Using Coordinated Care to Make Chronic Disease A Thing of the Past

Today, more than half of all adult Canadians suffer from a chronic disease such as asthma, depression diabetes, COPD, and heart or liver problems. For the elderly, the statistics are even worse.

In fact, chronic diseases drive the majority of Canada’s healthcare expenditures and are the leading cause of death and disability worldwide. According to the Federal Ministry of Health, chronic disease costs the Canadian $80 billion a year through illness and disability and accounts for 75 percent of healthcare costs. Acute care centres bear the brunt of these costs.

What’s going on? Longer life spans, sedentary lifestyles, lack of exercise, stress are the main factors contributing to higher incidence of chronic disease. Costs are growing because traditional treatment is reactive rather than proactive.

Coordinated care is a patient-centred approach for delivering better chronic disease management that provides functionality to address the end-to-end needs of care coordination. It is a preventive and proactive approach by healthcare systems to avoiding complications and acute episodes by managing the patient to clinical guidelines, sharing information on status and interventions with the care team, and supporting the patient in healthy behaviours and self-management. Corresponding behavioural changes are encouraged including better diet, increased exercise and smoking cessation.

Improving outcomes for patients with chronic disease and lowering costs for providers is the name of the game, and IBM is uniquely positioned to support health system managers in this objective, with proven tools and methods. IBM Canada’s Care Team consulting and tools support several key areas of activity:

- Care team coordination tools are used to proactively organize the activities of the care team around preventive approach to patient care. Driven by the medical office assistant, these tools encompass physicians, RNs, specialists, dieticians, pharmacists, and more.

- Decision-support tools give physicians better information to treat individual patients at the point of care for better outcomes according to evidence-based, best practices outlined in Clinical Guidelines.
• Business intelligence tools provide statistical feedback to help physicians evaluate their own practice against clinical guidelines as well as cohort, care team and population performance.

• Patient self-management tools help patients change behaviour to improve their condition or stop its progression. Information and support such as meal planners exercise guides is provided through portals, and using existing technologies such as Web 2.0 social networking tools.

Already, IBM decision support tools can provide the infrastructure for the information gathering and alerts needed in Remote Patient Monitoring – mobile technology enabling remote monitoring of high-risk patients. These tools could help chronic disease patients manage their condition from home by sending up-to-date information readings through a technology chain via the web to their care provider.

Every year, up to 200,000 deaths result from chronic disease in Canada. Costs to health systems are skyrocketing. With prevention and proactive treatment as the goal, there has never been a better time to apply medical technology know-how to improve outcomes and save lives.

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Coordinated Care and Patient Management from IBM

If community-based treatment of chronic diseases is the answer, why is it not more pervasive? One obstacle has been the complexity of coordinating care, which requires integrated and timely communication between health and community services to ensure that patients and their families receive proper treatment and support.

Current community-based chronic disease management is inefficient because of the lack of comprehensive, up-to-date and accessible patient information. Chronic disease patients are usually under the care of several providers and they all need a complete view of the patient’s health history. Technology can provide a real-time view of patient information at the point of care that supports sharing of authorized information with the community agencies that provide supplemental services.

Coordinated care can be supported by IBM Advanced Case Management solutions which enable healthcare providers and enterprises to consolidate and streamline complex cases which lead to faster, more efficient case outcomes. Advanced Case Management can:

• Streamline patient care by providing simultaneous access to patient records.

• Accelerate existing investments in key applications like electronic health care records.

• Share health information across communities, health networks, and regions.

• Support new initiatives such as the demand for higher quality care and patient-centric healthcare.

• Consolidate disparate case information into one streamlined platform.