Forum'
- The Regional Forum has certain responsibilities under the SPNHIA guidelines

# The next step - II

- The Regional Forum should: ‘enable DHBs to deliver a ... cost-effective regional configuration of health services and the introduction of new interventions’; ‘horizon scan for new health interventions that should be subject to formal assessment’; ‘horizon scan for services and health interventions that are obsolete..’; ‘collaborate with Regional Capital Committees..’; ‘provide analytic support to assist in the preparation of proposals for change and business cases for the introduction of service changes and new interventions with regional or national impacts’; and ‘be regional-level gatekeepers for service change and new health interventions proposals’
- It is expected that each Regional Forum will have a Secretariat (with analytical support) and a Work Plan.

# The next step - III

- In terms of what is required or expected of a SPNHIA Regional Forum, we do not yet have such an entity in the Auckland region
- Nevertheless, the LVAD proposal did get through to the National decision making structure of SPNHIA, the National Service and Technology Review Subcommittee (NSTR)
- The LVAD proposal has had a business case developed. This mature proposal has been through the various reference groups including the Service Framework Group and Service Improvement Group and eventually was viewed by each DHB CEO
- Whilst there is a loose agreement that LVAD therapy as a bridge to transplantation is reasonable, no outcome has occurred (funding from National Service Funds vetoed) – this has taken around 14 months.

# CPC perspective - I

- The members of the ADHB CPC believe wholeheartedly in the evidence-based approach to the acquisition of new health technologies or the resiling of old ones. We enjoy this work as we believe it is fair and transparent and has great potential to pick the best of the plethora of novel technologies
- We are hampered by the lack of a clear 'next step' for technologies that are of regional or national significance that cost more than current therapies but that score well (e.g. therapies that cost well under \$50,000 per QALY)

# CPC perspective - II

- Whilst it would help the CPC to have an extant Regional Forum with proper health technology assessment 'horsepower', the key impediment to success, as we see it, is the lack of a clear track for well-evidenced technologies to be funded at the far end of the SPNHIA/NSTR process
- What lies in wait at the end of the process, as it stands, is the need to obtain consensus from 21 DHB CEOs to give up some of their existing budgets for a new technology

# CPC perspective - III

- The innovators in the medical community that have made submissions through our committee that require one or more 'next steps' through the SPNHIA process are already getting agitated and annoyed. In the past, these same people found other avenues to get new health technology into practice (stealth, politics, the private sector etc)
- The 'other avenues' are not subject to careful technology review. We must improve or replace SPNHIA as soon as possible to avoid disenfranchisement

# Suggestions for the future

- There has to be an identifiable funding stream for new technology that does not detract from current DHB 'core business'
- A good model to look at is the Medical Services Advisory Committee (MSAC) in Australia which carefully evaluates new technology and then makes recommendations to the Minister for Health and Aging. That Minister then makes a funding decision.
- Of course alternatives that 'repair' SPNHIA exist but all would include an additional, contestable fund for new technology

