



Integration in Healthcare

A **Canada-Wide** Opinion Leader View

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Today's Presentation

- Future of Healthcare Study
- Objectives & Forces for change
- An overview of change: 2005-2012+
- The role of integration
- Closing



Why Integration?

Conclusion from "Future of Healthcare in Canada, 2005."

The key theme of healthcare change for the next decade will be integration.

INTEGRATION* =

COORDINATION + PARTICIPATION + SHARED RESPONSIBILITY

INTEGRATION \neq SINGLE COMMAND & CONTROL STRUCTURE

** As defined by The Brondesbury Group, 2005.*



Future of Healthcare Study

*“If you think the natives are stupid,
You haven’t been here long enough.”*

Mark Twain, The Innocents Abroad, 1869.



Future of Healthcare Study

- How will healthcare delivery change over the next 5-7 years? What impact will this have?
- Sponsored by Royal Bank of Canada & Manulife
- Repeat of 1995 Study sponsored by RBC alone
- Independent – No agenda – Good track record

- Opinion leader study across Canada
 - 86 face-to-face interviews with opinion leaders – 2 hours per
 - 55 core + 31 specialized
 - Extensive process to identify opinion leaders
 - Method derived from Delphi technique

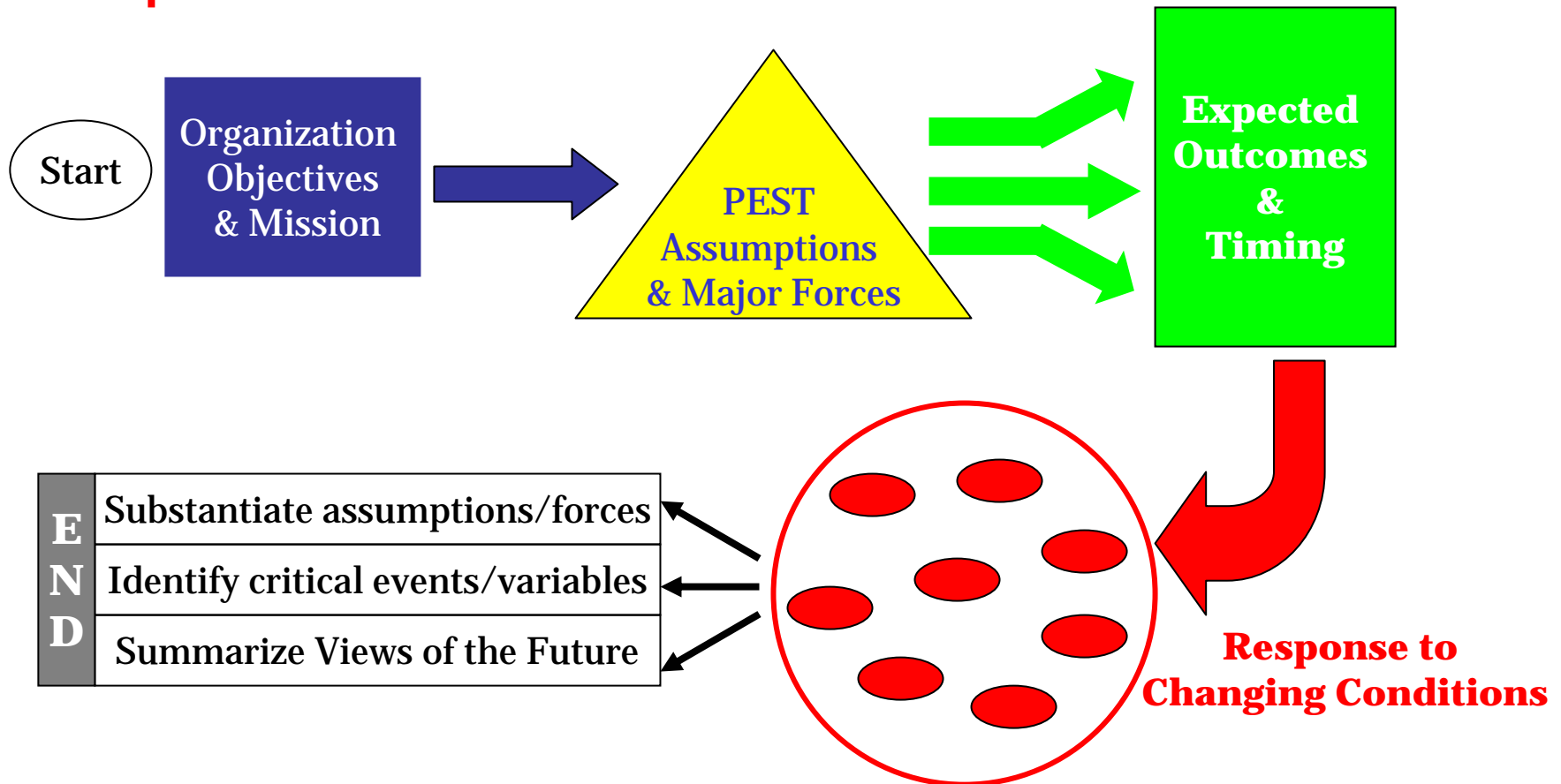


A Look at the Opinion Leader Study

- Highly structured personal interviews (~ 2 hours) – professionally conducted
- Opinion Leaders are people who make the future happen, as a result, their views are more predictive
- Diverse informants means all sides of the issue are examined. Despite diversity, views converge quickly
- Sophisticated analysis of futures information: PEST and cross-impact analysis, N6 content analysis and more
- Report on what will happen, why & when



An Opinion Leader Interview





Finding Opinion Leaders

- **Contact & nomination process until convergence**
 - Identify people that colleagues consistently identify as “people making the future happen”. Over 160 people, identified from presentations and publications, helped us find the right people.

- **Key Informants from diverse backgrounds**
 - Healthcare corporations/hospitals of all sizes
 - Long-term care & rehab. organizations
 - Government
 - Associations and Councils
 - Academics
 - Community Health
 - Specialized consultants



Five Big Changes since 1995

- Hospital care became healthcare
- More focus on “the patient experience” today
- Leadership shifted out of hospitals
- More complex because of more aims and integration
- Opinion leaders more optimistic today



Healthcare Objectives Today

*What are opinion leaders
trying to accomplish?*



Opinion Leader Objectives

- **Focus on Patient Experience**
 - Improve Access to care
 - Improve Quality of care
 - Reduce adverse patient events
 - Ensure day-to-day Delivery of care to patients
- **Improve System Operations**
 - Improve cost-effectiveness of healthcare
 - Foster positive change in healthcare (Leadership)
 - Educate healthcare professionals
 - Research on health-based issues
- **Improve Population Health**



Forces at Work – P.E.S.T.

■ Political Forces

- Public pressure is forcing political action
- Governments are not providing **coordinated** leadership
- Election cycle affects funded initiatives
- Jobs are a political issue

■ Economic Forces

- Lack of information on supply, demand, capacity & output allows inefficiencies
- Costs rising faster than inflation or GDP
- Drive to improve use of resources
- Traditional methods of compensation dysfunctional



Forces at Work – P.E.S.T.

■ Social-Demographic Forces



- ***Shortage of skilled healthcare personnel***
- Aging population
- More chronic illness in the populations
- Consumers expect a “patient-centric” system

■ Technological Forces



- New technologies raise ethical questions
- Significant changes in drug care
- Diagnostic imaging is high demand
- ***IT infrastructure for improved costs & outcomes***
- Willingness to adopt new technology is “uneven”



Overwhelmed Yet ?

Let's see what opinion leaders plan to do about the forces at work...

Let's take a look from the mountain top.



An Overview of Change

*Opinion Leader views of
2005 – 2012 and beyond*



Improve Patient Experience

REALIGNMENT

| |
|------------------------------------|
| Private Delivery of Public Care |
| Private Pay for Optional Care |
| Shift Care to the Patient & Family |

ACCESS

MANAGEMENT

| |
|------------------------------|
| Alternative Delivery Methods |
| Manage Access Demand |

INTEGRATION

| |
|----------------------------|
| Primary Healthcare Team |
| Chronic Disease Management |



Improve System Operations

REALIGNMENT

Public-Private
Partnerships (P3)

ACCESS MANAGEMENT

Match Demand
and Supply

Manage Access
Supply

INTEGRATION

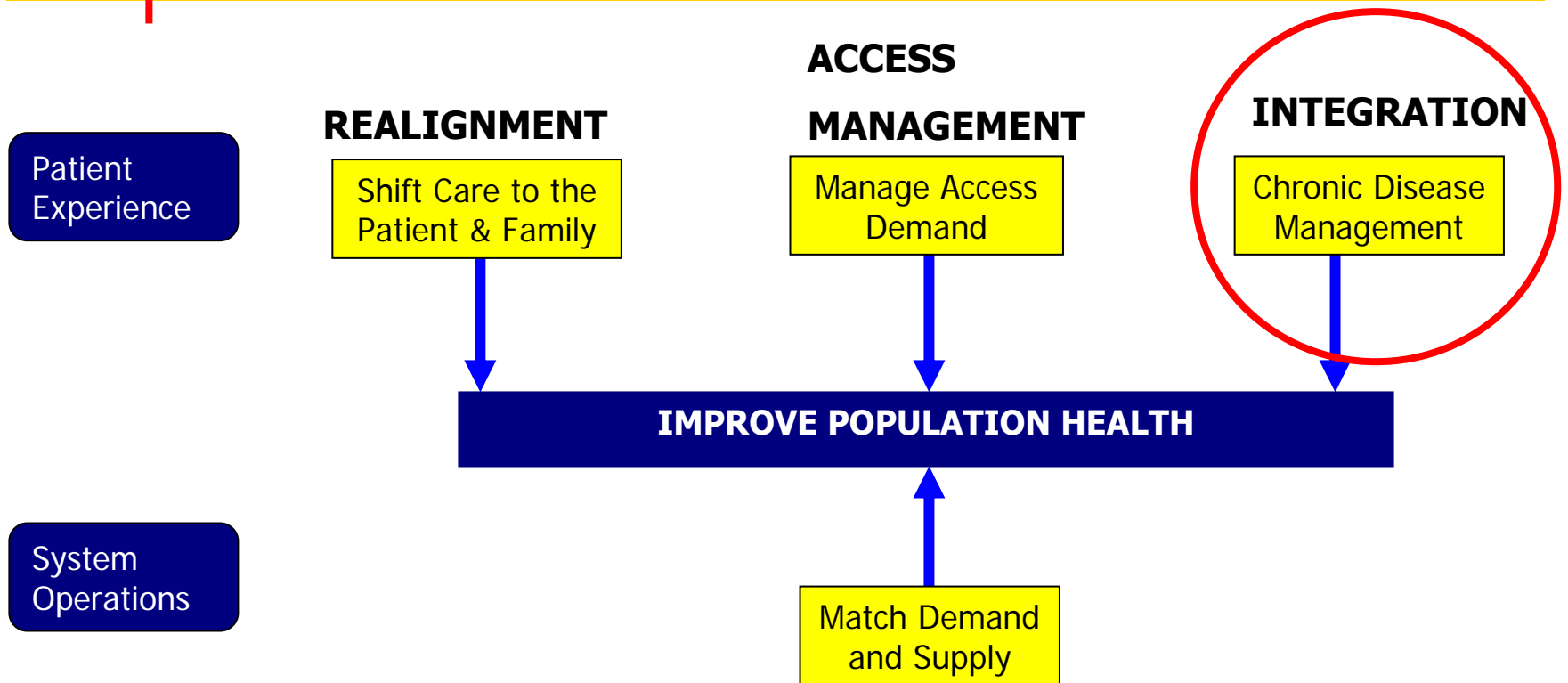
Cooperative IT
Infrastructure

Common Review
of Drugs & Tech

Shared
Administration

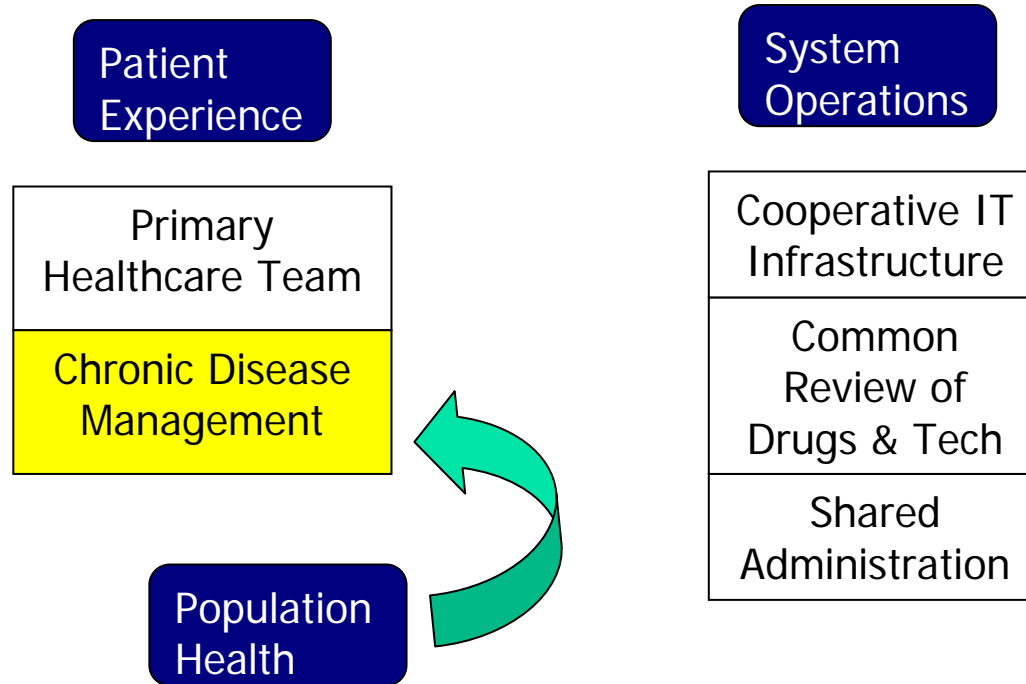


Improve Population Health





Five Integration Themes





The Role of Integration

*A Little more detail about
the future and integration*



Primary Healthcare Team

(2005-2010)

- PHT will be the foundation for integrating healthcare
 - Development well along in West
 - Physician and/or EPN + adapted team members
 - Pharmacist, educator, PT, OT, social worker, case manager +
 - Focal point for coordination of resources
 - Responsible for “hand-off” between treatment locales
- Improve quality, access & adverse events
 - Assessment, treatment, coordination and education roles
 - Help take the “seams” out of healthcare
 - Potentially more cost-effective – Need new compensation



Primary Healthcare Team

"Need to move to teams of mixed professionals. "Mall medicine" - can't get the same doctor, but other is available at 'off hours'... Same for specialists... Growth of multi-physician centres with physicians and nurses. Pushing to add pharmacists, PT, etc." (Government)

"Move to interdisciplinary teams. The healthcare system is not a system. Teams bring together fragmented care. We are moving care to a seamless system, including the patients." (Hospital)

"We will have a different distribution amongst various professional groups of what their responsibilities will be, e.g. nurses will do more active acute care such as nephrology, dialysis. They will do more without physician oversight. Physiotherapists will do more rehabilitation work. Technicians doing some of the nurse's work like monitoring, IV administration. Changing scope of practice. More inter-practice between professionals. Attitude is breaking down in the younger care givers, more collaboration with patients and families. Patients are more knowledgeable and we have to treat more than a narrow disease. We have to treat the whole person." (Academic)



Chronic Disease Management

(Patient Experience: 2009-2012)

- A key focus for PHT
 - Moving away from reactive treatment to proactive
 - Diabetes, Asthma, Arthritis, CHF, COPD & Dialysis
 - Coordinate monitoring, treatment & education
- Two main aims for CDM
 - Keep patients out of the hospital
 - Halt the progressive impact of their disease
- Major supports for success
 - Tele-health initiative
 - Satellite treatment centres with inter-provincial agreements
 - Integrated practice standards and care guidelines



Chronic Disease Management

(Population Health: 2009-2011)

- Major aims of CDM for population health
 - Disease prevention, early identification, screening
 - Education of patients to minimize impact
 - **Biggest shift** – more patient responsibility for own health

- Key Elements in Community/Population Health
 - Foster personal responsibility for health and care
 - Re-engineer processes to make “self-care” more practical
 - Plain language communications – culturally adapted
 - Supply information for care decisions
 - More shared patient responsibility in Assisted Living Centres



Chronic Disease Management

“Chronic disease management is key to future system health. Prevent acute episodes and secondary complications. The System now rewards episodic care. We need to intervene to reduce the incidence of sequelae. The Family Healthcare Team will help, but we need to integrate them with the rest of system.” (Government)

“Connecting with community at large... we cannot do it all. Health councils in neighbourhoods which include mayors, recreation departments, local hospital... engage the population. They can push wellness issues.” (Regional/Hospital)

“Radical change is needed in managing chronic disease. Common focus to prevention and disease management. Less grouping by disease and more by need. For example, diet management is key for diabetes, heart disease etc.” (Government)

“Wellness. Prevention. Screening. More effort... Develop plans where you pay less, if you get the screening... More emphasis on screening.” (Government)



Common Review – Drugs/Tech

(System Operations: 2005-2007)

- Cooperation in sharing review information
 - Coordinated reviews of drugs and medical technology
 - Cooperation to support mutual self-interest

- Cooperative efforts evolving rapidly
 - CCOHTA and others now
 - Expect that reviews done in one province (*and perhaps some OECD countries*) will be accepted by others as sufficient evidence for decision-making
 - Expect common core formulary of drugs that every province (*either openly or tacitly*) deems acceptable
 - NO national pharmacare – Feds coordinate catastrophic drugs
 - Shared bulk buying of core drugs by several provinces



Shared Administration

(System Operations: 2008-2010)

- Coordination among health facilities for non-core management functions
 - Extension of outsourcing trend begun a decade ago
 - Now extended to payroll, HR, accounting & other ops
 - Might extend to endowment funds & charitable donations
 - Some local IT initiatives will revert to provincial control

- Executives focus more on risk management
 - Professional liability, physical premises, natural disasters
 - Infectious outbreaks
 - Shortages of skilled staff
 - Financial risks (currency, cash flow, etc.)



Coordinated IT infrastructure

(System Operations: Mostly 2010 and beyond to achieve)

- IT infrastructure for patient & operational information
 - Clear thrust in every jurisdiction & opinion leader group

- Three main directions
 - Evidence-based decision-making systems
 - Resource allocation – supply, demand, capacity management
 - Identification of cost-effective treatments & practices
 - Comprehensive electronic health records (EHR)
 - Improves quality, reduces adverse events, more cost-effective
 - Currently a patchwork of local & special purpose applications
 - **PAIN issues** (**P**rivacy, **A**uthenticity, **I**ntegrity, **N**on-repudiation)
 - **Shared Service Organizations for non-core administration**



Coordinated IT infrastructure

“IT and health records have the ability to have a positive impact on the preventive side... Ability to share records more appropriately i.e. drug interaction/duplication of lab testing. Benefits of IT will be seen more on the quality side than on the time side.”
(Community Health)

“Implementing management practices - patient flow, supply chain redesign, outsourcing, performance management, etc. Allow us to provide more care at lower cost.”
(Regional/Hospital)

“Need to involve users in the creation of the systems or our investment will go to waste. Need to understand and put into practice the psycho-social side of computing.” (Academic)

“Resources should focus on capturing information that is locally available first, and then move to strategies that generate new information. ... We can probably get 80% of the value from an EHR at a relatively reasonable cost. Pursuing the hard-to-get information that might make an EHR more perfect - that last 20% -- should not be a priority over the next 5-7 years.” (Future of Healthcare Report, 2005, page 59)

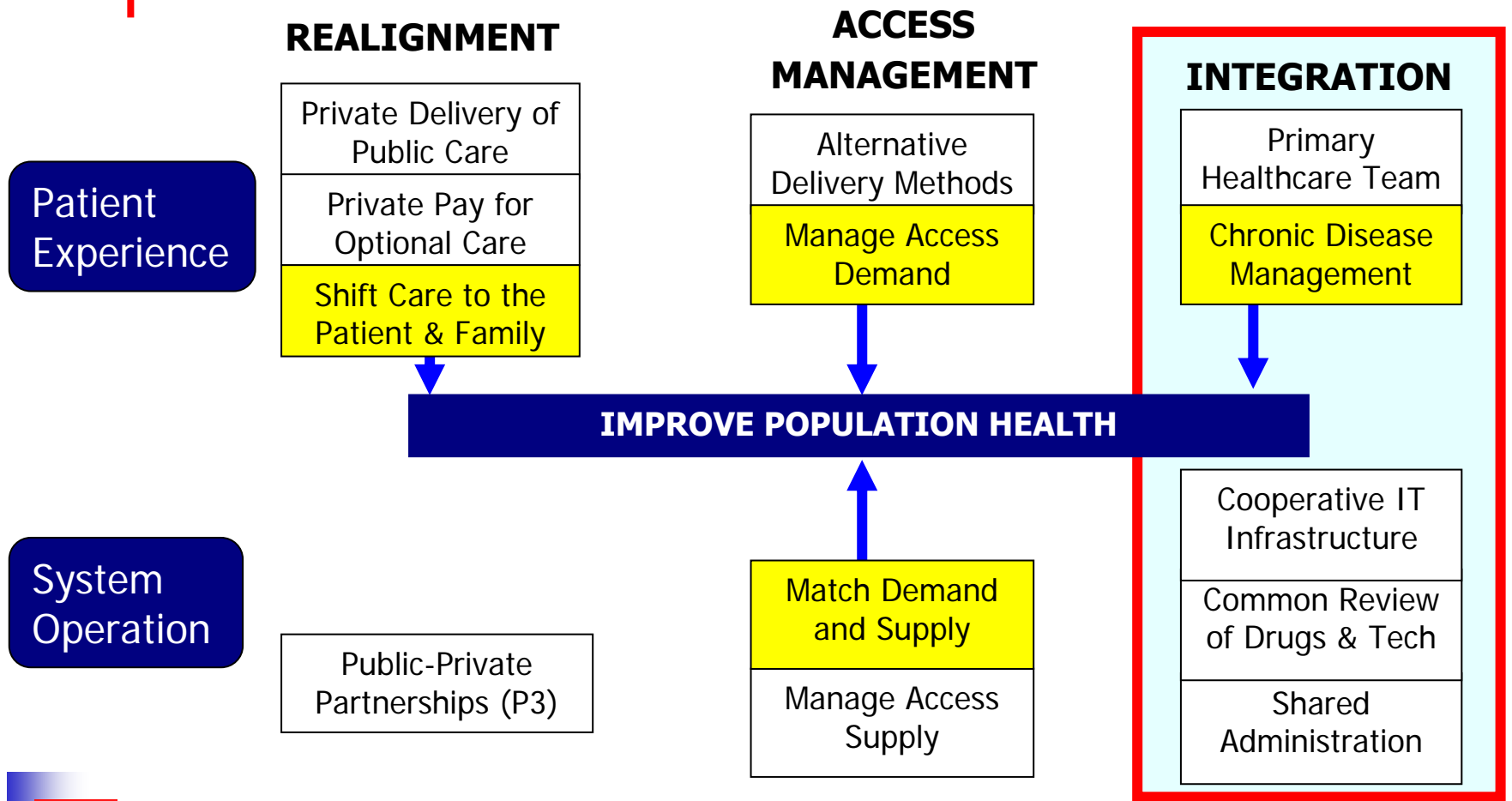


Closing Words

A Few Words About the Future



Integration is Only Part of the Future





But ...

- Integration is a key theme for the next decade
- It happens at different rates in different areas
 - Driven by politics, socio-demographic trends, economics & technology
 - There are 100's or 1000's of initiatives making it happen
- While opinion leaders have proved overly optimistic about time lines in the past, their predictions typically happen
- This is not what we want or what we think should happen...
What you have heard is what is most likely to happen



What Matters Most for UMNO Members



The Brondesbury Group EHR Model ©



THANK YOU

(And thanks to Royal Bank and Manulife)

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