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SYMPOSIUM. HEART FAILURE

Care models for polypathological patients☆

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Abstract Polypathological patients have specific clinical, functional, psychoaffective, social, family and spiritual characteristics. These patients are generally elderly and frail and have frequent decompensations. They frequently use healthcare resources, have significant functional impairment and have a high index of dependence. This results in a significant social impact, high mortality and a high consumption of resources. The current healthcare models have not answered these needs, which causes problems with accessibility to healthcare services, a lack of coordination among these services, a higher probability of adverse events related to polypharmacy and a high consumption of resources. In the past decade, the healthcare models have changed and are characterized by work in multidisciplinary and interlevel teams, patient self-care, the availability of tools for decision making, information and communication systems and prevention. The goal is to have prepared and proactive health teams and an informed and active patient population. The assessment of health results, processes and the costs for these programs is still based on moderate to low evidence. It is therefore not an easy task to determine the type and intensity of interventions or to determine the patient groups that could gain more benefits.

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Modelos de atención al paciente pluripatológico

Resumen Los pacientes pluripatológicos tienen unas características clínicas, funcionales, psicoafectivas, sociofamiliares y espirituales específicas. Son generalmente de edad avanzada, frágiles, con frecuentes descompensaciones, uso frecuente de recursos sanitarios, deterioro funcional importante y un elevado índice de dependencia; de lo que se deriva un importante impacto social, mortalidad elevada y consumo de recursos. Los modelos asistenciales actuales no han dado respuesta a estas necesidades, lo que produce problemas en la accesibilidad a los servicios sanitarios, descoordinación entre estos, mayor probabilidad de eventos adversos relacionados con la polimedicación y un alto consumo de recursos. En la última década, los modelos asistenciales están cambiando y se caracterizan por el trabajo en equipo multidisciplinar e interniveles, el autocuidado del paciente, la disponibilidad de herramientas para la toma de decisiones, los sistemas de información y comunicación y la prevención. Se pretende conseguir un equipo de salud preparado y proactivo y una población de pacientes informados y activados. La evaluación de los resultados en salud, procesos y costes de estos programas, se apoya todavía en evidencias moderadas o bajas. Por ello, no es fácil determinar el tipo e intensidad de las intervenciones, ni los grupos de pacientes sobre los que pueden aportar más beneficios.

Background

Polypathological patients experience multiple chronic diseases, which are generally interrelated but with none taking a central role, sharing equal complexity and the capacity for destabilization.[1,2] These patients also have common characteristics such as advanced age, frailty and frequent decompensations, which usually require health care, including hospitalization. These patients frequently have progressive functional impairment, a high degree of dependence (which affects their social environment), high mortality and greater resource consumption.[1,2]

In recent decades, the progressive improvements in the healthcare conditions of countries in the Organization for Economic Cooperation and Development (OECD) has helped prolong the survival of these patients but has also extended the period of disability. Chronic diseases accumulate in an individual as they age, with an average of more than 4 diseases after the age of 80 years.[3] Due to their greater demand for care, polypathological patients more often feel the effects of interlevel fragmentation in healthcare systems. Research in this area has focused on the clinical, epidemiological and prognostic characterization[4–6] and on the assessment of the public health impact.[7]

The current healthcare models are the fruit of the predominant healthcare planning of the 1990s,[8] aimed at the care of acute diseases. These models propose the separation of objectives, responsibilities and budgets within the healthcare system. The scarce coordination in healthcare is therefore apparent, particularly for patients with chronic diseases. In this old model, the ''typology of patients'' resulted in reduced accessibility to needed healthcare services, intralevel and interlevel incoordination, more specialties involvement in the care, increased hospital visits, increased probability of test duplication, lack of treatment reconciliation, increased risk of interactions and adverse events and a lack of healthcare continuity on admission or after hospitalization. These healthcare models also fail to sufficiently consider healthcare promotion strategies and do not consider the patient's values and preferences.

In short, the way in which patients get sick has changed,[9] and polypathological patients have been a healthcare problem in our present society. Although advances are being made in these patients' epidemiology and healthcare needs, healthcare models with demonstrated efficacy[10–12] need to be implemented for these patients, given the present fragmented system of care, prescription and communication.

General characteristics of the healthcare models for chronic diseases

The most widespread and assessed healthcare model is the Chronic Care Model (CCM) developed by the MacColl Institute for Healthcare Innovation of Seattle,[13] along with the two subsequent adaptations: the Expanded Chronic Care Model (ECCM), developed by the Government of the British Columbia of Canada,[14] and the Innovative Care for Chronic Conditions (ICCC) of the World Health Organization.[15]

These models are constructed with various components that are essential to providing optimal care to chronically ill patients, which refer to the healthcare system, to the healthcare organization and to the community (Fig. 1).

In terms of healthcare organization, four interdependent components have been identified[13]: (1) the design for the system for providing care, focusing on team work through the joint use of resources and the collaboration among