



Coordinated services =  
better health and lower  
health care costs

How  
healthy can  
you be

# WHEN YOU'RE SICK?

The role of primary care in complex  
chronic illness management



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.

# The primary care physician is the logical choice to case manage the various and often long-term generalist and specialist services that must be applied to complex cases

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**T**HE FIRST THREE bulletins provided evidence that the life-saving and episodic focus of acute care is often inappropriate for people affected by chronic and complex chronic conditions. By failing to recognize that their treatment should be fundamentally different, we inadvertently contribute to their health problems. In this bulletin, a case is made for linking primary care reform to the needs of people with illness at the complex end of the chronic illness spectrum – people with multiple chronic conditions.

The position we take at Bridgepoint is that **primary care, being the point of entry to the whole system, is the ideal locus for coordinated care.** It is the logical centre of the range of generalist and specialist services that must be utilized in complex cases.

Why is coordinated care so important? Because, **poorly coordinated care often results in health problems that are caused by the treatment rather than the underlying condition.** Here's what some studies are saying:

*“Drug to drug interactions are common, sometimes resulting in unnecessary hospitalizations and even death.”*  
Johns Hopkins University, *Chronic Conditions: Making the Case for Ongoing Care*, 2004

*“...individuals with four or more chronic conditions were 99 times more likely to have incurred a hospitalization that could have been prevented.”* *Archives of Internal Medicine*, November 2002

*“...we have put the care delivery system together in ways that ensure discontinuity, under-treat pain and other symptoms, discourage planning ahead...”* Rand Centre, *To Improve Care of the Dying*, 2001

These comments highlight the underlying problem. People with complex chronic illness require coordinated care that is sensitive to the interactions of multiple disease and the potential conflicts of multiple treatment regimens. Too often, they're not getting it.

There are lots of good reasons for the lack of coordination. To start with, chronic and complex chronic illnesses are relatively new in human experience – at least on the scale we see today. Also, research and medical training have been focused on life saving – an understandable priority. And, government funding reflects and perpetuates single disease medical structures. For instance, research is supported in single disease streams and clinicians are compensated on the basis of individual patients seen and individual conditions treated. But, this is inconsistent with a medical system that is being overwhelmed by people with complex conditions. Even the most forward thinking and adaptable clinicians are frustrated in their efforts to coordinate care. Generalists and specialists are often separated by geography, overwhelmed by daily demands and have different priorities.

**Communications breakdowns are unavoidable.** What happens then? The patient — the person with the least clinical knowledge, the person living with uncertainty and stress — is left to figure it out

on his own. Typically, within a year, the patient stops following the treatment program and his condition deteriorates to the point that he is re-admitted to an acute care hospital. Once his condition is stabilized he's released to start the cycle all over again. It is not the patient's fault.

*“...much of how doctors and nurses think is organized around diagnosis, and this drives the course of care and treatment. However, chronically ill people... ordinarily have multiple diagnoses, none of which maybe particularly revealing about aggregate severity of illness”* RAND Centre, *Living Well at the End of Life*, 2003

## THE ELEMENTS OF SUCCESSFUL COORDINATED CARE

People working in the field of chronic illness are realizing that the health care system, while not attuned to the needs of complex chronic care patients, does have many of the right resources and, that a realignment of those resources could lead to significant improvements in health and greatly reduced costs. Increasingly we see primary care as the centerpiece of reform.

*“Better primary care, especially coordination of care, could reduce avoidable hospitalization rates, especially for individuals with multiple chronic conditions.”* *Archives of Internal Medicine*, November 2002

*“... the defining features of primary care... continuity, comprehensiveness, and coordination – match the care needs of chronically ill persons.”* *Annals of Internal Medicine*, 2003

*“Primary care may be uniquely suited to meet the combination of clinical, behavioural, psychosocial, and socioeconomic needs of those with multiple chronic conditions and complex care needs.”* Centre for Health Services and Policy Research, *Chronic Conditions and Co-morbidity Among Residents of British Columbia*, 2005

*“One of the characteristics of most chronic diseases is that the care required for them cuts across several different health-care disciplines. Multidisciplinary health-care teams, centred on primary health care, are an effective means in all settings of achieving this goal and of improving health-care outcomes.”* World Health Organization, *Preventing Chronic Diseases, A Vital Investment*, 2005

There are many reasons for putting primary care at the centre of a coordinated model of care. First, the primary care physician is the person likely to know the most about the patient's health history and overall condition. The physician is likely to know and treat the patient's family and is able to communicate to all the patient's caregivers. He or she is also the best person to identify and coordinate the involvement of other specialties and knows how to best utilize them in what is called a “trans-disciplinary” or “shared care” team.

*“Several commentators have suggested that shared care between primary care physicians and specialists may produce the best outcomes.”* Rothman and Wagner, *Annals of Internal Medicine*, 2003

Similarly a nurse or nurse practitioner could provide the coordination role for stable complex patients who could manage on their own with some support and coordination of services. There are several ways in which a primary care intervention could result in health improvements:

### 1) CASE MANAGEMENT

In one model, Kaiser Permanente in the U.S. has described three levels of case management. Each envisions a role for a primary care practitioner.

**LEVEL 1: Usual care with support.** Primary care focuses on routinely monitoring the progress of the patient's conditions, but the dominant source of care is patient self-care and self-management.

**LEVEL 2: Assisted care or care management.** In more medically complex cases, additional care is provided and managed by a nurse or nurse practitioner. Physicians are consulted to develop overall care plans and to provide expert services when required.

**LEVEL 3: Intensive case management.** When complexities reach the stage of requiring intense care, patients are assigned case managers who closely track their conditions, communicate to the rest of the team, follow them through the system and advocate on their behalf. Primary care physicians are actively involved in the development of care programs, consulting with specialists, and directly providing care.

## How does it work?

### 1. PRIMARY CARE-BASED COORDINATED CARE.

The model relies on individualized, trans-disciplinary teams of caregivers where each member of the team is responsible to the others and to a coordinated, rationalized program of care. A case manager supervises the team.

### 2. PATIENT-CENTRED.

The nature of complex chronic illness dictates that the patient be considered as a whole person and that their individual conditions and the resulting emotional and spiritual burdens be factored into the care plan.

### 3. COMMUNICATION.

Involving patients in their own care, teaching them to ask the right questions, encouraging them to provide all relevant health information to their caregivers and providing them with reliable information about their illnesses or conditions is critical.

**4. INTEGRATION.** As people age, their conditions will change or deteriorate. At different stages, they will need different types and intensities of care. The transition from one type or level of care to another – such as from hospital to a complex care facility, long-term care or the home — must be seamless and well supported.

## 2) TRANSITION MANAGEMENT

A primary care coordinator could also help prevent the poor communication that is often a feature of transferring patients from one place to another or from one level of care to another. If those transitions were better managed and patients and their families better informed, mistakes and duplications of service could be avoided. Again, a nurse or nurse practitioner could manage the process and coordinate the activities of team members. Currently, the complexity and fragmentation of the healthcare system causes difficulties that can include delays, physical and functional deterioration, duplication, and health crises.

Dr. Eric Coleman, in a 2004 issue of the *Journal of the American Geriatrics Society*, wrote that he has found, with the intervention of a primary care coordinator and transition plans that involve the patient and his family, **the rate of re-hospitalization can be reduced by 50%**.

## 3) AND MORE

There is also an important role for primary care in health promotion and home care. Trials in each of these areas are showing encouraging results among people with complex chronic illness. In every case the success of these programs is based on care coordination and the involvement of a case manager who works closely with the patient at all stages of illness. Future bulletins will deal with them in detail.

## THE EVIDENCE

Treatment projects in Canada, Great Britain and the U.S. are providing evidence of the benefits of a primary care-based, trans-disciplinary approach to case management.

For instance, the CHOICE program in Edmonton cares for a population of elderly people with complex chronic illness. A 2004 report from the Toronto District Health Council noted the following benefits of the CHOICE program:

- participants had an **86%** reduction in pharmaceutical claims
- inpatient length of stay was reduced by **55%**

- inpatient acute care admissions showed a **30%** reduction
- ambulatory care total costs were reduced by **25%**
- ambulance use was reduced by **11%**

Another program called Evercare, which was developed by United Healthcare in the U.S. and has been adopted by the U.K., uses specially trained nurse practitioners to lead the delivery of trans-disciplinary care to the frail elderly. Pilots in both the U.S. and the UK are getting impressive results:

*“the incidence of hospitalizations was twice as high among control residents as Evercare residents over a 15 month period ... the rate of emergency room use by Evercare enrollees was half that of control residents” Evaluation of the Evercare Demonstration Program Final Report 2002*

The Neighborhood Health Program (NHP) in Boston using a primary care-based team approach with people with heart disease has found:

*“In the three-year period from 1997-2000, hospital admissions for patients with congestive heart failure dropped 42%, and emergency room visits were down by 20%.” Dr. David Lawrence, From Chaos to Care – The Promise of Team-Based Medicine*

Considering that current estimates have complex chronic care consuming more than **60%** of every health care dollar and that the annual cost of illness, disability and death due to chronic illness in Canada is around **\$80** billion (from the Chronic Disease Prevention Alliance of Canada – The Case for Change), you would think that complex chronic illness management would be at or near the top of the public agenda.

We believe that strengthening the role of primary care in the treatment of people with complex illness could be the catalyst in a cascading wave of reform in clinical practice. The social and personal cost of the status quo is no longer affordable.

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