

Boomers, chronic disease challenge system

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As a physician, working with patients with chronic diseases can be both rewarding and also an enormous challenge. As our baby boom generation grows older and lives longer, they become affected by conditions like diabetes, heart failure, arthritis or osteoporosis. Most often, they have not one but many of these conditions at the same time. Living with these conditions erodes their independence and quality of life.

From a physician's perspective, the list of things that we are supposed to be doing for these patients -- putting them on the right drugs, monitoring lab values, counselling them about diet, exercise, lifestyle or social supports -- keeps growing. At the same time, there is the time pressure of having to squeeze in all of the right care into each clinic visit. All too often, our interaction ends in a brief lecture to the patient that "you should be doing more of this," without engaging the patient to allow them to really take control of their own condition. We then feel frustrated when the patient comes back and hasn't stayed on their medication, or hasn't made any progress in improving their lifestyle.

This all too common scenario illustrates that we aren't doing a good enough job of managing chronic diseases in Ontario. This isn't a criticism of the people who work in the system, but of the shortcomings of how our health care system is set up to deal with these conditions. We don't yet have the right information systems, the level of teamwork and co-ordination, nor the level of patient engagement we need to tackle this problem.

As the Ontario Health Quality Council noted earlier this year, Ontario is facing a growing epidemic. One in three Ontarians have at least one chronic disease, and among those over age 65, the proportion is four of five. About 70 per cent of those with chronic conditions suffer from two or more conditions at the same time. Chronic diseases account for over 60 per cent of health care spending and billions of dollars of lost economic productivity.

Fortunately, several organizations in Ontario are pushing new frontiers in chronic disease management. For instance, Bridgepoint Health in Toronto is the first health care organization in Canada focused entirely on addressing the needs of people living with complex chronic disease and disability (i.e. patients with two or more chronic diseases that impact each other). Bridgepoint offers an internationally recognized patient self-management program to enable individuals to build the knowledge, skills and confidence to take more control of their condition.

Delivering patient-centred care focused on chronic disease is also a hallmark of the Group Health Centre in Sault Ste. Marie. In 1997, the GHC implemented what was then Canada's largest electronic medical records system. This decision, along with the development of the health promotion initiatives program, has transformed the delivery of care for chronic disease patients by providing a common platform for sharing information and evidence-based care plans among the entire interdisciplinary health care team. This "paperless" system tracks all clinical activity on patients, including visits to doctors, nurse practitioners, clinics, labs and hospitals. GHC's approach delivers. Patients in the diabetes program have improved blood sugar results by 20 per cent. The congestive heart failure program initially cut re-admissions by 68 per cent.

As the GHC model suggests, one of the cornerstones for preventing and better managing chronic disease involves giving patients access to a wider variety of health service providers operating in multi-disciplinary teams. At the Blue Sky Family Health Team in North Bay -- one of 150 family health teams in various stages of development in Ontario -- patients can draw on the services of physicians, pharmacists, nurse practitioners, nurses, dietitians, social workers and mental health workers. This approach has allowed the team to take on 3,000 new patients this year to address the needs of the aging baby boomers in the region.

Preventing disease and improving health isn't just about health-care professionals. It's also about empowering patients to better understand healthy living and manage their own diseases. As part of a major shift in organizational strategy, the Barrie Community Health Centre embraced the opportunity to improve patient self-management. It recognized that with the right volunteer-led education and support, people can learn to be active participants in living with and managing their conditions.

We need far more examples if we are to truly serve the needs of Ontario's citizens. We need a co-ordinated, system-wide strategy for reducing and better managing chronic disease. Fortunately, the lessons learned from best practices can be applied across the province. That doesn't mean it will be easy. It will take leadership. It will take a commitment to move from a multi-silo approach to an interdisciplinary one. It will also take a significant investment in an electronic medical records infrastructure.

The dividends, however, will be massive, whether measured in terms of increased health savings or reduced pain and discomfort. Ontario's baby boom generation and those that follow would not only enjoy longer lives, they would live happier and healthier ones as well.

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