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Insight on health, performance and the bottom line.
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DIABETES: Bittersweet Progress

SAMPLE

ARE WE SMARTER THAN A BUREAUCRAT?

businesshealth sets out to provide "insight on health, performance and the bottom line." Sometimes, this is hard to do without appearing critical of our health system. This massive creature consumed $150 billion last year. It employs hundreds of thousands of people directly. It will resist change. But seventy percent of that spending is public and, as Canadians, we rightly demand accountability and transparency. Those funds should be buying better health.

Of course, accountability doesn't just apply to governments. Employers must also shine a bright light on themselves, their benefits, and their suppliers.

The Health Council of Canada (*www.healthcouncilcanada.ca*) was established by the senior governments to monitor and report on the progress of health care renewal. In its three annual reports, it has been properly critical of painfully slow progress by governments and health leaders in making change. But it's easy to be a critic, right?

The Council set up an online consultation process to put us at the desk of government decision-making. (See *www.hcc.dialoguecircles.com*, but just until April 15.) It is a necessarily simple exercise, but helps create a broader perspective on the types of changes possible, identify priorities, and ensure we understand that choosing one path probably shuts down or delays others, no matter how worthy. Turns out it's pretty tough to walk a mile in their shoes, but very healthy to try.

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Chris Bonnett, Editor, **businesshealth**.

The Fight for Progress:
Innovation or Inertia?

bh IN BRIEF

Change comes slowly in health services, despite an overwhelming need to reflect current science, budgets, and consumer practices. Recent studies indicate that many more Canadians, up to 9% of us, may have diabetes than had been previously assumed. This occurs despite compelling knowledge of the benefits of 'best practices' care: a small change in blood sugar makes important differences in the cost and quality of care. An important missing link is the Electronic Health Record, particularly in Ontario. But in Edmonton, Capital Health has recently announced an exciting new initiative to integrate screening and care for the region's diabetic population – all of them. There is reason for hope.

Sources:

[1] News release, *Diabetes increase surpasses WHO prediction.*

[2] Health Council of Canada, March 2007. *Why Health Care Renewal Matters: Lessons from Diabetes.* Backgrounder.

[3] Canada Health Infoway, 2006. *Beyond Good Intentions; Accelerating the Electronic Health Record in Canada,* Executive Summary.

[4] Deloitte Consulting, Operational Review Final Report, Smart Systems for Health Agency.

[5] News release, January 17, 2007. *Capital Health aims to be North American leader in diabetes management.*

In health care, inertia always seems to win. Just what is it that makes health organizations and leaders so resolute?

Over four years ago, the Romanow Commission made one prescient plea: let new healthcare money buy change. Well, Canada spent $33 billion more on health in 2006 than in 2002. Has much changed?

To answer this, let's consider diabetes, a common and serious health condition, and its interface with a key piece of information technology, the Electronic Health Record (EHR). Diabetes costs over $13 billion to treat nationally, has a host of serious complications, and is preventable. An EHR provides the mechanism to collect and present health information from across various domains, such as hospitals, telehealth and diagnostic services, pharmacies, and public health. New reports shed some light on what leadership looks like.

THE STARTING GATE

Diabetes – A recent study discovered that between 1995 and 2005, the number of known diabetics increased 70% in Ontario. Extrapolated, that would mean almost three million Canadians have the disease. Many more are thought to suffer, though they have not yet been diagnosed. Obesity, ageing, immigration, and better treatments that prolong the lives of those with diabetes are thought to be responsible.[1]

In another report, the Health Council of Canada dangles the carrot before us: a mere one percent reduction in blood sugar is associated with 14% fewer heart attacks and 21% fewer deaths due to complications of diabetes. On the money side, research in BC found the combined cost of physician and hospital care for an elderly population was 47% lower for those who received high (vs. low) quality care.[2] Clearly, change is needed in diabetes prevention and care.

EHR – Healthcare decision-makers have focused on doctors and nurses, on bricks and mortar, and on healing rather than preventing. As a nation, we have not spent enough on health systems.

Canada Health Infoway, a federal-provincial-territorial organization charged with implementing health information systems, calls healthcare "the world's most information intensive industry."

Currently, health care organizations spend about 1.5% of revenue on information technology and support, versus 4% - 5% in other industries. A fully developed EHR in Canada has been projected to cost $1 billion annually for about ten years, which sounds like a lot of money, but is only *two-thirds of one percent* of our total direct annual expenditures.[3] The key bits are in place (funding, urgency, technology), but health leaders have rarely embraced it.

Infoway projects have been underway for almost two years in all provinces except Ontario, so one-third of Canadians are not even in the game. As of November 2006, Ontario had not yet even approved a comprehensive eHealth strategy, and its major agency, Smart Systems for Health, was in a state of disarray.[4]

Now, what if higher prevalence and poor management could be met with better health services that improved health, *and* lowered costs?

CONVERGING TRACKS

In January, Edmonton's Capital Health Region announced its goal to identify and properly treat 100% of its diabetic population (at least 90,000 people) by 2009.[5] Surprisingly, it's already at the 90% threshold. The tools will be its 3-year old EHR (netCARE), and a new electronic regional diabetes registry that ensures evidence-based care from multi-disciplinary health care teams. Capital Health believes it is the first jurisdiction in North America to organize a systematic and targeted disease management strategy. This is what leadership looks like.

In contrast to Ontario's failure to execute, netCARE took just one year to develop using a consortium of six international computer systems companies. It spans 13 hospitals, 28 public health centres and specialty care clinics, 9 community mental health services, and many other community care services.

NOW WHAT?

Jacques Chirac, President of France, took a different view of the world than most health service leaders. He said in 1998: "There is nothing more dangerous than standing still in a world that is changing."

Enough talk? Then let's make it happen!

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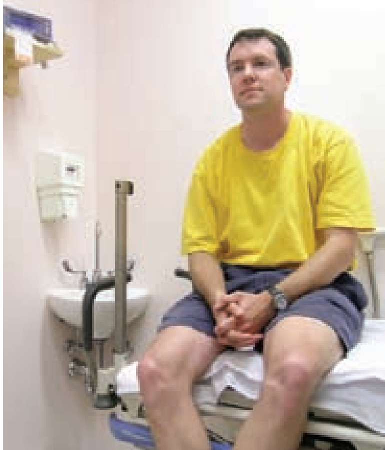
An Interview with Donald Speers, Controller, Arrow Hose & Tubing Inc.

View from the Top



bh IN BRIEF

Arrow Hose, a small manufacturer, has taken a lead in developing its pandemic flu plan. Driven by a customer inquiry, it used external resources to create the plan and integrate it with an overall business continuity plan. The plan will be kept current through its ISO quality management procedures. Arrow assists its employees with a traditional benefit plan, but also through innovations like personal financial planning, and using webinars for additional training. A smoking cessation program and a keen focus on safety round out the offering, proving you don't have to be big to take care of your employees, so they can take care of your business.

Arrow Hose & Tubing Inc. is a manufacturer located in Guelph, Ontario with 54 employees.

Q: The majority of smaller businesses have been slow in developing plans for pandemic flu. What motivated Arrow ?

A: The subject came up in a management meeting about two years ago, but it wasn't until some of our customers started asking us about what we were doing that we really took notice. Not only did we begin seeing this as a potentially serious business issue in continuing to supply our customers, but as an employee issue in continuing to provide work and income for our employees.

Q: What steps did you take to get started? Where are you now, and how do you plan to keep it current in the future?

A: As the champion for this initiative, the first thing that I did was some reading. I attended a pandemic planning symposium geared to small business in November 2006, where I got connected to resources and more information. We then contracted with a Human Resources consultant to help us develop a draft plan.

We have now completed our second draft plan which includes the need to ensure our vendors have their plans in place. The plan will then be communicated to our employees and tested to make sure it works. Management will review the plan semi-annually, and it will become part of our ISO procedures to help ensure we include new or updated information.

Q: Was planning done as part of an overall 'business continuity' plan, or specific to pandemic flu? How does it link back to your customers?

A: This project was part of our 'business continuity' plan, and the systems we have set up cover several emergencies. Our customers will be made aware of our pandemic plan, and they can request a copy. We hope this will give them confidence that their interests will be safeguarded in an outbreak. Planning was time consuming but information and feedback from outside agencies was very helpful.

Q: What workplace health issues are you facing over the next few years? What plans do you have to deal with them?

A: We are lucky to have a relatively young workforce, but we really don't know what some of their future health issues will be. That's why we are looking at contracting with a firm to do some health screening. Most of our employees are men, and as such not big on regular doctor visits. We think screening will uncover issues before they actually impact an employee's health and the cost of our benefit plan.

A large percentage of our employees smoke. We have a smoking policy in place, and we may add coverage for smoking cessation products. The new provincial smoking legislation was the catalyst for us to plan and implement those requirements six months before the law was enforced.

Safety is also of paramount importance. As of March 2007, we have a record of 863 days of no lost time injuries. This is something that any company would be proud of! We have worked closely with a safety group to help us implement several safety initiatives that will reduce our WSIB claims exposure, and keep us current on legislative changes. We are also creating an ergonomics committee.

Q: It sounds like Arrow Tube has a strong focus on the wellbeing of its employees. What role has management played ?

A: From day one, 17 years ago, the owners and management have been strongly committed to our employees. Even in the early days when the owners needed to take money out of their own pockets, every employee received an annual bonus. We have added EAP [Employee Assistance Plan] services, which include financial counselling.

We set up RRSPs, help with personal budgeting issues, and provide access to additional training through webinars or university or college courses. Arrow Hose believes that what is good for our employees is good for the company.

SAMPLE

Co-authored by Deputy Chief Keith Forde, Human Resources Command,
Toronto Police Service and Denise Balch, President, Connex Health Consulting.

A Force for Change

bh IN BRIEF

The Toronto Police Service (TPS) has a long tradition of service to the public. Faced with work that is at times both routine and heart-pounding, new territory is being staked out in both organizational health and personal fitness. TPS is creating a modern organization to address the health issues of modern life. A voluntary health risk assessment found high incidence of nutrition, fitness, and sleep deficits, as well as too many overweight members. Though unique in many ways, its process will mirror that of private companies: collect data, improve management techniques, and more closely connect senior leadership with the health and productivity needs of the (work) force. An arresting development.

IN TORONTO, POLICING TRADITION MEETS MODERN MANAGEMENT

Police services across Canada are focused on the safety and protection of the public. But policing is inherently dangerous work, so police officers are carefully and continuously trained to keep themselves safe. And now, healthy. Just like the rest of us, long and irregular hours spent in cars and behind desks tends to de-condition and open the door to more health problems.

Beyond simple fitness, increasing public scrutiny means policing must adapt modern management strategies to improve accountability and bring out the best in their officers and civilian staff. The ambitious goal of the Toronto Police Service (TPS) is to arrest a decline in the health of many of its personnel, to reduce their stress, to improve the organization, and to restore good lifestyle habits. The culture of policing focuses on strength, command, and tradition, so accepting and addressing a fundamental need to change is no easy task, and no short-term fix.

GETTING THERE FROM HERE

In 1999, the TPS began their first healthy workplace planning. Their group insurer conducted a study that indicated improvement was needed in managing stress, obesity, and physical fitness, as well as personal finances. In 2002, a full-time wellness coordinator was hired, and the National Quality Institute's (*www.nqi.ca*) healthy workplace roadmap model was adopted. Health promotion programs soon began. Then a *HealthEvidence*™ analysis was used to identify organizational costs and build the financial case for change.

Command (senior) officers have walked the beat themselves, and endorse the strategy, as does the Toronto Police Services Board. The new Chief has been spotted in the lunchroom having a bowl of soup, an important symbol of more accessible leadership. Member needs have been directly solicited and specifically targeted. Answering the need for more data, late in 2005, TPS invited its members to participate in a confidential on-line health risk assessment (HRA) survey.

GATHERING EVIDENCE

The HRA was launched on the Service's intranet to facilitate participation throughout the Service's operations. Beyond health risks, the HRA captured information on health and work behaviours and factors that affect individual performance.

A response rate of just under 30% was below target, but still had enough statistical power to reliably represent the risk factors and organizational issues affecting health.

"Ideally we would have liked to see participation at the 45% - 50% mark. Higher participation means three things: First, that people are aware of the HRA and the organization's health strategy. Second, it illustrates a level of trust. Third, it will increase the chances that people will participate in health promotion programming."

– Denise Balch, Connex Health

DRAWING CONCLUSIONS

The findings were dramatic, but not unexpected. When publicly reported to the Police Services Board, the results drew attention to important health and organizational culture issues.

TABLE 1

TORONTO POLICE SERVICE
MOST IMPORTANT HRA RESULTS

Unhealthy Risk Category	Readiness to Change
1. Nutrition	1. Sleep
2. Body Mass Index	2. Smoking
3. Fitness	3. Job Stress
4. Sleep	4. Work-Life Balance
5. Job Stress	5. Waist Circumference
6. Work-Life Balance	6. Fitness
7. Smoking	7. Social Wellbeing
8. Alcohol	8. Alcohol
9. Waist Circumference	9. Body Mass Index
10. Social Wellbeing	10. Nutrition

On the personal side, almost 75% of those responding had three or more lifestyle risk factors for the development of disease. **Table 1** ranks the ten most common of these. Some of the biggest health risks (e.g., nutrition, BMI, fitness) ranked relatively low in readiness to change. A high number of family-related issues surfaced. Interestingly, despite high stress levels, the smoking rate was far below the Canadian average.

Behavioural markers indicated many members were ready to make changes to their lifestyle and the survey identified the most desirable programs and services.

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Among organizational factors, the overall Business Health Culture Index (BHCI – see *Defining Organizational Health*) score was close to target levels. TPS and its workplace consultant are closely examining low-ranking units, and are working with managers and employee volunteers to understand, develop and maintain short- and long-term approaches to reduce stress and create a healthier work culture. Some units have already identified opportunities to improve their work climate.

NEW THIS YEAR

As part of its strategic approach, the TPS will introduce a new series of screening clinics in 2007 that will encourage a physician visit if required and participation among those with a need to improve their fitness levels. Using HRA results, programs will address fitness, nutrition/weight management, work/life balance and shift work, and have a particular emphasis on sleep issues.

There will be a new focus on the individual measurement of cardio-metabolic risk factors (e.g., hypertension, diabetes), absenteeism, and productivity. Finally, clinic data will be collected and used to evaluate the impact of programming on both individuals and the Service, including calculating return on investment.

By borrowing a page from its business counterparts, the TPS is confident it will capture improved personal fitness and a more modern organization. Truly 'a force for change' and a high-profile example in its community and among its policing counterparts.

"This project has reinforced our belief that we have a significant opportunity to help our uniform and civilian members reduce their risk factors for disease, improve their health practices, and enhance their working environment. We are convinced that these changes can only result in improved service to the communities we serve."

– **Keith Forde, Toronto Police Service.**

DEFINING HEALTH

Organizational – Organizations take on many of the same characteristics of the people who work for them. That's the logic behind the Business Health Culture Index (BHCI) used by the TPS. The BHCI is a validated measure that translates personal stress-related scores into a company-level marker. It serves to describe the extent to which the health culture of an organization works for or against its business objectives.

There is another important and research-supported impact of stress measurements. Over time, the personal stress response begins a series of physical and mental changes that in turn affect workplace satisfaction and productivity, and increase absence, disability, and drug plan use.* In blunt terms, sustained stress produces measurable changes in feelings, performance and biological function.** These changes cost organizations money.

Personal – Four factors significantly affect individual health and performance, the first three of which are modifiable:

- Individual lifestyle/self-care practices
- Existing diseases/conditions
- Readiness to change
- Family history of chronic disease.

References:

* From Health at Work Profile Report, accessed March 2007 at The Health Communication Unit website: *www.thcu.ca/workplace/sat/pubs/res81_1.doc.*

**From "Reducing the Risk of Musculoskeletal Disorders, W. MacDonald, Faculty of Health Sciences, Latrobe University, Melbourne, Australia. Accessed at: *http://www.latrobe.edu.au/ergonomics/SIA%202006%20MSDs%20and%20Consultation.pdf.*

Bottom Line Commentary

by George Cuthbert, CA, ACMA

NOBODY WANTS TO SEE A POLICE OFFICER HURT OR INJURED

Training and safe practices are emphasized and reinforced from Police College onwards. But businesses and other organizations are repeatedly and unequivocally proving that such skills training, without investing in health, is like a three cornered stool with a leg missing. It is neither stable nor effective.

Also learned early on in their career is the importance of fitness, and it is a requirement for graduation. But once out into a police officer's often hostile work environment, fraught with risk and stress, mental acuity and resilience and physical fitness are constantly tested. This early momentum needs to be recaptured. Police services everywhere would be well served by a robust, career-long healthy workplace strategy.

"To Serve and Protect" is the proud motto of the TPS. There is nothing selfish about first "serving and protecting" our fine officers through a comprehensive wellness strategy.

The TPS deserve credit for getting stared in 1999. A return on investment is admittedly more important to profit-making companies, but there is also the 'human performance' return, which is just as essential to public services like the TPS.

"THE BOTTOM LINE" IS:

- Healthier and safer police officers, with positive effects on their families,
- Improved public service,
- Better value for the public purse, and,
- Becoming a role model for their community.

TPS would be better "served and protected" with an accelerated and committed implementation of a strategy with what are now well-proven wellness tools, programmes and measurements.

SAMPLE

Diabetes

Diabetes and its complications cost the Canadian health care system an estimated $13.2 billion... By 2010... the associated costs on the health care system will [be] more than $15.6 billion a year...

Diabetes is a contributing factor in the deaths of approximately 45,000 Canadians each year. Canadian adults with diabetes are twice as likely to die prematurely, compared to persons without diabetes. In fact, one in two people with type 2 diabetes does not have their blood sugar under control. This is a clear sign that better management of diabetes is needed to achieve improved targets.

– Canadian Diabetes Association website, *www.diabetes.ca*

Diabetes is expensive, whether measured in dollars, or lives lost, or quality of life foregone. Clearly there is a significant gap between our well-established medical knowledge of this disease and our appetite for detecting and managing it. How might employers help? The two major avenues are screening and programming.

SCREENING

The objective of screening clinics is to catch emerging and even full-blown health problems that would otherwise go undetected.

Clinics would typically be a half or full day, and be staffed by one or more Registered Nurses. Screening most often occurs for more than one condition, for example, diabetes and heart disease, because the two conditions very often co-exist. Each person is at the clinic for 20-30 minutes. Measurements include blood glucose, blood pressure, waist circumference, body fat, cholesterol, and weight. Additional measures could also occur, such as A1C levels for suspected diabetics. Counseling follows for certain individuals. Typically, about one-third of employees who are invited to attend actually appear.

Clinics allow employees to get easy access to something that would otherwise require at least two offsite medical appointments and a half-day or longer absence from the workplace. The cost of a clinic is reasonable in light of other avoided health-related costs.

PROGRAMS

Diabetes management programs may be funded by provincial and federal governments, regional health authorities, local health units, and sometimes by pharmaceutical companies, pharmacy chains, and employers themselves.

Of course, knowledge is just the start, and modifying behaviour is the real key to success in changing health practices and the course of diabetes or any other disease.

In smaller communities or for smaller companies, several organizations could band together to offer screening or even diabetes management programs. These activities might be an ideal role for a local Chamber of Commerce, which could lower the per capita cost and spread it over a much wider base and establish a convenient, central location. A local hospital or medical clinic could also be a willing partner.

CHANGING BEHAVIOUR

Many theories apply, but all contain these three essential elements, according to a review by The Health Communication Unit (L. Hershfield, et al, 2004, available at *www.thcu.ca*):

1. The person has formed a strong positive intention or committed to perform the behaviour.
2. There are no environmental constraints that make it impossible for a behaviour to occur.
3. The person has the necessary skills to perform the behaviour.

IDEAS

So, let's say you wanted to introduce a diabetes program in your workplace. Where would you go for help, and for solid, well-researched programs? Here are a few places to start:

- **Canadian Diabetes Association** – Local chapters across Canada offer educational and support programs on diabetes, nutrition, or directed to special audiences such as youth or aboriginals. Larger offices may supply speakers familiar with the disease, and there is a national workplace program (See: *http://www.diabetes.ca/Section_Services/pps_hwi.asp*).
- **Government** – Have a look at: *www.canadian-health-network.ca*, provincial Ministries of Health, e.g., *http://www.diabetesontario.org/pub_regions*.asp, Regional Health Authorities or Local Health Integration Networks (ON).
- **Hospitals** –Focus on those with diabetes education programs.
- **Corporate** – Eli Lilly (*www.lilly.ca*) and Roche (*www.rochecanada.com*) have two of the best sites for disease information. Diabetes equipment manufacturers – Becton Dickinson (*http://www.bddiabetes.com/ca/english/index.asp*) and LifeScan (*http://www.lifescan.ca*) – also have high quality content.

In the end, don't forget to evaluate your program, through brief questionnaires or surveys of both participants (Did they find it worthwhile?) and non-participants (Why did they not participate?). This allows your organization to learn how to improve future efforts for the benefit of employees and the good name of your organization.

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Mona Fanous, RPh., BSc.Phm.
Director, Pharmacy Practice and Professional Programs
Katz Group Canada, Edmonton, AB

Pharmacist on Call

bh IN BRIEF

For many years, pharmacists have worked to align their training and skills with the broader health needs of their customers. Diabetes presents many opportunities for pharmacists to help patients manage their health, whether adult or child. Many stores feature diabetes 'clinic days' that provide comprehensive education, sometimes including representatives from drug and equipment manufacturers.
Two provincial initiatives – new legislation in Ontario, and an important scope-of-practice change in Alberta – will have important effects on the profession and on patients. These two changes also present employers with significant challenges. On the surface, both may increase costs, but they also present new opportunities to engage pharmacists to create more value in employer-sponsored drug plans.

"COGNITIVE SERVICES" INCLUDE:

- Reviewing patient profiles on current prescription and non-prescription drug use,
- Developing a patient care plan with the patient to resolve drug-related problems,
- Patient lifestyle assessments on factors like nutrition, stress, exercise, or smoking status.

The Katz (pronounced Kates) Group includes 1,800 drug stores in Canada and the US under the PharmaPlus, Rexall, IDA, Medicine Shoppe and MediTrust banners.

Q: Each year, 60,000 people are told they have diabetes for the first time. Why does this matter to employers and the workplace in general?

A: Apart from adults, Type 2 diabetes is also hitting more and more young people. Soon parents will need more time off to visit doctors and look after their unhealthy kids. But later, these unhealthy young adults will generate costs we don't currently expect until much later in life.

Q: Is there still interest in having pharmacists work with employers, insurers, or benefit advisors to manage diabetes in the workplace?

A: Unlike a few years ago, there are few current examples in workplace settings. While continuity has been a problem, the current shortage of pharmacists also means there is less time for work outside the store.

Still pharmacists can positively impact health outcomes. For example, we can help patients understand why they're checking blood glucose and specifically what to do with their results. If they don't understand or comply, long term complications arise, and none of them are good.

Many pharmacists regularly offer diabetes programs at their store, which include educational materials and follow-up telephone calls focused on compliance. These "clinic days" could be promoted by employers among their employees.

Q: Beyond diabetes, in your role at Katz, what issues have been consuming your time?

A: We are paying close attention to two recent provincial changes. First, we have been heavily involved with Ontario's new Transparent Drug System for Patients Act ("Bill 102"). The Act will cut drug mark-up on the provincial plan from 10% to 8% effective April 1, 2007. It is not yet clear whether private plans will match this. Employers should also be concerned about recent price changes on brand-name and generic products, enabled by this Act. For pharmacy, one piece of good news is that the Act allows pharmacists to earn cognitive (professional) service fees for drug regimen consultations. When three or more medications are reviewed, the government plan will pay $50 per patient. Apart from extra income, this will require measurement and therefore accountability. Other provinces are watching closely: Nova Scotia has already said it will follow the Ontario government's revised drug pricing.

Also on April 1, 2007, pharmacists in Alberta will have prescribing rights for "Schedule 1" products, and be able to administer injections such as vaccines. Pharmacists will not make diagnoses, but will be able to modify a prescription, that is, change the dose, form, or frequency after a thorough patient review. They will be able to issue an emergency supply of an initial prescription if there is no reasonably accessible alternative, such as a local hospital or physician clinic. Finally, with special authorization by the College (regulator), a pharmacist will be able to select the most appropriate drug products to address a patient's drug needs, following a physician's diagnosis. This will occur mostly in hospital or special clinic situations or collaborative community settings. Though training programs are in place, a compensation schedule has still not been issued by the government.

While each issue reflects just one province's legislation right now, we think these will indeed become national issues.

Q: Some provincial health plans are or will soon be paying pharmacists for "cognitive services". How soon will this impact the market, and should employers follow suit?

A: Assuming reasonable regulations are proposed, this change will take time to become professional practice. We are cautious. A few years ago, Québec introduced a fee for a "pharmaceutical opinion", but the reimbursement process was so cumbersome, many pharmacists did not submit claims.

Employers may try to avoid these new pharmacist costs. They make sense for government plan beneficiaries, so why not for certain employees or family members? I think interventions by pharmacists today will provide important savings in the future.

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