

The Story of Evolution: Health Care Bottlenecks

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Bridgepoint Health, Toronto
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“Changing The World For People Living With Complex Disease and Disability”

Chapter 1:

In The Beginning

There was Infectious and
Communicable Diseases –
and people died young

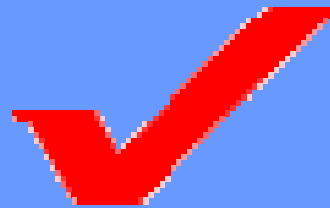
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First Frontier of Modern Medicine

=

Eradication of Communicable Disease



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Chapter 2:

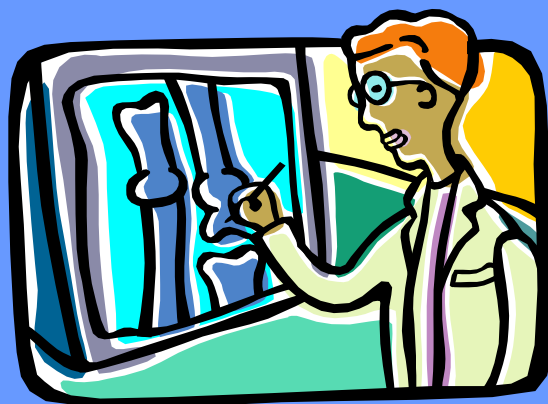
And then...
Woman/Man Started
to Live Longer

And Along Came...
Body System Failures

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Second Frontier = Diagnose and Treat Illness and Disability...



Find the Cure

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Since That Time...Not Many Cures But...Very Successful

All efforts focus on Acute,
Episodic Life-Saving Treatments

**Acute Care = Centre of the
Universe**



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Chapter 3:

Now...
The World is Changing
People are Living Longer
But...
With Complex Illness
and Disability

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Enter...

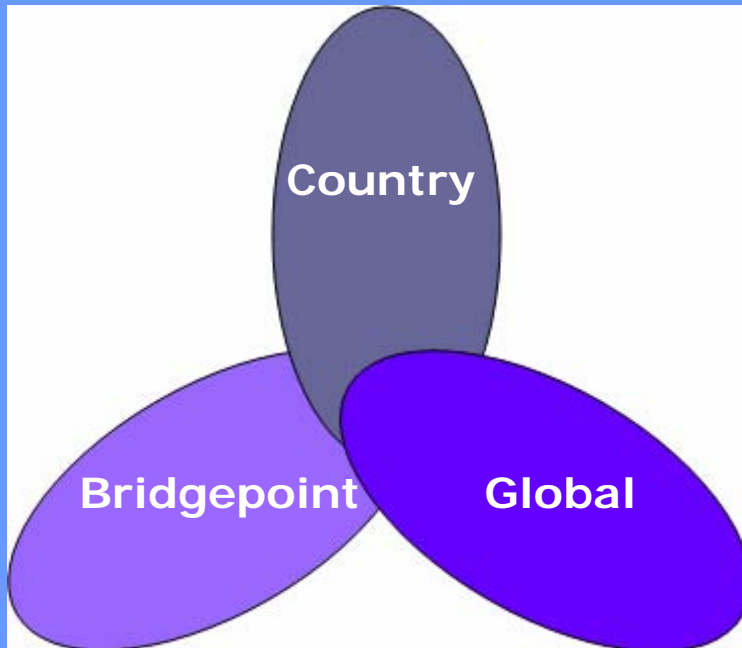


The Third Frontier

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Discovering The New Frontier



"The future of health care lies not just in saving life but in optimizing the lives of those who are living with chronic and complex diseases and disabilities. This is the Third Frontier of Health Care."

Marian Walsh

"Development of a new focus on people with chronic disease and disability is essential to the creation of a modern health care system."

Roy Romanow

"The management of all chronic conditions – non-communicable disease, long-term mental disorders, and certain communicable diseases such as HIV/AIDS – is one of the greatest challenges facing health care systems throughout the world."

WHO 2002

There's Good News and Bad News



First, the Bad
News...
Chronic Disease
is costly

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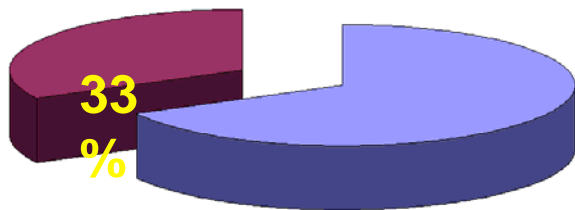


- **16 million Canadians have chronic disease**
- **90% of disability comes from chronic disease**
- **Chronic disease costs Canadians \$160B (1998)**

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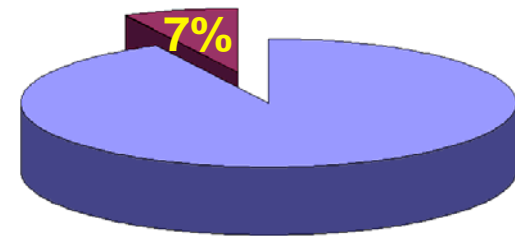
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Multiple Co-morbidities Are Commonplace And Incidence Increases With Age

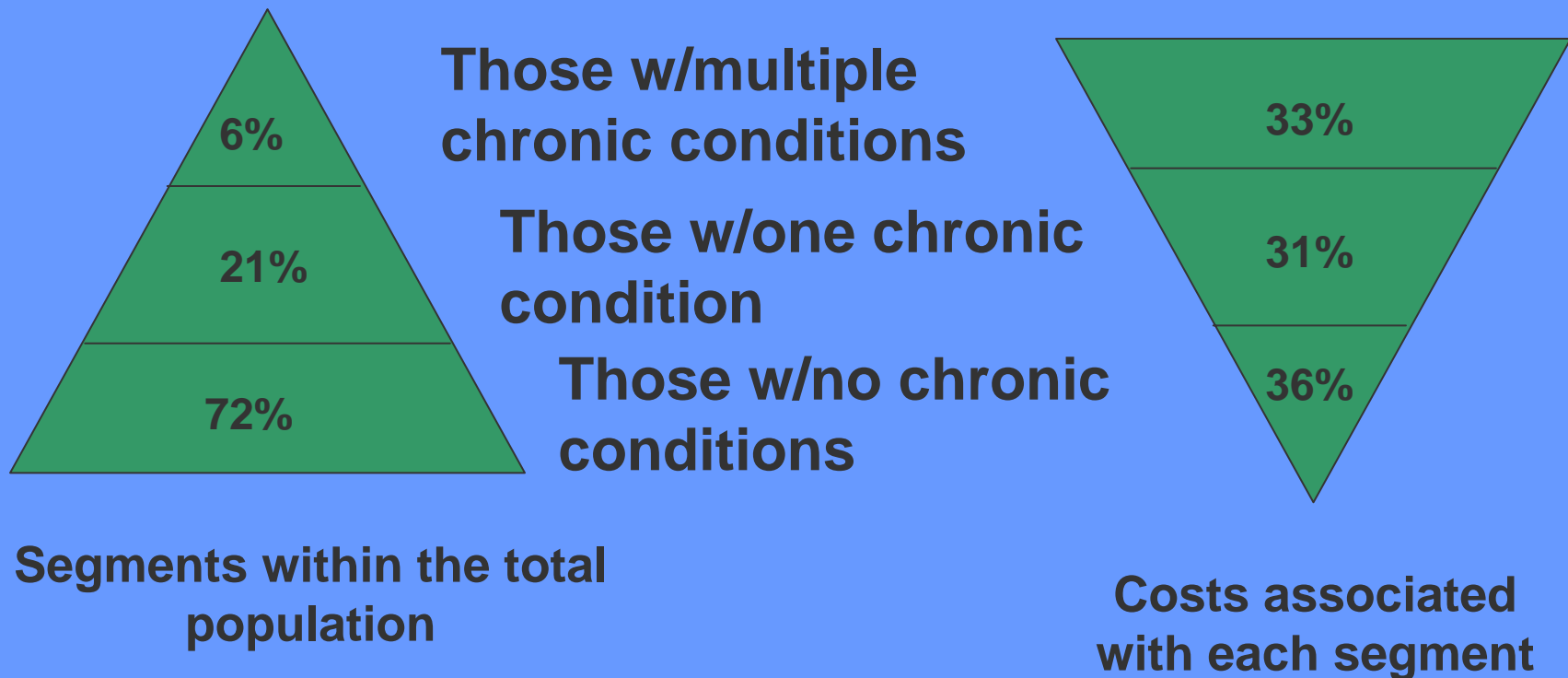


33% of the Canadian population above the age of 60 have 3 or more chronic conditions

While 7% of the Canadian population under the age of 60 have 3 or more chronic conditions



Kaiser Study: Chronic Illness Drives Medical Care Costs



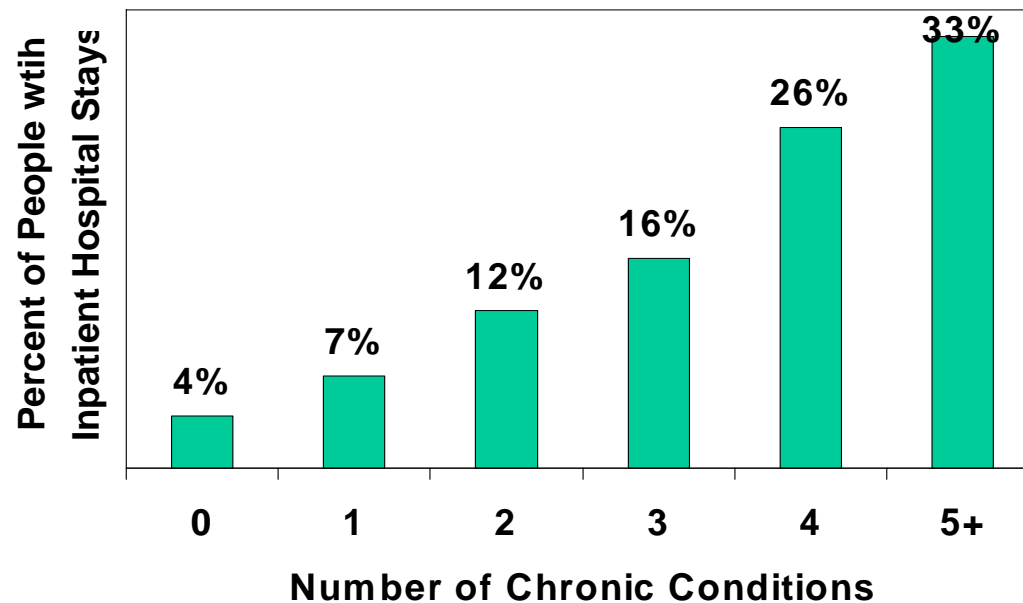
Chronic Disease Drives Costs

- In Canada, 67% of total direct health care costs are expended on chronic diseases
- Chronic disease accounts for 60% of total indirect costs – burden of disease associated with loss of productivity and foregone income



Who Uses Most Health Care...

People with Multiple Chronic Conditions are Much More Likely to be Hospitalized



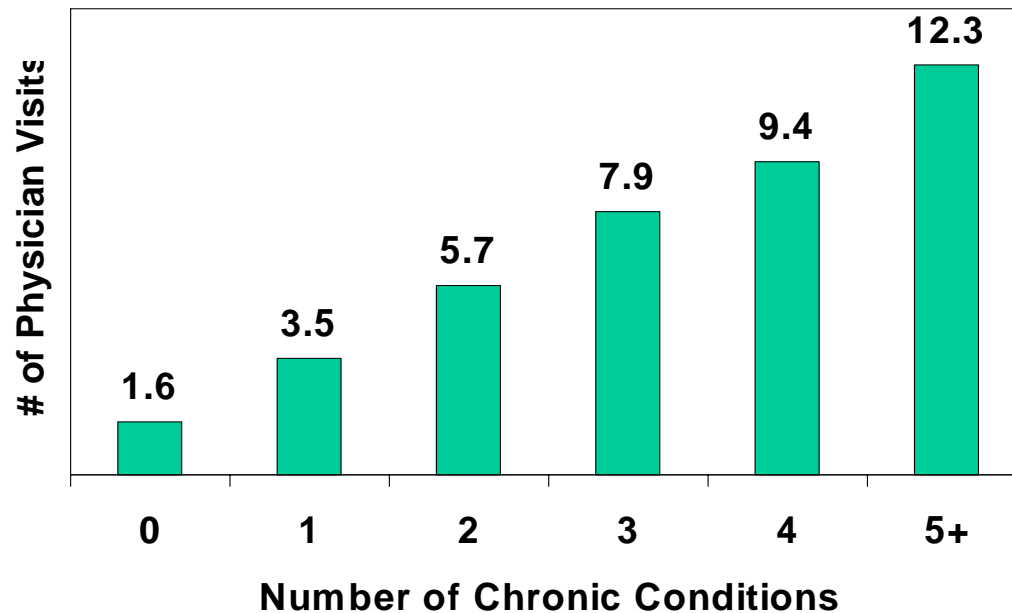
Source: Partnership for Solutions. *Chronic Conditions: Making the Case for Ongoing Care* – Sept 2004 Update, John's Hopkins University, 2004

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Who Uses Most Health Care...

People with Multiple Chronic Conditions Make More Physician Visits



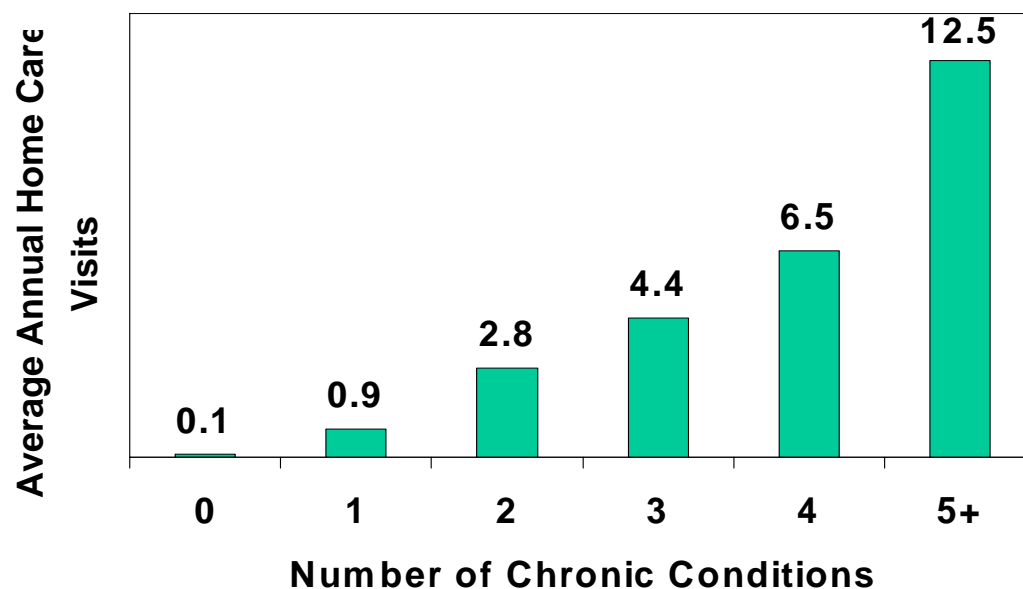
Source: Partnership for Solutions. *Chronic Conditions: Making the Case for Ongoing Care – Sept 2004 Update*, John's Hopkins University, 2004

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Who Uses Most Health Care...

People with Multiple Chronic Conditions Have More Home Care Visits



Source: Partnership for Solutions. *Chronic Conditions: Making the Case for Ongoing Care* – Sept 2004 Update, John's Hopkins University, 2004

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And...Health Care is Misaligned

- Health care system designed to treat acute episodic and urgent concerns
- Providers not trained and organized to manage chronic/complex illness
- Primary and Community support networks lacking

And...

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Health Care is Misaligned

- **Provider incentives are misaligned**
 - ✓ **Encourages physicians to act as respondents rather than initiators**
 - ✓ **Prioritizes urgency over severity**
 - ✓ **Health care system is highly fragmented**
- **Information systems that share information between providers have not been implemented**
- **Provision of evidence-based care is not widespread**

20,000 – 60,000 Complex Patients Are Spread Across the Toronto Health Care System

Where Could They Be? Different Pressures
on Different Parts of the System:

- **Emergency Department** – “we stabilize them”
- **Tertiary Care** – “we diagnose and try to cure them”
- **Rehab** – “we restore function if possible within a reasonable time”
- **Home Care** – “we support them at home while they function reasonably well”
- **Nursing Home** – “we deal with the stable frail elderly”
- **Primary Care** – “we diagnose & treat day-to-day problems of stable patients”
- **Caregiver** – “I support his/her day-to-day needs at home as long as I can”

Bottlenecks

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Now, The Good News...



There is a Lot That We Can Do

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A Lot of Chronic Disease is Preventable

**Primary
Prevention =
A BIG Pay-Off**



WELLNESS

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For Those With Chronic Disease...

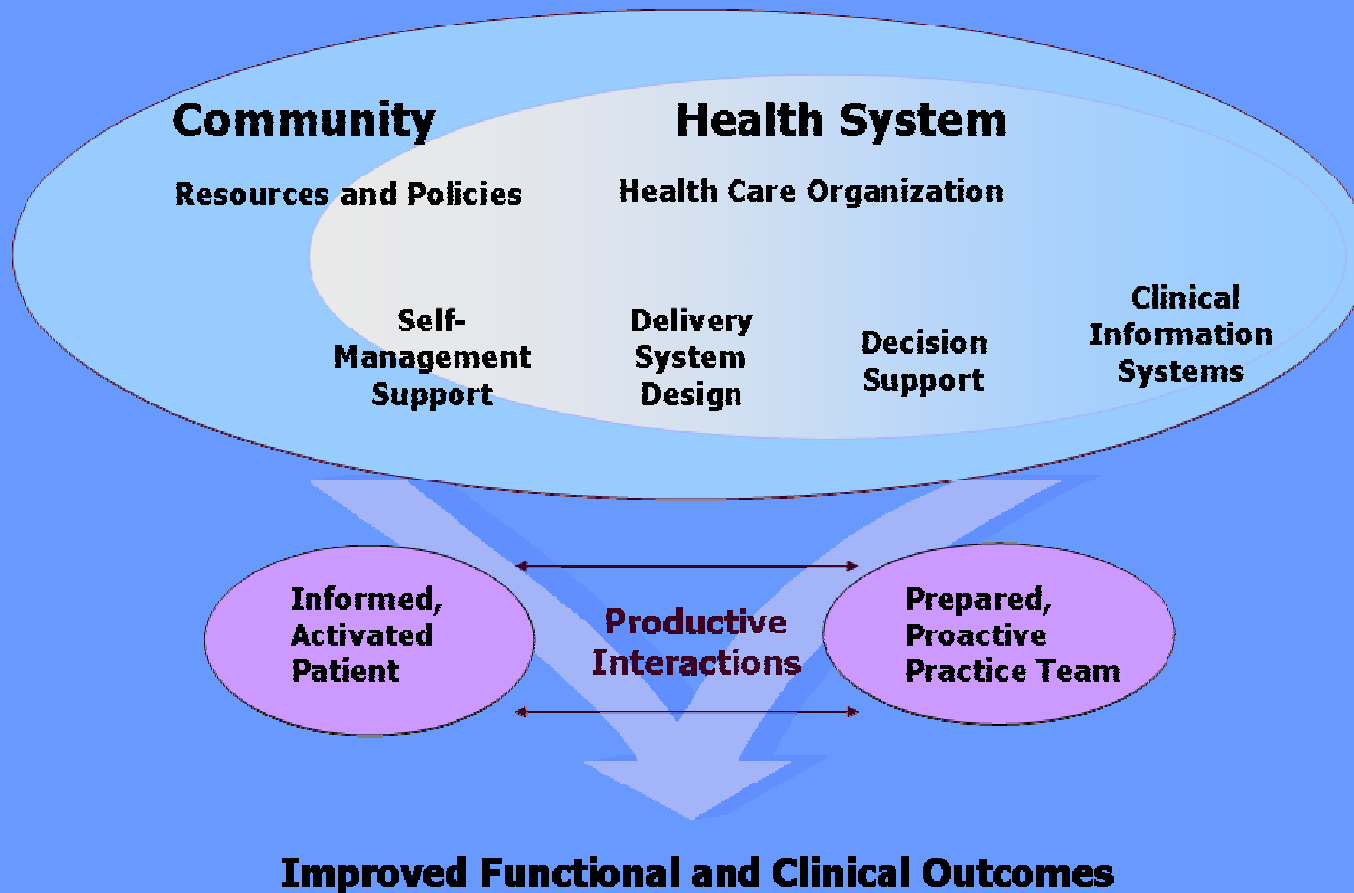
There Is Still A Lot We Can Do



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The Chronic Care Model: Criteria for a Successful Chronic Disease Management (CDM) Program

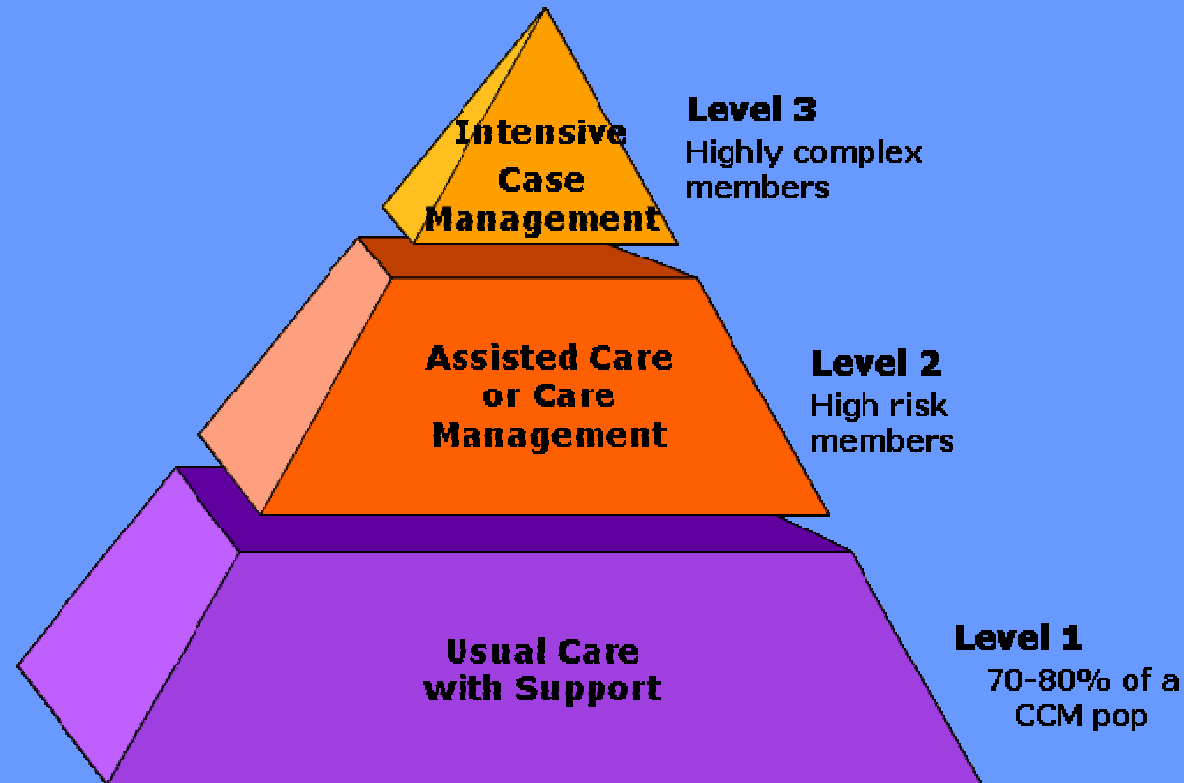


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Kaiser Permanente Model

Population-focused model that identifies and stratifies patients with chronic illnesses



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Kaiser Permanente Model (continued)

- Key factors of the Kaiser system include:
 - Focus on minimizing acute hospital stays
 - Patient education programs to teach patients to care for themselves
 - Emphasis on skilled nursing (rehab & complex care)
 - Home Care and Prevention Big Features

***“[in terms of chronic disease management]...
hospitalization is an indicator of system
failure”***

Ham, *Learning from Kaiser Permanente: a progress report*. London: Department of Health, 2003

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CDM Activities in Other Jurisdictions

United Kingdom

- National strategies in the UK to promote primary care trusts and their active management of chronic diseases

United States

- Kaiser and managed care organizations, such as Group Health of Puget Sound and United Healthcare, have developed effective disease management programs, emulated across the world

Alberta

- Capital Health and Calgary Health Regions have developed effective stroke and diabetes disease management programs in Canada

Western Provinces

- WHIC members have established a common CDM initiative

Results are Impressive

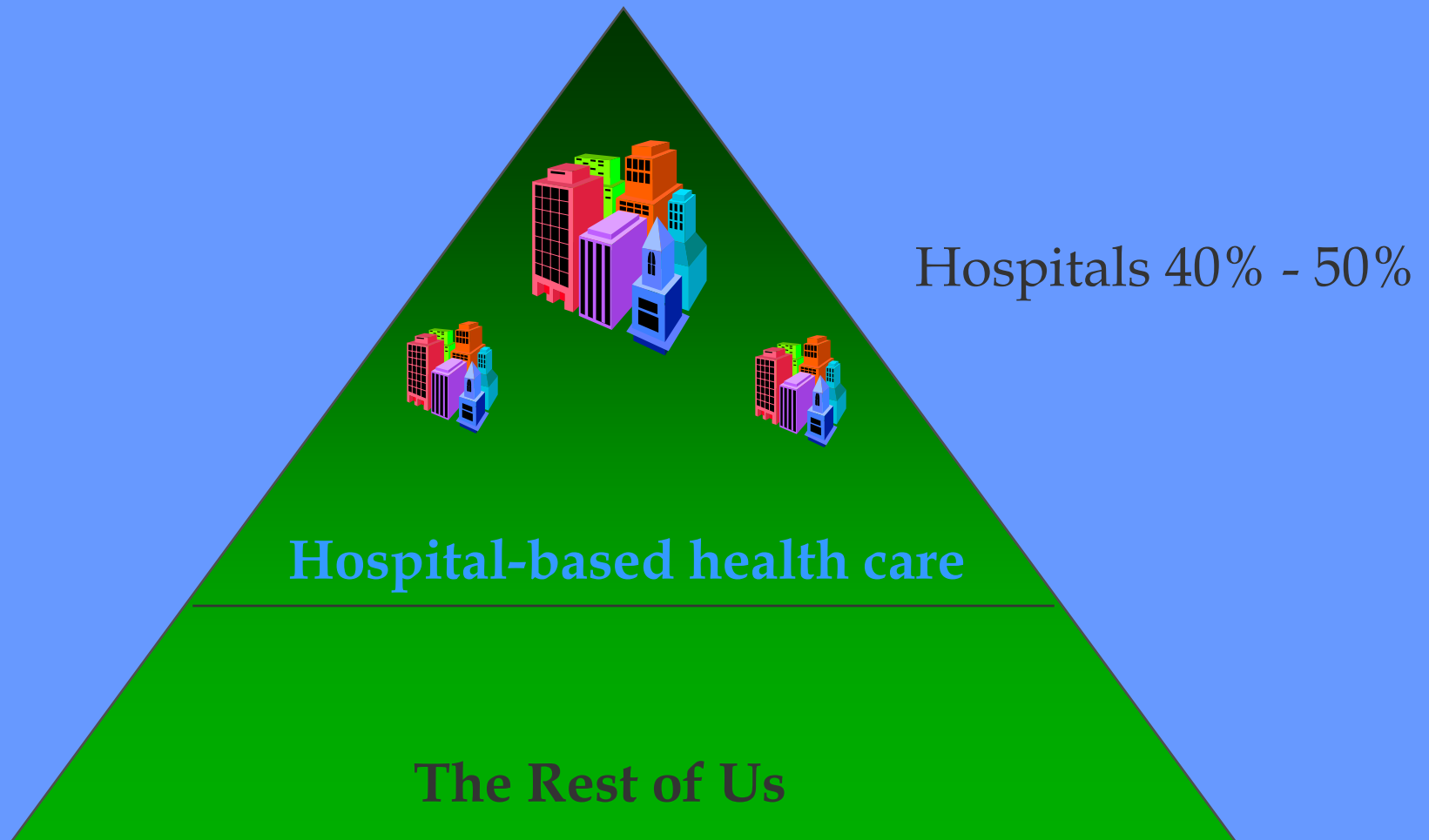
- Reduced admissions to hospital
- Lower length of stay
- Higher satisfaction rates
- Reduced urgent and emergent care visits



Ontario CDM Programs: Not There Yet...

- Existing CDM programs have been developed with a hospital-based focus
- CDM programs have been developed for specific diseases, encouraging the “silo” mentality
 - There are no established guidelines for treating patients with more than one chronic disease
- Existing CDM programs have not integrated prevention, home care, community and primary care programs
 - Care remains fragmented between different health care settings
- Most existing CDM initiatives have no formal budgets and are operated on the energies and convictions of few people
 - Initiatives are not sustainable

The Health Care Apex Today

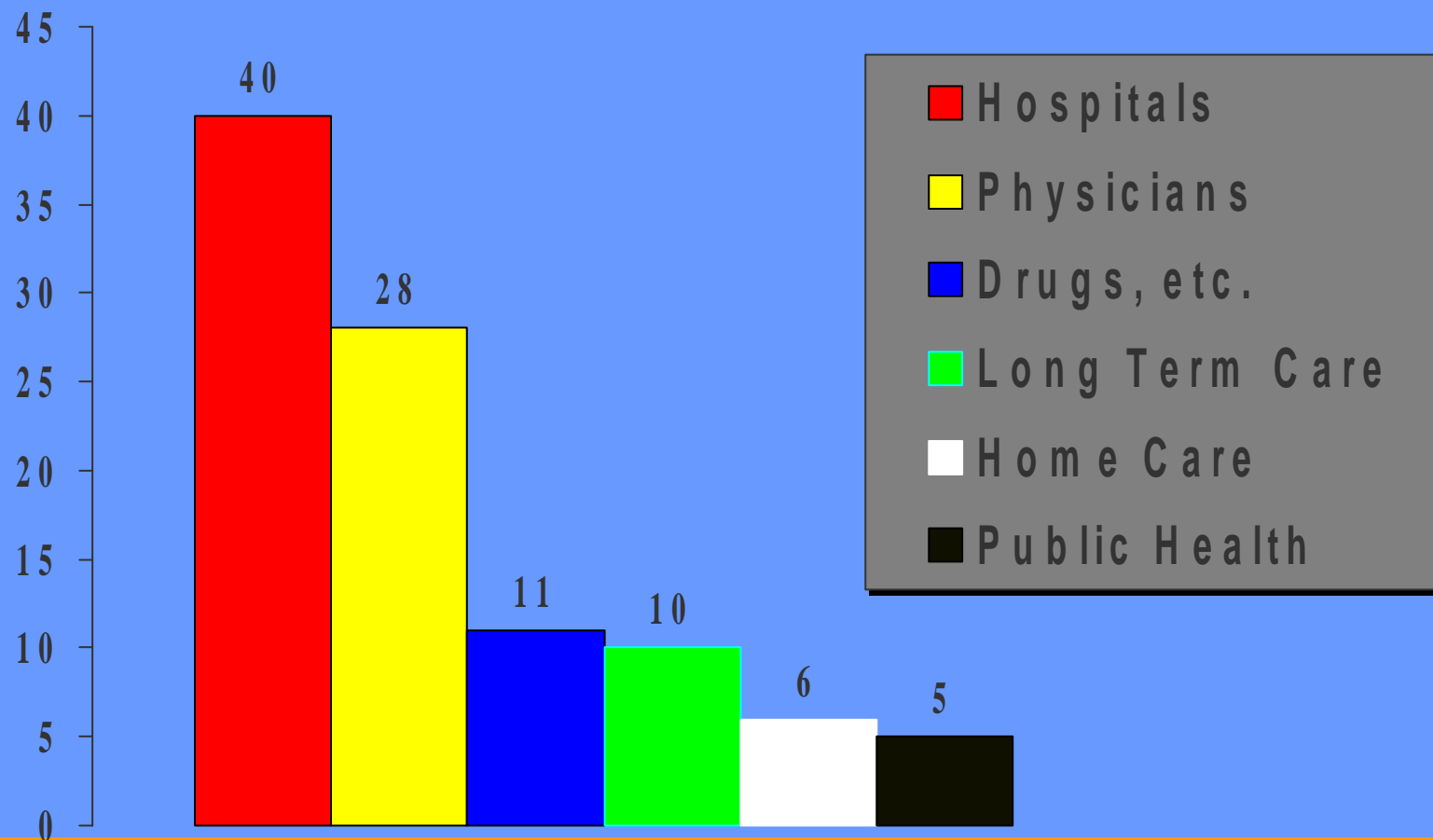


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Trevor Hancock

Health Care Spending

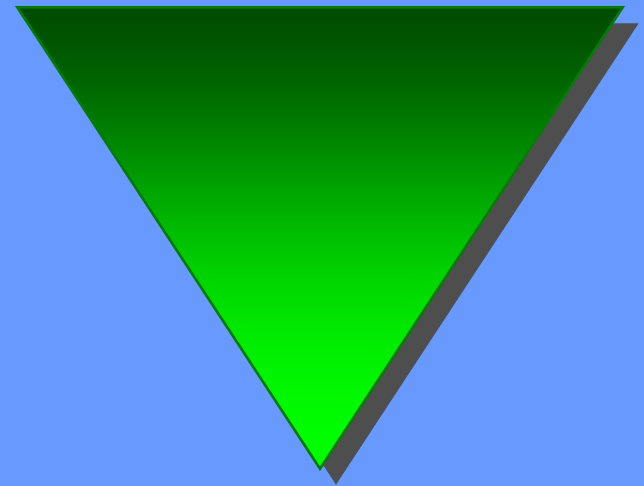


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Imagine a.

- Right time
- Right service
- Right place
- Fully integrated
- Service-oriented
- Outcome Oriented
- Individually funded
- Health Care Promotion System



A Bottom-Down Health System

A
Health
System
Promotes
Health

Health Promotion
Health Protection
Wellness/Health Maintenance
Self-Care & Mutual Aid
Disease Prevention
Primary Care
Home Care
Specialist/Ambulatory Care
Community Facilities
Community Hospitals
Specialist/
Referral
Hospitals

A
Sick
Care
System
Takes Care
Of Sick People

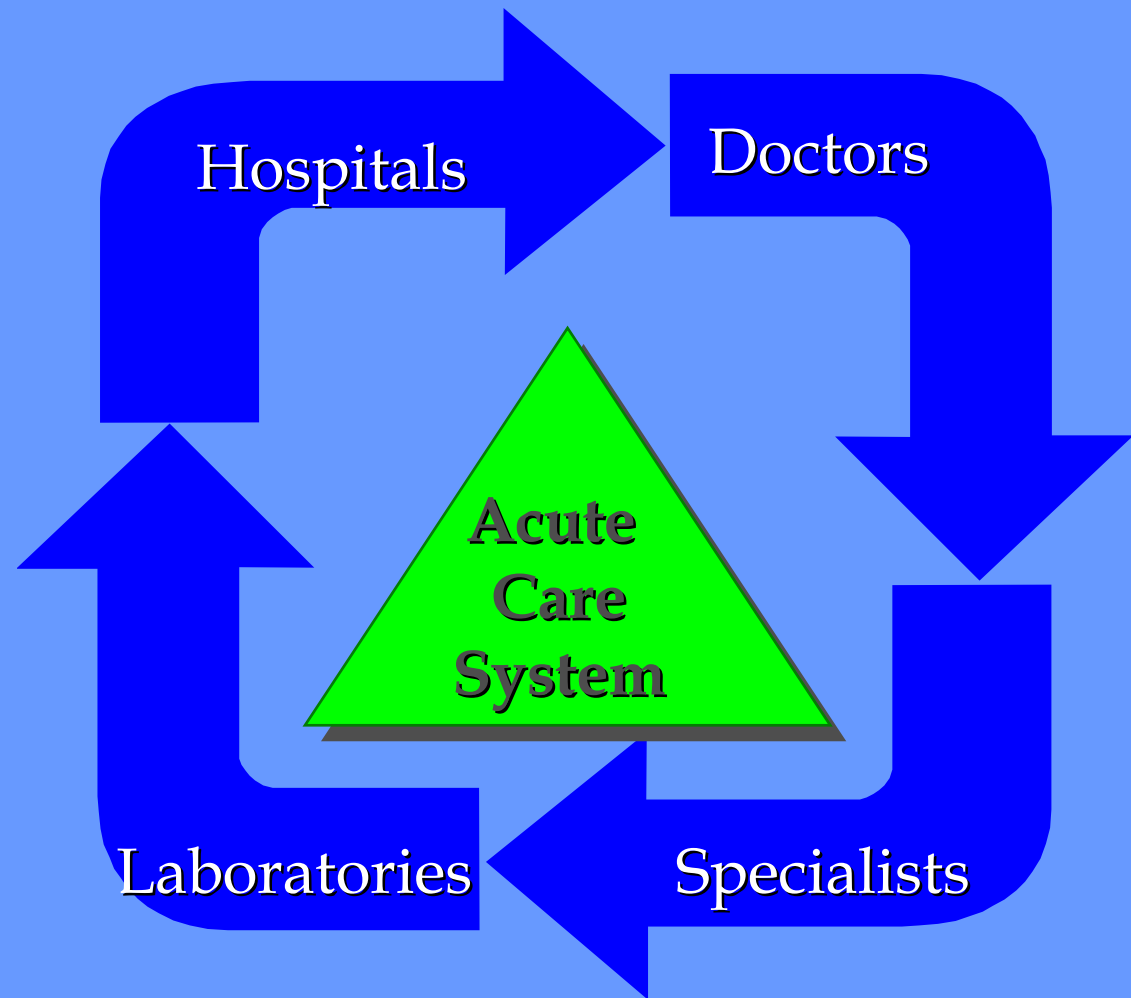
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A New Direction for Health

Replace the
Gatekeepers



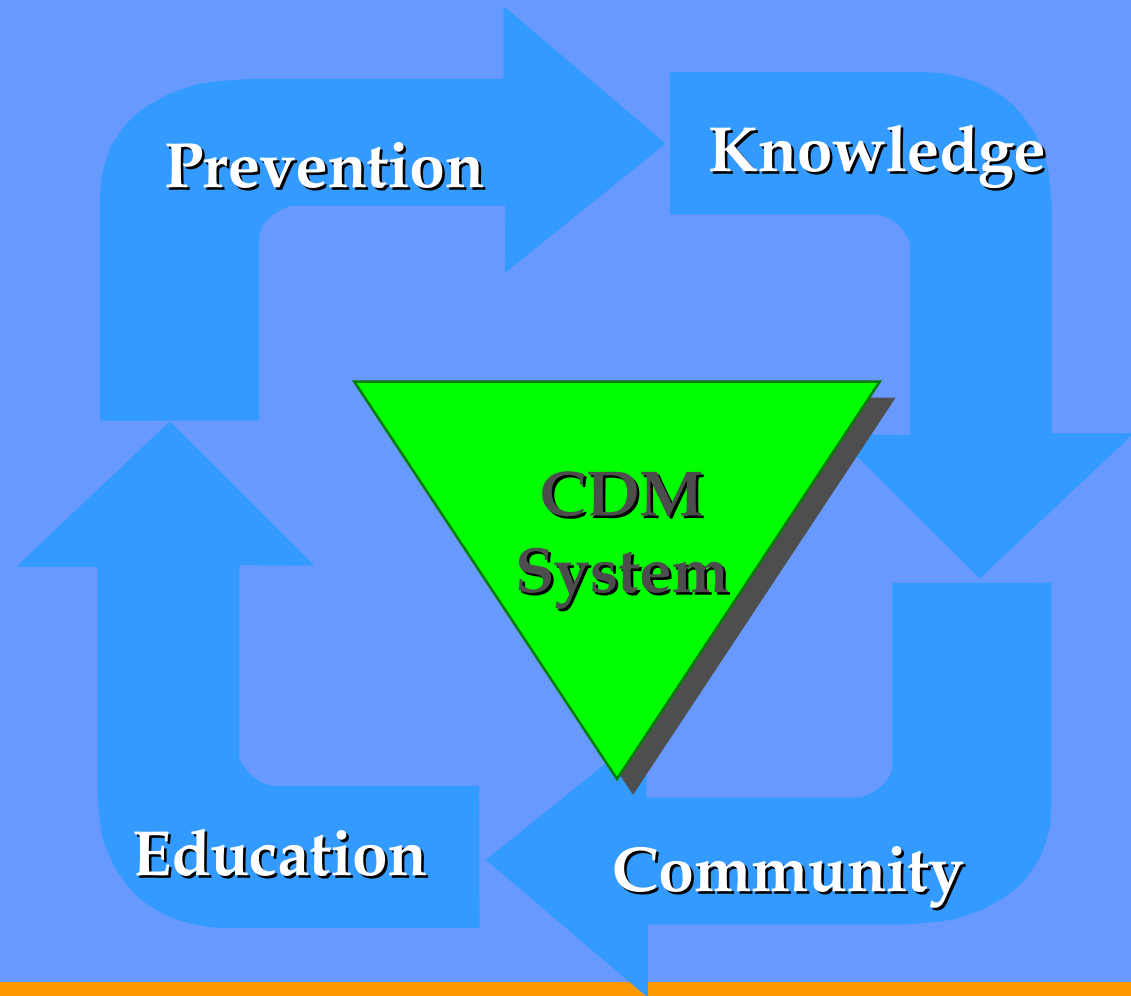
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A New Direction for Health

Replace the
Gatekeepers

with



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Summary & Conclusions

Integrated Health Systems

are

ESSENTIAL

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Summary & Conclusions

Focus On

**Chronic Disease
Prevention and
Management**

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**To Achieve This We
Need To:**

Shift Our Values And Our Spending

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Thank You.

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