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Short Communication

Older People with Chronic Illnesses: A Vision of the Future

Antonio Masiá Alegre*

Specialist in Family and Community Medicine, Diploma in the Treatment of Chronic Pain, Catholic University of Valencia, San Vicente Mártir, Spain

***Corresponding Author**: Antonio Masiá Alegre, Specialist in Family and Community Medicine, Diploma in the Treatment of Chronic Pain, Catholic University of Valencia, San Vicente Mártir, Spain.

Received: May 21, 2019; **Published:** May 31, 2019

According to the World Health Organization (WHO) Chronic diseases (EC) were the cause of 63% of world mortality during 2008 and are expected to account for 75% in 2020. If these data indicate an improvement in living conditions with greater life expectancy, they also reflect that the pattern of diseases and their attentions are changing. 45.6% of the population over 16 years old suffers a chronic process and 22% two or more. With age grows the presence of EC and at the same time the amount of services. They need to care for the health of the elderly due TO the number of EC they suffer.

The challenge is not the EC but the chronicity. It is not only to diagnose and treat a disease but to adapt to the person who suffers from the environment in which he or she lives. Addressing the chronicity must be to protect and promote health, combining individualized attention and the participation of different social agents at all levels of society.

For the last two decades, several EC [1-4] management models have been developed with the intention of preparing strategies for the chronicity. All of them get the best results in health when the patient, active, informed and considered as a fundamental piece works with a professional team, proactive and prepared.

In the need to solve the problems arising from the attention to THE EC, different international organizations SUCH as the OECD, the un or the European Parliament have addressed this issue [5]. In our country we must highlight the strategy to face the challenge of the chronicity in Euskadi [6] and the consensus reached in the "Declaration of Evil" [7], between sixteen scientific societies, the health services of seventeen Autonomous Communities, the Ministry of Health and, the Spanish Patients Forum, advocated for the realization of a comprehensive autonomic Plan of care for patients with EC in each of the autonomous regions; as well as the Health Plan of Catalonia 2011 - 2015 [8], the plan of CARE for patients with EC of THE Valencian Community (CV) [9] or the health plans of the CV [10]; Within an integrated national strategy and Approved by the Interterritorial Council of the SNS, on June 27th, 2012.

Currently the dominant epidemiological pattern is that of the EC due to the increase in life expectancy, improvement in public health and health care.

Chronicity and dependency are closely related, producing the need for health and social services. Of the change of model, with integral management and coordination of the different social agents arises the strategy for the approach of the chronicity of the Ministry of Health, Social services and equality, with the participation of scientific societies, associations of Patients and health Ministries of the autonomous regions.

It is not so important to apply a theoretical or provision model to develop health care chronicity [11], enhance primary care teams (EAP), reorganize care and involve patients in the knowledge and care of his illness.

As for figures referring to Spain, in the year 2011 17% of the population was greater than 65 years, estimated 20% for 2020 (one in five Spaniards), reaching 35% in 2050.

Currently, 35% of the Spanish population (5% of the total) are people over 80 years old and have two or more EC.

According to WHO, in the year 2005, EC produced 60% of world mortality, between 70 - 80% of total health expenditure, 80% of primary care consultations (AP), 60% of income and 75% of lar Emergency Hospital.

The costs of patients with more than one EC were multiplied by six compared to patients with one or no EC. More than five EC multiplied by seventeen the health expenditure and by twenty-five the hospital expenditure [12].

An example of the impact of the EC in our country is chronic heart failure (ICC) [13]:

- Prevalence of 10% over 70 years.
- Most frequent cause of hospitalization and readmissions over 65 years.
- Cost per hospitalization twice as much as cancer.
- 3rd cause of Mortality in Spain.
- Consumes 1 - 2% of total health expenditure.
- 10% of the hospital beds with an average stay of 7 days.
- High comorbidity: 78% is associated with two or more EC and 54% to three or more
- 60% of patients are 80 years old or older.
- High drug consumption: 8.69 D media with a range of 1 - 23.

In the context of the chronicity, at the level of the Valencian Community, and as it is estimated in its III health Plan [14] 78,7% of the health care will go to the chronic pathology and this must adapt to a model of proactive management, centered in the Prevention and care and that defines the segmentation or stratification of the population according to the needs identifying three levels of intervention according to the complexity of the chronic patient:

- Level 3: Patients with greater complexity and frequent comorbidity. Comprehensive case management.
- Level 2: High-risk patients with lower comorbidity. Disease management.
- Level 1: Patients with EC in stages incipience's Self.

In the CV, currently, it is estimated that approximately 60% of the adult population suffers some EC, which consumes between 70 and 80% of total health expenditure, requiring adequate management of the chronicity to ensure the sustainability of the health system.

The chronic pathology in the CV represents 80% of the consultations of AP, 60% of the incomes Hospital < Aryan and 2/3 parts of the visits to the emergency, being most chronic patients poly-medicated. Among the main EC stand out ICC, COPD, asthma, Heart disease ischaemic, HTA and Diabetes.

The Project ESCARVAL (Project Predictivo), objective of the Plan of provision cardiovascular of the Conselleria of sanitary of the CV, investigates in the clinical practice of the AP, carries out a Monitoring of the Valencian population through the tool of management of the history of Electronic Health (HSE) as is images II and carries out a specific scale of the vascular risk for the CV.

The screening to identify the main risk factors in the CV such as alcohol consumption, smoking, hypertension, DM or dyslipidemia, acting on them produces a great impact on the prevention of EC.

The objective of the strategy of patient care with EC in the CV is an integral attention, to reduce the consequences of the disease and the dependence, to adapt the services to every moment and situation to obtain better health results, greater satisfaction Socio-assistance and better quality of life.

His vision includes:

- A model of attention adapted to the real needs of these patients, offering the attention to me.
- To enhance in AP its management work of the patients and to provide to the professionals tools of work in the best conditions.
- Organisational improvements with the support of the technologies, an ideal and more rational management of the resources.

As specific objectives are indicated:

- Care strategies adapted to the characteristics of patients with EC.
- Proper use of health resources.
- Telemedicine and new technological tools.
- Self-management of the disease and improve the quality of life.
- To promote patient management in EAP.
- To make the coordination between the different welfare and social resources effective.
- New professional competencies through training and new care roles.

The application of this Plan should achieve a better quality of life, reduce unnecessary and preventable hospital incomes, delay as far as possible the evolution of the disease, enhance the self-care and active participation of the patient on his disease, contributing to the sustainability of the system optimizing the activity and resources dedicated to the care of the chronicity.

In the CV the Chronicity Plan is based on the evolution of the organisational model and on the effective integration of the care grades, taking into account not only the needs of the patients with EC but also the optimum of there sources and the Incorporation of new technologies based on information and knowledge.

The Valcrónic program has been implemented as a model, which incorporates innovative technologies that enable remote monitoring, tele-care and clinical decision support, Offering the included patients and their professionals different services. It also stratified the population to identify levels of risk related to the chronicity to act on them and develops an effective coordination of resources and degrees of care to Manerto integral and continuous.

To carry out the stratification of the patients has utilized the model CARS adapted for the program next to the Polytechnic University of Valencia.

In the binomial chronicity-ageing but with a vision of the future but actually implemented in different departments of health of the Conselleria of sanitary of the CV This program allows to follow and to know the evolution of the patients of form not In-person, articulated through a management platform that gives technological support to the functions of the same.

There are a large number of chronic patients and many of the EC are suffering, so in the future of present solutions, their management that is transversal to the Organization should consider shared clinical information as a key part of the management technology of care activity.

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Volume 14 Issue 6 June 2019
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