Canadian Academy of Health Sciences
Académie canadienne des sciences de la santé

Review of Chronic Care for the Veterans Affairs Canada

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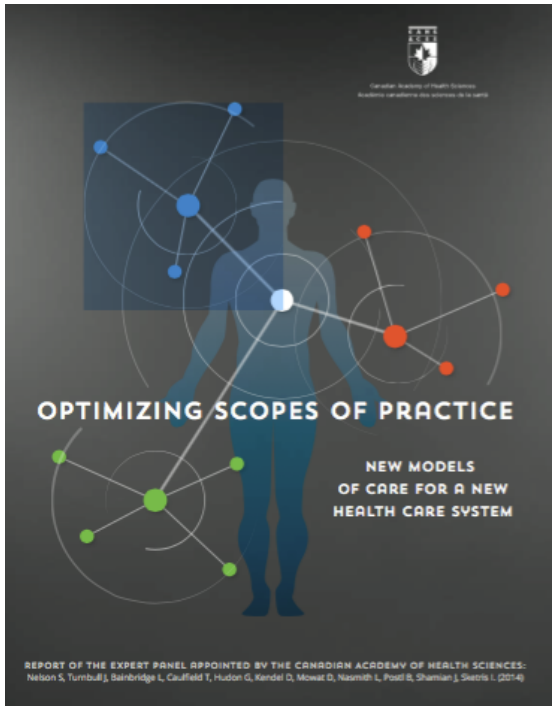
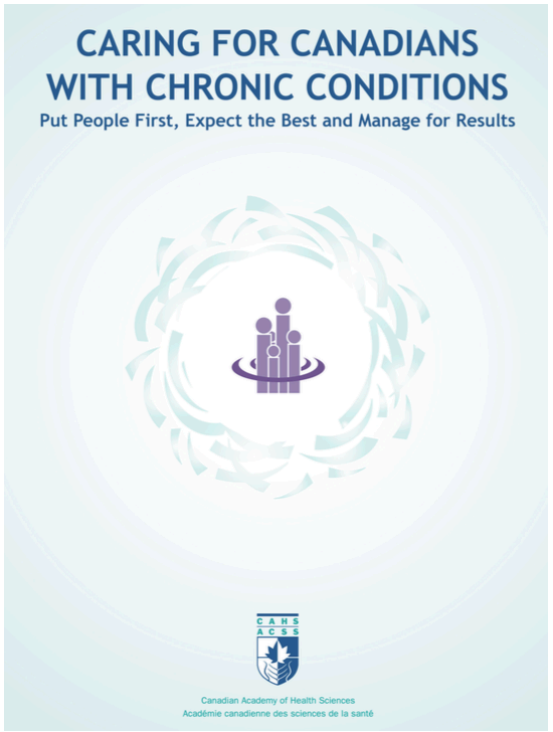
About the CAHS

- Honorific membership organization and a policy research organization
- Elected Fellows from diverse disciplines
- Timely, informed, and unbiased assessments of urgent issues affecting the health of Canadians
- Process is designed to assure appropriate expertise, the integration of the best science, and the avoidance of bias and conflict of interest.

Previous assessments





Scope of VAC report

- Examination of how the presence of chronic health conditions affects the quality of life of individuals
- Examination of services related to physical health conditions through the publicly funded health care system
- Report on current best practices and new and emerging trends

Important, but beyond scope:

- Additional and unique needs related to mental health,
- Addressing the social determinants of health

VAC Questions

- What are the problem areas?
- What can be done to change the system to better accommodate patients with chronic health problems?
- What efforts could be made to modernize the ways in which Canada responds to chronic health problems?
- What are the best practices in managing chronic health problems?

Key messages

- There is a high prevalence of multiple chronic conditions in the general Canadian population.
- Patient-centred primary care is required for the effective management of chronic health conditions to ensure comprehensiveness, coordination and continuity of care.
- Critical elements of such patient-centred primary care models include an interdisciplinary team working with community and specialty resources to ensure needed services and support patient self-management.
- Clinicians require guidance and decision making tools that consider the overall burden of diseases to effectively manage care for people with multiple chronic conditions.
- The Chronic Care Model remains the most promising model of care for people with chronic health conditions, in spite of limited evidence.

Chronic Health Conditions in Veterans & General Population

- High prevalence of people with multiple (3+) chronic conditions in the the general (14 to 38%) population
- **The greater the number and complexity of chronic conditions, the more vulnerable the patient and the more difficult it is to manage their health.**
- The goals of chronic care are generally not to cure, but **to enhance quality of life and physical, cognitive, and social functionality, prevent secondary conditions, and minimize distressing symptoms**.

Impact of multiple chronic conditions

People with multiple chronic conditions:

- More likely to die prematurely,
- More likely to be admitted and re-admitted to hospital
- Have longer hospital stays
- Have poorer quality of life and greater disability
- Are at increased risks of drug interactions and adverse events with complex medication management

Impact extends to:

- Families & other caregivers
- Health System

What are the problem areas?

The Canadian health system has not evolved to address the needs of the increasing number of people with multiple chronic conditions.

Care delivery model

- Episodic/acute oriented
- Medically necessary community based services remain discretionary
- Professional silos reinforced through training and scopes of practice

Disease-focused evidence

- Most clinical guidelines do not consider the additional complexities in improving the health of people with multiple chronic conditions

What can be done?

Disease-Specific Care	Patient-Centred care
Strong orientation towards a single disease	All conditions are considered simultaneously without a focus on a particular one
Strong orientation towards a single disease	Possible interaction between concomitant conditions is systematically taken into account
Treatment oriented by evidence-based guidelines for specific diseases	Guidelines for specific diseases have to be adapted as their strict application is potentially harmful
Treatment seeks to induce remission of the disease in physio pathologic outcomes that may not reflect improvement in patient outcome	Treatment oriented towards outcomes that matter to patients, considering their preferences and integrating biomedical, emotional and social needs
Assumption that treatment will positively affect the accompanying conditions	Polypharmacy and negative drug interactions are a concern; such factors may negate expected benefits
Treating physician acting in solo	Care based on teamwork, which is usually generalist-led
Coordination of care is limited	Coordination of care is an essential component

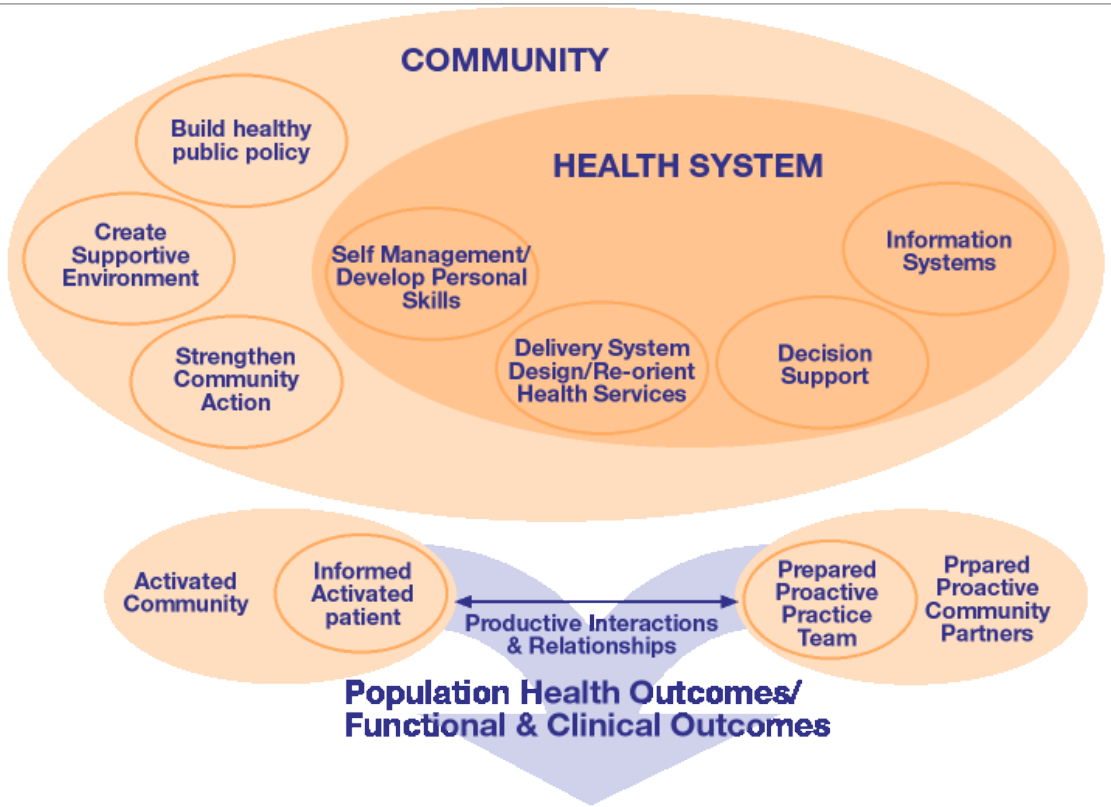
What can be done?

Patient-centred primary care is required for the effective management of chronic health conditions to ensure comprehensiveness, coordination and continuity of care.

Critical elements include:

- an interdisciplinary team
- working with community and specialty resources
- ensuring needed services and support for patient self-management

Best practice: Chronic Care Model



Created by: Victoria Barr, Sylvia Robinson, brenda Marin-Link, Lisa Underhill, Anita Dotts & Darlene Revenadale (2002)
Adapted from Glasgow, R., Orleans, C., Wagner, E., Curry, S., Solberg, L. (2001). Does the Chronic Care Model also serve as a template for improving prevention? The Milbank Quarterly. 79(4), *and* World Health Organization, Helath and Welfare Canada and Canadian Public Health Association. (1986). Ottawa Charter of Health Promotion.

What are the best practices?

The Chronic Care Model remains the most promising model of care for people with chronic health conditions, in spite of limited evidence.

The evidence is promising, albeit inconsistent:

- variation between studies regarding the combination and implementation of elements
- studies use a wide range of measures, with little consensus between studies
- frequently the evidence is insufficient to draw firm conclusions

BUT - new data are emerging that demonstrates positive and promising results!

How can we modernize the system?

Team-based patient-centred primary care:

System that permits the time and relationships needed for health professionals to engage in comprehensive, continuous and integrated care with community and specialty services.

Supported self-management:

Acknowledge the central role that patients have in managing their own care and the responsibility of providers to help people be more engaged in their self care.

Summary

There is a high prevalence of multiple chronic conditions in the general Canadian population.

Patient-centred primary care is required for the effective management of chronic health conditions to ensure comprehensiveness, coordination and continuity of care.

Critical elements of such patient-centred primary care models include an interdisciplinary team working with community and specialty resources to ensure needed services and support for patient self-management.

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