
CONFERENCE ABSTRACT

Managing Chronic Disease Through Social Integration

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Introduction

Chronic diseases have been cited as being responsible for 80% of healthcare costs and morbidity. Accordingly, effectively controlling chronic disease has been emphasized by many national and international bodies. Despite this, control rates for chronic disease have remained relatively unchanged. Our work has led us to conclude that the so-called care gaps are not due to medical issues, but relate to social factors. The challenge has been to integrate social management strategies with medical management.

Context

This work is being carried out in the context of a totally public, government-funded, universal healthcare system which allows us access to chronic disease data on every individual in the province of Alberta, Canada. Every individual is encouraged to have a family physician and family physicians are organized into primary care networks. Capitated funding is provided to hire other healthcare professionals and to provide care to the patient panels. Unfortunately, there is no universal pharmacare program in Canada for those under 65 years of age.

Targeted population

Although the entire population of Alberta, Canada is targeted, particular attention is paid to those whose chronic diseases are not well-controlled.

Highlights

A major finding of this research-turned-to-policy, was that care gaps in chronic disease management closely correlated with social variables and with lack of regular primary care visits. In order to understand and address these findings, interviews and surveys were carried out amongst this population and with social agencies. This work highlighted barriers such as cost, transportation and particularly competing priorities as contributing to care gaps. As one respondent stated: “you don’t care what your cholesterol, blood pressure or 10 year cardiovascular risk is when you don’t know whether you will have a roof over your head or food on the table tonight”. Similarly, with these competing priorities, people did not visit primary care providers for proactive chronic disease management, but rather only sought episodic care for acute problems. With this understanding, the

questioning about social determinants is being incorporated into primary care-based chronic disease management. Community health navigators are being introduced, along with social prescribing, to address the social issues. Similarly, we are using outreach methods, community pharmacists, and other opportunistic methods to deal with chronic disease. One premise is that chronic diseases cannot be addressed until social issues are dealt with.

Transferrability

The situation we experience with care gaps in chronic disease is likely universal. Thus, this approach is highly transferrable although the identification and resources available to deal with these social issues may vary between health systems.

Conclusions

Identifying and dealing with social issues is a necessary pre-condition to achieving chronic disease control across the population. Our experience has shown that when social issues are dealt with, chronic disease control can occur with very little additional effort. Understanding what is important to individuals at the moment, and sorting out competing priorities is a necessary process. The traditional medical model of “prescribing more pills”, or scolding the patient, is both ineffective and inappropriate in these care settings.