



How
healthy can
you be

WHEN YOU'RE SICK?

PART TWO

By helping patients address unhealthy behaviours such as smoking, drinking, overeating, and inactivity, we can help them improve their health outcomes

Healthy living makes sense even when living with chronic conditions



Bridgepoint Health is a leading health care provider, researcher and advocate on behalf of people with complex chronic illness. It has developed a series of newsletters which will be issued monthly to government, academic institutions, health care practitioners, health care associations and the media to raise awareness of a new frontier of healthcare – complex chronic illness – and, to encourage a national dialogue on complex chronic illness management.

There are five major risk factors for chronic illness; two are outside of our control – age and heredity – while three are preventable – poor diet, physical inactivity, and tobacco use

By Marian Walsh,
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“The health of the world is generally improving, with fewer people dying from infectious diseases and, therefore, in many cases, living long enough to develop chronic diseases. Increases in the causes of chronic diseases, including unhealthy diet, physical inactivity and tobacco use are leading to people developing chronic diseases at younger ages...” World Health Organization, Preventing Chronic Diseases, A Vital Investment, 2005

PREVENTABLE ILLNESS

In the midst of our busy and demanding lives, most of us overlook the impact unhealthy habits have on our bodies. But according to the 2005 World Health Organization report on chronic illness, there are five major risk factors for chronic illness; two are outside of our control – age and heredity – while three are preventable – poor diet, physical inactivity, and tobacco use.

The recently organized Canadian advocacy group Chronic Disease Prevention Alliance of Canada (CDPAC) focuses attention on the preventable risk factors for chronic illness on their web site:

“Predominantly indicated in chronic conditions are lifestyles that embrace unhealthy behaviours and patterns of consumption. Tobacco use, prolonged and unhealthy nutrition, physical inactivity, excessive alcohol use, unsafe sexual practices and unmanaged psychosocial stress are major causes and risk factors for chronic conditions.”

The major chronic illnesses are heart disease, stroke, cancer, respiratory illnesses, and diabetes. According to *The Health of Canadians, Final Report 2002* from Health Canada, many of these are largely preventable.

- Cardiovascular illnesses, including heart disease and stroke, account for 38% of all deaths in Canada every year and are a leading cause of hospitalization. These illnesses are largely caused by smoking, poor diet, and too little exercise.
- Cancer kills 29% of us each year, and most of the common cancers, such as lung, respiratory, and digestive system cancers, are preventable.

- Other respiratory illnesses, such as emphysema, are caused by smoking and are preventable.
- Diabetes, a major cause of coronary heart disease and a leading cause of blindness and limb amputations, is taking on epidemic proportions and is frequently caused by poor diet and obesity.

A reference from a 2002 report of World Health Organization, in the *Final Report of the Commission on the Future of Health Care in Canada* (Romanow Report), makes the point in the clearest of terms:

“Over 90% of type II (adult onset) diabetes and 80% of heart disease could be avoided with good nutrition, regular exercise, elimination of smoking, and stress management.”

The conclusion is inescapable. **If you are aging and have hereditary risks, minimizing the preventable factors is critically important to maintaining your health. If you are young and don't have hereditary markers but have one or more of the other risk factors, you are taking serious chances with your health.**

The CDPAC reports that, incredibly,

“Two-thirds of Canadians have at least one modifiable risk factor for chronic disease: smoking, low levels of physical activity, unhealthy eating habits or overweight and obesity. Only 4% of adults 18 to 74 years old have no major risk factor for cardiovascular disease.”

And it suggests the situation is actually getting worse:

“Several preventable diseases and conditions pose key challenges, either be-

cause they are already prevalent, or because epidemiological data show large rates of increase in their risk factors.”

You will recall from previous bulletins that chronic illnesses tend to cluster and that about half of the people with chronic illness have more than one illness, or complex chronic illness. Considering that many of the chronic illnesses we're talking about here are largely caused by the same risk factors, it is not difficult to see why this might be. Making unhealthy choices may contribute to the development of multiple illnesses. And their impact doesn't stop once you've developed illness. They continue to contribute to health deterioration and the need for more and more costly medical interventions.

THE COST OF ILLNESS

In addition to the impact chronic illness has on patients' lives, there is the impact chronic illness has on society and on health care costs in particular. Chronic and complex chronic illnesses account for over 80% of our national health care spending. According to information contained in *Preventing Chronic Disease and Promoting Public Health: An Agenda for Health System Reform* (Terrence Sullivan, 2002), that amounts to over \$80 billion annually. Broken down by major category, the costs look like this:

- Cardiovascular diseases - \$28 billion per year
- Diabetes and its complications - \$14 billion per year
- Cancers - \$13 billion per year
- Respiratory illnesses - \$8 billion per year

- Obesity (including hypertension, diabetes and coronary artery disease) - \$1.8 billion per year
- We're paying a high price for our unhealthy behaviour.

TAKING CONTROL

Fortunately, having a chronic illness or even several chronic illnesses does not necessarily condemn a person to a rapid deterioration of their health or a continuous cycle of health crises. In fact, a coordinated approach to care that includes healthy living education, healthy choices, and ongoing support for those choices can help people with complex illnesses enjoy better health, greater independence, and a higher quality of life. It is increasingly believed that health promotion and self-management should be cornerstones of any coordinated program of care.

It is a fact that **70-80% of complex chronic patients can effectively manage their conditions** (From Kaiser Permanente) - **if supported**. Unfortunately, many are not meeting this potential. A study published in *Healthcare Quarterly* in 2005 suggests that **40-50% of chronically ill patients do not persist with initial treatment plans beyond 12 months**. We need to ask ourselves why this is. One reason may be that health promotion and support for patient self-management haven't been identified as important areas of overall disease management.

Data is emerging that suggests that patients are not treated as partners in care,

they are not adequately schooled in what they need to do and why, nor are they offered much in the way of support following discharge from hospital. For example, in a recent study by the College of Family Physicians of Canada, 60% of family physicians said that they are not informed when their patients are referred into home care, while 49% reported that they are not consulted on their patients' post-hospitalization care plans.

People who have complex chronic illness need more than just health promotion information. They require a proactive health promotion system that is an integral part of their overall case management and provides the information and support necessary to facilitate self-management.

CASE MANAGEMENT

Case management should be the core element of care coordination and health promotion for people with complex illness. Its role should be to develop the programs, manage the transitions, anticipate the challenges, and provide the encouragement that helps patients achieve the highest level of functioning possible. It should coordinate efforts in the areas of rehabilitation, medication self-management, coping skills, diet, exercise, and other aspects of overall wellness.

The ideal case management model would be a team, led by a primary care provider (a physician or nurse practitioner), with a dietitian, a pharmacist, a physiotherapist, an occupational therapist, a psychologist, a social worker, and

A Health Promotion Model

1. PLANNING. The case management team works with the patient to develop an informed and supported self-management program.

2. OUTREACH. The case management team establishes a routine series of educational and motivational contacts that include regular calls from the case manager and other team members and communications devices like websites or regular reminders through the mail or email.

3. GROUP EDUCATION. Group education and group consultations provide patients with a strong peer support network, putting them in touch with people who are having similar experiences. Group visits can be held monthly. The primary care practitioner and other members of the case management team and family members/caregivers would be invited and expected to attend.

the patient and his or her family or other caregivers. Together they would develop a comprehensive program of care and self-management. One of the primary care clinicians would have the day-to-day, personal relationship with the patient and provide the support and encouragement necessary to adherence.

SELF MANAGEMENT

Self-management is not a euphemism for “You’re on your own.” It should be an important element of the care plan that recognizes the patient as a key partner in his or her own care. It shifts some responsibility to the patient, but provides the knowledge, understanding, tools, and partnerships that will help the patient succeed. It needs to be well structured. It needs continuous follow-up. It is a commitment between caregivers and patients.

Before discharge, a patient would be given a personalized program of diet and exercise, a coordinated medication program that would anticipate and prevent harmful drug interactions, tips on what to look for in health changes, and a regular program of communication – such as support groups, a schedule of clinic or home care visits, or telehealth consultations. In addition, special programs would be developed to help the patient break unhealthy habits that work against their goals.

EVIDENCE OF EFFECTIVENESS

A 2004 article in Health Affairs reported on a U.S. study examining the effectiveness of a disease management program that included health promotion

interventions for patients with diabetes. The study reported a 22-30% decrease in hospitalizations. The program involved web-based education, repeated telephone outreach by various health care professionals, remote monitoring devices, and reminders and educational mailings throughout the year.

In 2001, Dr. Eric Coleman of the University of Colorado published a study in Effective Clinical Practice that looked at the effect of group counseling on the number of hospital emergency visits by older people with chronic illness. Group meetings of between eight and 12 people were held monthly. Spouses and caregivers were invited. The primary care physician, nurse, and clinical pharmacist routinely attended, with other health care professionals as needed. The study found that “intervention participants were one third as likely to have an emergency visit for any reason and were less likely to make multiple emergency visits.”

A large scale study published by Health Canada in 2001 calculated that 2.5% of all health care costs are the result of physical inactivity alone and estimated that a 10% increase in physical activity could reduce

health care expenditures by \$150 million each year.

CONCLUSION

Studies have proven that **much chronic illness can be prevented and that conditions can be improved even after the onset of illness.** It is clear that healthy behaviours can have a huge, positive impact on our health and on the cost of health care. It is not easy to change habits, but we do know where to begin.

First, we need to accelerate primary care reforms that will place primary care at the centre of a coordinated approach to care that includes health promotion.

Second, we must make it known that even people who are already ill can be less ill and less of a burden on the system if they are supported in managing in their illness and in making healthy choices.

And, third, we must invest in a larger role for public health in public education.

For more information about complex illness management and Bridgepoint Health, please visit www.bridgepointhealth.ca

