

Care needs  
have evolved –  
system hasn't

Proficiency at  
life saving has  
to be matched  
by proficiency  
in illness  
management

# HEALTHCARE MISMATCH



Drug to drug to interactions are common, sometimes resulting in unnecessary hospitalizations and even death.

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.

# Health care is organized around an acute, episodic model of care that no longer meets the needs of many patients, especially those with **chronic conditions**

By Marian Walsh,  
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**I**N ISSUE #1 OF THE Bridgepoint Bulletin, we discussed the emergence of a new category of illness — complex chronic illness. We explained that it has arisen from advances in modern medicine which have converted formerly fatal illnesses into chronic illnesses. In this bulletin, we take a look at the emerging conflict between chronic illness — particularly the complex end of chronic illness — and the conventional approach to care.

A 2002 World Health Organization (WHO) report, *Innovative Care for Chronic Conditions*, reported, “**Health care is organized around an acute, episodic model of care that no longer meets the needs of many patients, especially those with chronic conditions. ... There is a mismatch between health problems and health care.**”

In a 2005 report released by the British Columbia Centre for Health Services and Policy Research, “*Chronic Conditions and Co-morbidity Among Residents of British Columbia*”, the authors

referred to other evidence that suggested that **chronic care is an unconnected series of symptom-driven events** that direct patients to different places and services none of which has complete information about the patient or what other care givers are prescribing.

More pointedly, the 2004 Johns Hopkins’ report, *Chronic Conditions, Making the Case for Ongoing Care* noted: “**People with chronic conditions are getting services, but those services are not necessarily in sync with one another, and they are not always the services needed to maintain health and functioning.**”

What is true for a single chronic illness is compounded for multiple chronic illnesses. **We know from statistics that half the people with one chronic illness have more than one.** They are dealing with both the normal affects of each illness and the results of disease interactions. It is complicated and the implications for the use of health care services are enormous.

A study published in 2004 in an issue of *Chronic Diseases in Canada* reported:

*“... for individuals under age 60, each additional chronic disease results in a 76% increase in the probability that the individual will have been a high user of physician services and a 44% higher probability of having being hospitalized in the previous year”*

*“The risk of suboptimal or ... adverse outcomes increases for patients as their complexity increases and as their corresponding resource use increases.”*

Why does the risk of adverse effects increase along with increased use of the system?

Dr. Vincent Chien, a leading internist working with St. Michael’s and Bridgepoint Hospitals, has reported encountering a significant number of patients who are suffering as much from conflicting advice and drug interactions as they are from their underlying conditions. He has concerns about the lack of coordination that makes current health

care “teams” collections of separate and uncoordinated disciplines. **The lack of coordination often has negative results. The care becomes part of the complication.**

International studies support this observation. The 2004 Johns Hopkins’ report said:

*“...many people with chronic conditions report receiving conflicting advice from different physicians and differing diagnoses for the same set of symptoms. Drug to drug interactions are common, sometimes resulting in unnecessary hospitalizations and even death. People with chronic conditions are getting services but [they] are not necessarily in sync with one another, and they are not always the services needed to maintain health and functioning.”*

*“... protocols developed for the treatment of a single disease may be contraindicated among patients with specific co-occurring diseases.”*

## How do we respond?

**ONE.** Recognize that the majority of patients in Ontario are people with chronic illness. They are, or will become, complex patients.

**TWO.** Recognize that complex patients must be treated for conditions that interact with each other and cause complications.

**THREE.** Accept that their care must be integrated over time, coordinated across services and continuously managed for the rest of their lives.

**FOUR.** Shift some attention from episodic care to the development of truly integrated continuing care.

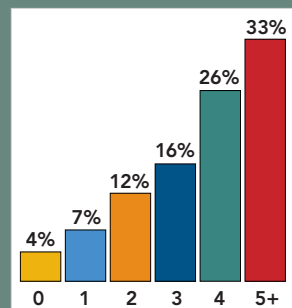
**FIVE.** Educate clinicians about the special requirements of people with complex conditions.

**SIX.** Move complex patients out of costly acute care hospitals and into surroundings that provide better care and produce better outcomes at a lower cost.

**SEVEN.** Redirect some of our health care investment into an expansion of complex chronic care research, training and infrastructure in order to relieve the burden on acute care facilities.

## People with chronic conditions are more likely to be hospitalized

Percent of people with inpatient hospital stays

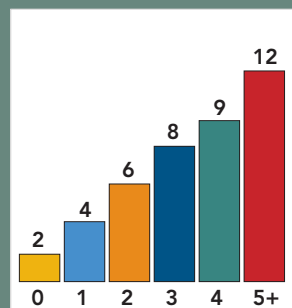


### NUMBER OF CHRONIC CONDITIONS

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

## People with multiple chronic conditions make more physician visits

Number of physician visits



### NUMBER OF CHRONIC CONDITIONS

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

An issue of the *European Journal of Public Health* (2001 / 11:365-372) stated, "patients with comorbid conditions are [likely] to receive treatment for unrelated disorders."

And, from a 2004 issue of *Annals of Internal Medicine*, Lost in Transition: Challenges and Opportunities for Improving the Quality of Transitional Care,

*"Rarely do clinicians have complete information with which to monitor the entire [medication] regimen adequately, much less intervene to reduce discrepancies, duplications or errors. ... 19% of patients discharged ... experienced an associated adverse event within 3 weeks..."*

What can we conclude from this? An obvious conclusion is that **there is a new patient category that doesn't respond well to the episodic, disease-specific types of treatments that are typically offered.** In a report issued by the *European Journal of Public Health*, which studied people with multiple chronic conditions between 1990 and 1997, the evidence indicated that people with complex chronic illness need very specific combinations of services and new approaches to delivering those services.

In Canada, too, there is a growing conviction that **complex chronic illness is a new category of illness and needs fresh approaches.** There is also a growing awareness that people with complex illness can enjoy better health and place

fewer demands on the over-stretched health care system.

Right now in Canada, between **10% and 20%** of people in acute care beds are patients with complex chronic illness. **The problems that sent them to hospital likely could have been prevented** if the focus of care was the whole patient rather than the individual illnesses.

So, we are facing two challenges: we have a huge and rapidly growing number of people with complex chronic illness, and a health care system that is not structured to provide them with the best care.

Complex chronic illness forms the next frontier of illness and treatment. Defining this as a new category has only just begun and is not consistent across jurisdictions. The complex part of the chronic illness spectrum has never had its own field of research or treatment protocols. Much needs to be done. With its mission of "changing the world" for people with complex illness and disability, Bridgepoint Health is one of Canada's leaders in advocating for and treating people with complex illness. Bridgepoint believes that these people can maintain better health and live better lives. The social and personal cost of failing to address this new frontier is already being felt.

For more information about Bridgepoint Health and complex illness please visit [www.bridgepointhealth.ca](http://www.bridgepointhealth.ca).

