Further Reading

Linked Healthcare

Taken from a speech delivered by Hon. Deb Matthews, Minister of Health and Long-Term Care, Ontario at the final conference session of HealthAchieve, Nov. 7, 2012.

Deb Matthews

We need to work to link all the health care providers in a given geographic area who are providing care to individuals in the top 1% or top 5%. So that primary care docs know when their patients are getting care elsewhere – in the hospital, from the specialist, from home care. So that all the providers have the same information about a patient: what medication they are on, what tests they have had and what those results are…

Then we need that network of linked health care providers to work as a team to collectively manage the needs of those patients with the greatest needs, in partnership with family and community, so they move smoothly through the system, always confident that they're being looked after. That they don't fall through the "gaps" in the system. They will work to ensure that there is one "most responsible provider" for each patient. Someone responsible for making sure that that patient is getting the right care, at the right time, in the right place. That the patient is getting pro-active care. To keep people out of hospital, out of long-term care.

…that's why I'm very happy to announce that in coming weeks, you'll be hearing about a competition for early-adopters of this new way of caring for people.

Working with the LHINS, we will be asking partners to work together on their proposals and describe how they would reach our common goals, like better care for high needs patients, and lower re-admission rates. We recognize that the proposals from rural and northern communities will look different from those in the cities. But start talking now. The potential here is unlimited.

I see a time, somewhere in the future, where this integrated model will exist right across the province. But we need to start learning about how best to provide coordinated, pro-active care, and I don't think there's a better way to do that then to put out a call to Ontario's most innovative health care leaders.

Our job, at the Ministry is to enable this kind of transformation.

Our new motto is: if it's better for patients, and it's better value for money, then YES, WE CAN!

Deputy Saäd Rafi has even appointed a new Associate Deputy Minister, Helen Angus, to drive this kind of transformation. I call her the "silo-buster". Her job is to remove barriers to innovation, so we can provide better care to our patients and get better value for money.

Further Reading

Eight Step Change Model

John P. Kotter

Kotter's eight step change model can be summarized as:

Increase urgency – inspire people to move, make objectives real and relevant.

Build the guiding team – get the right people in place with the right emotional commitment, and the right mix of skills and levels.

Get the vision right – get the team to establish a simple vision and strategy, focus on emotional and creative aspects necessary to drive service and efficiency.

Communicate for buy-in – Involve as many people as possible, communicate the essentials, simply, and to appeal and respond to people's needs. De-clutter communications – make technology work for you rather than against.

Empower action – Remove obstacles, enable constructive feedback and lots of support from leaders – reward and recognize progress and achievements.

Create short-term wins – Set aims that are easy to achieve – in bite-size chunks. Manageable numbers of initiatives. Finish current stages before starting new ones.

Don't let up – Foster and encourage determination and persistence – ongoing change – encourage ongoing progress reporting – highlight achieved and future milestones.

Make change stick – Reinforce the value of successful change via recruitment, promotion, new change leaders. Weave change into culture.

Kotter's eight step model is explained more fully on his website www.kotterinternational.com

About the Author
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Acknowledgment
John P. Kotter is internationally known and widely regarded as the foremost speaker on the topics of Leadership and Change. His is the premier voice on how the best organizations actually achieve successful transformations. The Konosuke Matsushita Professor of Leadership, Emeritus at the Harvard Business School and a graduate of MIT and Harvard.

Further Reading

Improving Healthcare Delivery Through Integrated Patient Care

Barry Burk

While little has changed recently in terms of healthcare's challenges – including an aging population driving increasing demand for services, and rising costs consuming disproportionately large portions of provincial budgets – we see analytics technologies continuing to speed advances in quality of care.

This smarter approach to healthcare turns data into clinical and business insights for better outcomes. It instruments processes with those insights in real time for point-of-care decisions and productivity. It allows care teams to view information seamlessly across the continuum, allowing them to plan patient-centered, holistic approaches emphasizing prevention and wellness.

It's an idea whose time has come. While healthcare organizations are amassing vast amounts of data, and the number of published healthcare articles annually is measured in the 100,000s, "multiple versions of the truth" lead to errors across multiple settings. Physicians have been on information overload for decades, contributing to the estimated 15 per cent of diagnoses that are inaccurate or incomplete, according to an April, 2010 article in *Harvard Business Review*.

In addition, the practice of focusing on acute care, to the detriment of proactive wellness, prevention and population health strategies, is unsustainable. Preventing recurring admissions, complications and errors, delayed diagnoses and ineffective treatment therapies can all help ensure more patients stay below the 'acute care threshold' and its significant cost implications.

It's a point that's easy to concede, but difficult to address, as it requires clinicians to identify which patients are at highest risk of readmission, predict which will require acute care, prescribe the best treatment options for that individual patient, and monitor compliance of care plans across a number of caregivers.

Managing high-cost patients and keeping them out of acute care is being looked at by more jurisdictions as an untapped opportunity to enhance quality, reduce costs, reduce readmission, and improve the delivery of safe and effective care for patients. But it's an approach all patients can benefit from, and it requires improved

coordination among all levels of caregivers, from acute and primary to community-based care.

Today, IBM is working with many forward thinking organizations around the world applying analytics to help them create new data-driven insights to identify high risk patients, uncover early intervention opportunities to reduce onset or readmission; and coordinate a patient-centred care plan, shared among a care team, the patient, and the patient's family. The adoption of these technologies based on big data provides one of the best ways we see to accelerate change in the healthcare space.

IBM is working with clients across Canada to build a sustainable healthcare system that can deliver better patient care and outcomes. Along with our partners, IBM brings together deep expertise in managing and integrating solutions which are redefining value and success. Together we are helping to build a smarter healthcare industry.

For more information
visit www.ibm.com/healthcare/ca

Barry Burk is Vice-President,
Healthcare Industry,
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Further Reading

Health Links: How To Successfully Execute A Great Idea

John Ronson

Ontario's Health Links initiative was announced by Minister of Health and Long-Term Care Deb Matthews in November, 2012. It is aimed at better meeting the healthcare needs of that small percentage of individuals who are attempting to manage multiple chronic conditions such as diabetes, depression, congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). These individuals struggle to manage their conditions successfully in a highly fragmented system, often ending up in the emergency department or admitted to hospital because of uncoordinated primary and specialty care. This population also consume a disproportionate share of healthcare resources, ultimately putting system sustainability at risk.

The essence of strategy is the focused application of resources against an important organizational or system opportunity or problem. The high users of a healthcare system present both a problem and a potential opportunity. Focusing on meeting their needs may result in both better healthcare and also system savings. Whether the cut-off point is the top 1% of users or the top 5%, we know that they use a vastly disproportionate share of system resources. This is not an original idea (see Kaiser Permanente's pyramid and a multitude of other examples) but it may be a timely one. One clinical leader told me recently that this is the first major public policy initiative he has seen where there is virtual unanimity that we are pursuing the right goal and the right target population. In hundreds of conversations over the past year he has not heard a single dissenting voice signaling that this is the wrong public policy objective.

So we have the right target. How are we doing on execution?

Following the Minister's announcement, the Ministry picked 19 pilot sites across the Province and should get full marks for its choices. The essence of care for high system users is coordinating and integrating care for these individuals across primary care, acute care and homecare. A lead organization was designated for each of the 19 projects and they were chosen from a selection of primary care

(Family Health Teams and Community Health Centres), acute care hospitals and homecare (Community Care Access Centres). Primary care is potentially the most problematic because it is so fragmented in many communities, so again the Ministry chose wisely in picking communities like Barrie and Peterborough, which both have large and inclusive family health teams, to be part of the initial wave of projects.

The Ministry also required each of the Health Links projects to have its business plan "signed off" by its regional Local Health Integration Network ("LHIN") before it was submitted. The Ministry provided little direction on the contents required in the business plans and there was a wide variety of interpretations taken by the LHINs on their level of involvement in coordinating the submissions. At one end of the spectrum, some LHINs allowed the lead organization to in fact lead and the key primary care, acute care and home care organizations to self-organize to come up with a proposal to address the needs of high system users. At the other end, some LHINs effectively assumed the lead role, mandating who should be at the table and what the direction of the business plan should be. Unfortunately, some lost the thread – too many players at the table is not always helpful. Marginalizing acute care organizations, which happened in a number of instances, means that Health Links projects cannot and will not succeed. The three-legged stool of primary, acute and homecare is essential to the public policy objective being achieved. A two legged stool tips over!

Ontario has also created a very challenging environment in which to implement new policy initiatives because it has not chosen a regional health authority approach like that adopted by other Canadian provinces. The end result is a multiplicity of delivery and planning organizations with competing and overlapping mandates. The author has written elsewhere (see LHINs at Five Years – What Now? *Healthcare Quarterly*, 2011 and Local Health Integration Networks: Will "Made in Ontario" Work? *Healthcare Quarterly* Vol. 9 No. 1, 2006) about the challenges of the Ontario approach, but rolling-out a major change

initiative such as Health Links will put coordination across multiple organizations to a true test.

The second provincial challenge is one of measuring success. Ontario has spawned a variety of agencies that impose a variety of reporting demands on healthcare organizations. These requirements are in addition to Ministry and national (Canadian Institute for Health Information) requirements and have resulted in literally hundreds of aspects of healthcare delivery and outcomes being measured and presumably monitored. The danger for Health Links is that there need to be just a handful of critical measures agreed to and reported so that public accountability is clear for an initiative that will be critical but also expensive.

There are also Health Links projects chasing technological solutions that will almost certainly fail because they do not adequately take into account the needs of clinicians. Zero or minimal disruption to clinical workflow is essential. This means single-sign-on through either the electronic medical record (EMR) for community-based clinicians or through the clinical information system (CIS) for hospital-based providers. Next, providers want only the clinical information that is essential to treating their patients. Time after time clinicians identify the big four categories as: medication history, lab results, diagnostic images and summary reports such as discharge summaries and radiology reports. Finally, clinicians want complete data sets. If they can't trust the information because something may be missing, they won't use it.

The Ministry has correctly identified that some aspects of Health Links are better done provincially (or perhaps regionally) rather than locally. Ontario has invested major taxpayer resources in a variety of healthcare technology initiatives. In most instances it may be better to complete what we've started rather than invest in something new. The Ontario Telemedicine Network is working on developing an effective home health monitoring solution and has learned many of the hard lessons along the way. Most, if not all, of the Health Links projects will want to incorporate home monitoring as part of clinical oversight of their identified patients. Even the

Ontario Laboratory Information System (OLIS), a historic money pit, is showing signs of life and, more importantly, clinical utility and may prove useful as the Health Links projects move to implementation.

Finally, the Ministry, the LHINs and the first wave of projects need to remember that Health Links fundamentally needs to be a clinical initiative. Primary care, acute care and home care are the key actors. The handful of chronic diseases that require focused attention are the same across all projects, although the chosen starting point may be different. A diabetes patient in Toronto is no different than a diabetes patient in Prince Edward County. Some of the infrastructure to support these patients may vary, but we must not lose sight of this reality.

Health Links has the potential to be a game-changer for patients who need it most and a key measure in ensuring the sustainability of our overall healthcare system. It is critical to get this right.

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Further Reading

The Great Canadian Healthcare Evasion

Jeffrey Simpson, The Globe and Mail

Health care remains the biggest no-go zone in Canadian public discussion. According to University of Toronto president David Naylor, it's "the third rail of Canadian politics," a U.S. expression denoting something as lethal as the electrical rail in a subway.

Professor Naylor should know. He has been around medicine, public policy and health-care policy all his adult life as a physician, Rhodes Scholar in public administration and dean of medicine. But even he won't touch one part of that "third rail," the competition for public funds that postsecondary education continues to lose to health care. It's too risky a comparison for a university president with a huge faculty of medicine and links to some of Canada's leading hospitals.

Nonetheless, Prof. Naylor is frustrated by the unwillingness of Canadians and their politicians even to debate health care. For him, the essential public system should be maintained, but Canadians don't confront the question of how.

Health care's share of every provincial budget is rising year after year, but that has led to what he calls "one of those great Canadian evasions." There would be no question of sustaining ever-higher health-care spending if Canadians were willing to pay more tax or constrain other areas of government spending. But they prefer to limp along with costs that grow by more than government revenues adjusted for inflation and population.

"If there's lots of red ink, maybe we could have a go at it," Prof. Naylor says. "We'll only face tough questions when there's a crisis… but is this a conversation Canadians want to have?"

The question is rhetorical, judging by the silence surrounding the issue, except for those "experts," some at U of T, who believe that the answer to any spending pressures from health care is to wring more efficiency from the existing system.

Prof. Naylor doesn't buy that argument. Yes, efficiency gains are always possible, but Canada should look to Europe, where "there are no perfect health-care systems" and "no magic bullets," but where there is a "degree of pluralism in financing and institutions."

In Canada, he says, "almost any time there is talk of a health-care financing change, we imagine a two-tier system. It trips off the

tongue with remarkable frequency." Two-tier is political shorthand for U.S.-style medicine, which is not at all what he proposes.

"If we want to be heretical, we should think of a pluralism of financing arrangement with a public backbone of a system," Prof. Naylor says. Health care is not just a "public good" for all of society but a "private good" for individuals, he argues. A balance between the two must be found because at the moment, the scales are tipped toward health care as a "public good."

With so many entrenched stakeholders in health care, change is terribly hard, since each group protects its gains and mobilizes for more. (See the current advertising campaign of the Ontario Medical Association.)

Prof. Naylor would like to see an integrated system of health-care delivery with physicians paid a salary with incentives for volume, working collaboratively with others in the system, instead of the silo approach now so prevalent and fee-for-service for doctors.

He says he has studied opinion polls about health care, and "I'm not sure what polls are telling us." It would appear that "any reconsideration is unthinkable. But I'm not sure how fixed we should be about that interpretation, because there's a kind of split screen whereby more payments out of pocket would be contemplated if it led to faster treatment for self or loved ones."

He notes that "there is core discomfort with anything that departs from the successful model in which fairness is highly valued. It's just that we might not be adequately served by the system."

Forget opening up a serious debate of the kind Prof. Naylor would appreciate. Politicians everywhere are convinced of the "third rail" politics, in part because Canadians have embraced health care as part of their national identification. Prof. Naylor is correct is noting that "it is a bit disturbing that Canadians would fix their self-definition around a system that is far from unique."

But there you have it: a system that Canadians know and value, that they fear changing, that they will not willingly pay higher taxes to support or agree that other programs should be compressed to pay for its rising costs. Apparently, no debate is the preferred option.