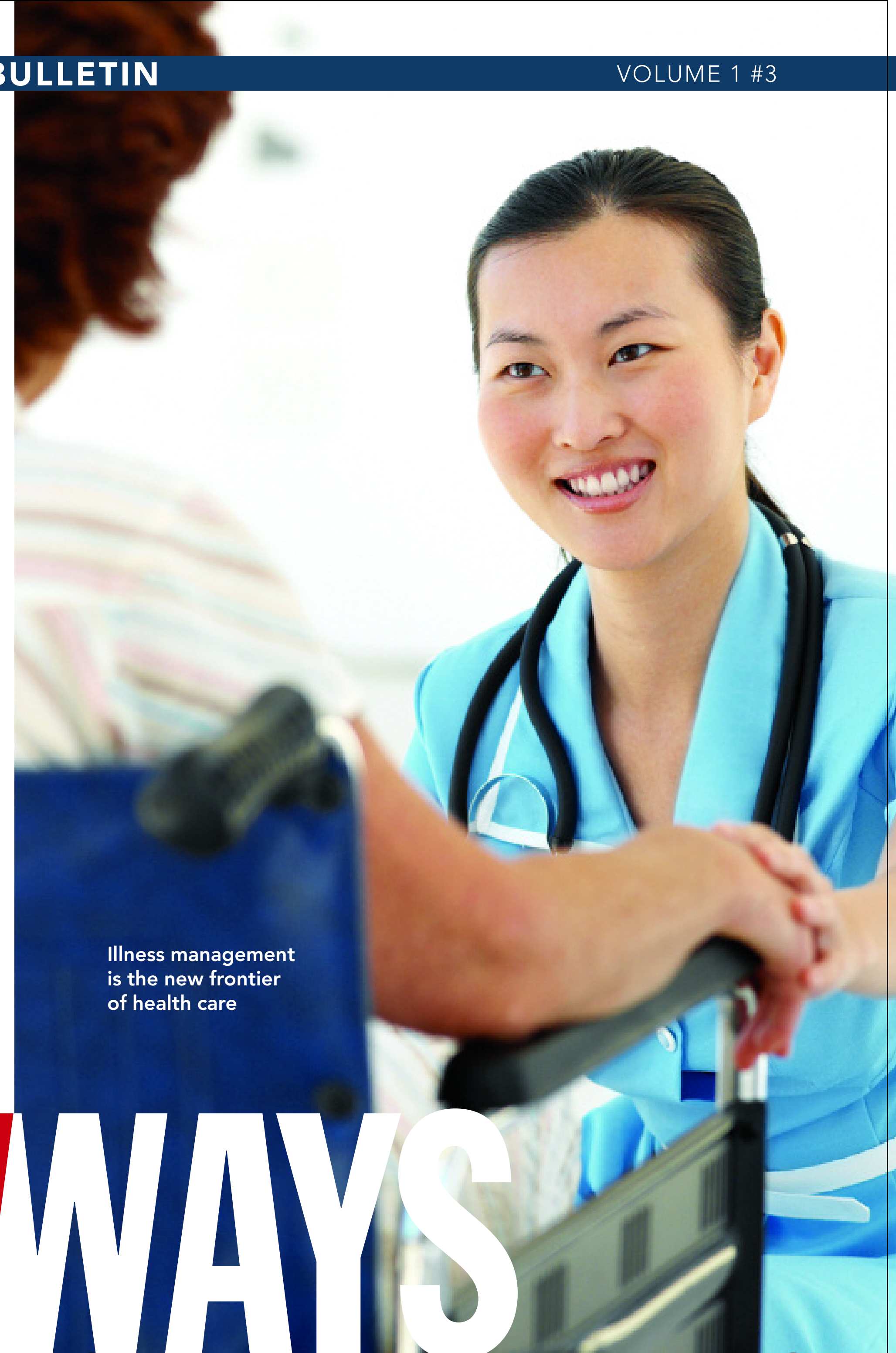
BRIDGEPOINT HEALTH **BULLETIN** VOLUME 1 #3



Illness management is the new frontier of health care

Looking at NEW WAYS TO SOLVE OLD PROBLEMS

The 4 Pillars of Complex Chronic Illness Management: Research and Education; Integrated Care; Illness Prevention; and, Informed Self-Management

BRIDGEPOINT BULLETIN VOLUME 1 ISSUE 3 - NEW APPROACHES FOR COMPLEX CHRONIC ILLNESS
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.

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By Marian Walsh, President and CEO, Bridgepoint Health

REPORTS FROM ALL over the world are revealing the new challenges facing policy makers and health care providers as the burden of illness shifts from life-saving to chronic and complex chronic illness management. They are beginning to advocate different approaches to treatment and different structural responses. While legislators struggle to contain wildly increasing costs, studies are overwhelmingly finding that, with a different approach to care, chronic and complex chronic patients can enjoy better health, reach a higher level of functioning and be less costly to the health care system. In this bulletin, we will introduce some new ideas about caring for a patient population that does not thrive under conventional approaches

We are growing more and more confident that good complex illness management is comprised of four distinct but linked elements: coordinated case management and services; specialized complex illness research and education, illness and accident prevention programs; and, informed patient self-management. Future bulletins will deal with each of these subjects in detail.

COORDINATED CARE

Conventional, disease-focused care is an out-of-date approach for the 25% of the general population that has complex chronic illness. At Bridgepoint, we have learned that **coordinated care programs, which take into account the interactions of multiple illness and the natural deterioration that comes with aging and, that move a patient seamlessly from one level of care to another can result in better health and reduced health care demands.** Although coordinated services are much discussed, they are still not widely applied. Considering that about **60%** of Ontario's health care budget is spent on people with complex chronic illness, it is clear that there is an urgent need for this discussion to be higher on the public agenda.

Studies from all over the world are coming to the same conclusions:

In 2001 the *European Journal of Public Health* said: ***"…patients with specific patterns of co-morbidity may have particular health care needs and may require specific combinations of health services [and] new designs for the delivery of health care…"***

In 2002 *Archives of Internal Medicine* stated, ***"Clinicians … need to be aware of the high proportion of their patients with multiple chronic conditions and to know how to coordinate their care with other clinical providers"***

The 2002 World Health Organization (WHO) report, *Innovative Care for Chronic Conditions – Global Report on Chronic Illness* agreed: *"Patients need integrated care that cuts across time, setting, and providers and patients need self-care skills for managing problems at home. Organized systems of care are essential."*

And, more recently, a 2005 WHO report called, *Preventing Chronic Diseases, A Vital Investment* said: *"the provision of multidisciplinary health-care teams can be a highly effective approach to improving chronic disease care; the support of patient self-management is a core element of effective chronic disease care"*

RESEARCH AND EDUCATION

Similarly, conventional research does not address the special problems of people with multiple, interacting conditions. Currently, research is organized around individual diseases. While it is unquestionably valuable to continue studying the causes, potential treatments and cures for them, there are limits to the usefulness of this information for the treatment of complex illness. None of these streams of research studies the behaviour of multiple, interacting conditions. **Another stream of research is now clearly required: research into the effects of multiple conditions acting in one body.**

Also, medical education is largely organized around disease specialties. Again, this training is useful but limited because it provides no framework for developing coordinated care programs nor does it encourage integrating services.

A 2005 report from the British Columbia Centre for Health Services and Policy Research, *Chronic Conditions and Co-morbidity Among Residents of British Columbia*, describes how fundamental the need for information is:

> ***Chronic disease programs often focus on a single condition.… In the US, more than 40 percent of individuals with chronic conditions—and almost 70 per cent of those aged 65 and over—[have] more than one chronic condition.*** *Yet little is known about the distribution of people with single or multiple chronic health conditions in Canada.* ***This type of information is critical to planning and organizing health services …***

HEALTH PROMOTION

Health promotion, too, has emerged as an important factor in improving the health of people with complex illness. It may seem counterintuitive to talk about health promotion for people who are already ill but the logic quickly becomes apparent; people who don't exercise, who have poor diets, who smoke and drink too much are the people who develop chronic illness. **If these bad habits persist, their illnesses will deteriorate more quickly and their quality of life will suffer more than necessary.**

The 2004 John Hopkins report, *Chronic Conditions: Making the Case for Ongoing Support*, states that a higher priority must be placed on illness prevention, both before and after people have contracted illness: *"In addition to improving the coordination of care the health care system must place a higher priority on primary, secondary and tertiary prevention to avert disease or slow its progression."*

Retooling for the new challenge

1. INVEST IN COMPLEX ILLNESS RESEARCH. Health research has always been organized by disease, so there hasn't been any research into the interaction and treatment of multiple illnesses. Bridgepoint has launched the first research institute in Canada for complex illness. We gave it a mandate to study multi-factored illness and trans-disciplinary approaches. In addition we asked it to develop a framework for study that would allow us to share our learning with clinicians, academics, medical students, patients and their families.

2. COORDINATE CARE ACROSS DISCIPLINES. Healthcare disciplines do not effectively coordinate their work. Many health care professionals will comment that existing teams do not function optimally because they lack understanding of

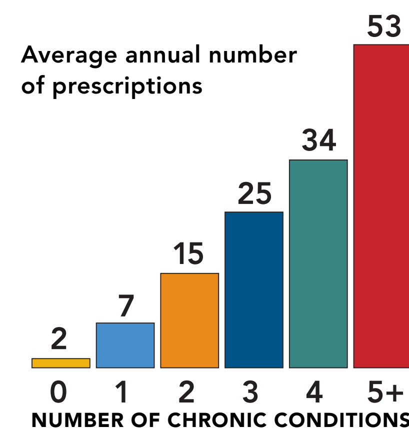
the roles and expertise offered by other disciplines. They are not trained to encourage integrative behaviour. A restructuring of the healthcare education curriculum is required. Bridgepoint is working with the University of Toronto to develop a research and education program for medical students.

3. PROMOTE ILLNESS PREVENTION. Bridgepoint has learned that social and psychological factors contribute to unhealthy choices and have an impact on patient outcomes. So Bridgepoint is developing coping and prevention specialities for complex illness management.

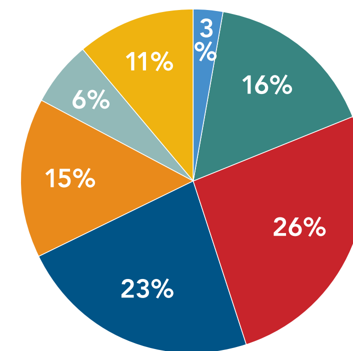
4. INTEGRATE SERVICES. Bridgepoint is building bridges between services, between levels of care and between institutions and the community. Bridgepoint is taking its therapies to peoples' offices and residences and giving their families the skills to manage outside a hospital environment. Also, Bridgepoint has been building teams of multidisciplinary intervenors who operate in acute care settings to give people a head start on rehabilitation.

5. COMMUNICATE ACROSS DISCIPLINES, ACROSS SERVICES, ACROSS FACILITIES AND WITH PATIENTS. A properly managed case requires the full understanding and participation of the patient. This requires that services be coordinated and communicated across medical disciplines, with the patient and with the family. Patients who don't understand their treatments have a tendency to discontinue them, resulting in acute episodes.

People with multiple chronic conditions fill more prescriptions



More than half of people with serious chronic conditions have three or more different physicians



Source: Partnership for Solutions. Chronic Conditions: *Making the Case for Ongoing Care – Sept 2005 Update*, John's Hopkins University University, 2004

SELF MANAGEMENT

Poor coordination inevitably leads to poor communication with the patient and poor patient self-management. Patients often have little understanding of their conditions and how they interact. Many of them discontinue their treatments because of discouraging and unnecessary side effects. A 2005 issue of *Healthcare Quarterly* said that **40% to 50% of chronic patients lapse in taking their medications, eating properly and exercising by the 12-month mark.** If patients won't or can't comply with treatment recommendations it is absolutely guaranteed that they will have repeated and costly health crises that send them back to emergency departments and acute care hospital beds.

CONCLUSION

Bridgepoint's experience in supporting individuals with complex needs has brought us to two realizations: one, that the absence of research means there is no empirical evidence on which to set common standards of treatment and results measurement, and, two, **experience strongly suggests that a trans-disciplinary model of care would be a big step in the right direction.**

Right now, in Ontario, it is conservatively estimated that **10% to 20% of all patients in the acute care setting are complex patients who do not belong there, are not getting the right kind of care** and are consuming over 60% of health care resources. They contribute greatly to increased waiting times. However, despite the tremendous impact of complex chronic illness on personal health and health spending, society continues to focus on the life-saving and episodic parts of the health care.

WHAT DO WE DO?

We need to start by recognizing that a huge change in health has occurred and that acute care is not the right kind of care for people with complex chronic conditions. These patients need illness management programs - treatments and strategies that help them remain as well and independent as possible, that slow down the progression of disease and that can, at least in part, be self-managed. **Illness management is not what acute care is designed to do.**

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