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Care in Chronic Diseases and in "Frail" Patients in General Practice

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Abstract

The world of chronicity is an area in progressive growth that involves a considerable commitment of resources, requiring continuity of assistance for long periods of time and a strong integration of health services with social ones and those requiring residential and territorial services often not sufficiently designed and developed. The fundamental aim of the treatment of chronic systems is to keep as much as possible the patient at home and prevent or reduce the risk of institutionalization. GP could put their expertise to good use in the Complex of Primary Care Units and Territorial Functional Aggregations, reducing the costs of the health service.

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Introduction

The world of chronicity is an area in progressive growth that involves a considerable commitment of resources, requiring continuity of assistance for long periods of time and a strong integration of health services with social ones and those requiring residential and territorial services often not sufficiently designed and developed.

Globally the WHO definition of chronic disease ("health problems that require ongoing treatment over a period of time from years to decades") refers to the commitment of resources, human, managerial and economic, in terms of both direct costs (hospitalization , drugs, medical assistance etc.) and indirect (premature mortality, long-term disability, reduced quality of life etc.), necessary for their control. *"The lives of far too many people in the world are being blighted and cut short by chronic diseases such as heart disease, stroke, cancer, chronic respiratory diseases and diabetes. This is no longer only happening in high income countries"*[1].

It was also observed that social inequalities are one of the most important factors in determining the health condition [2]. However, for many of them it can be a useful preventive acting on common risk factors: tobacco and alcohol use, poor diet and physical inactivity. Chronicity is associated with the decline in aspects of life such as autonomy, mobility, functional capacity and relationship life with a consequent increase in psychological stress, hospitalizations, use of resources (health, social, welfare) and mortality [3].

The demand for health services for the elderly with chronic diseases in recent years has become increasingly high and, therefore, increased the amount of health care resources allocated to this segment of the population. It has been calculated that almost a third of general and specialist visits in Italy are provided to the multi-chronic population. About 30% of those are dedicated to people with serious chronic diseases [4].

Effective, Efficient and Patient-Centered Management

For the purposes of protection of health and sustainability of the system, one cannot but emphasize the essential value of prevention. The consensus on the principle that the challenge to chronicity is a "system challenge", which must go beyond the limits of the various institutions, overcome the boundaries between health and social services, promote the integration between different professional skills, attribute an effective and efficient "centrality" to the person and his care and life project [5].

The balance and integration between hospital and community care is now one of the priorities of health policy to which the most advanced healthcare systems have been directed to give concrete answers to new health needs determined by the effects of the three transitions (epidemiological, demographic and social) that have changed the reference framework in recent decades leading to a structural and organizational change [6].

Hospital should therefore be conceived as a highly specialized hub of the chronic care system, which interacts with the outpatient specialist and with primary care, through new organizational formulas that provide for the creation of dedicated multi-specialist networks and "assisted discharge " in the territory, aimed at reducing the drop-out from the service network, a common cause of re-hospitalization and short-term adverse outcomes in patients with chronicity.

The discontinuity between the three classic levels of care (primary care, territorial specialist, hospital stay) must be eliminated, giving rise to a *"continuum"* that includes the identification of specific "products" (clinical and non-clinical) by each care actor (or team of which it is a component) in relation to the set health objective. In short, an assessment oriented on the patient-person, on the achievable outcomes and on the socio-health system [7,8].

The fundamental aim of the treatment of chronic systems is to keep as much as possible the patient at home and prevent or reduce the risk of institutionalization. Home care is one of the most effective responses to the care needs of elderly people with chronic and non-self-sufficient diseases, disabled people, as well as patients who need palliative treatments, provided that they are technically treatable at home, and, in general, of all patients in conditions of frailty for whom the removal from the usual context of life can aggravate the pathological condition and destabilize both physical and psychological balance with

often devastating consequences[9].

With the home care setting it is easier for the treating team to promote patient empowerment, improving his ability to 'cope' with the disease and developing self-healing skills without releasing all the weight of assistance on the family. Thus, consistent with the health, social and housing of the person, the Health System is committed to privilege, wherever possible, domiciliary care than institutionalization, ensuring the health and performance needed by activating the formal and informal resources to give support to the person and the family in carrying out daily life activities [10].

Home care must involve, in different roles, operators with different professional backgrounds first of all the general practitioner, who assume responsibility for the clinical management of taking charge, ensuring the coordination of the professional contributions provided by the operators of the assistance service home care and specialists, and continuity of care in the delivery of treatment. Therefore, the patient's journey with chronic disease should be planned in the long run and managed proactively and differentiated to respond effectively and efficiently to specific needs. It must prevent the occurrence of avoidable complications and be shared and managed by a team consisting of different figures (GP as coordinator, Nurse, territorial and hospital specialist, social worker, etc.) in a logic of cooperation and shared responsibility [11]. The follow-up must be managed by the GP who took charge of a chronic patient, dosing a greater or lesser presence of one or the other assistance actor, depending on the phases and the degree of complexity.

When the general practitioner enters a patient's home, he can know the whole background of family life from past experience [9]. The ongoing relationship between the GP and the patient should be appropriately used to achieve some "strategic" objectives, often corresponding to as many assistance criticalities (adherence to lifestyles, adherence to therapies and the treatment path, achievement of therapeutic targets, etc.).

The change in care models for chronicity confirms the need for an ever closer relationship between primary and specialist care; a new figure of general practitioner who integrates his role as generalist with the knowledge of a disciplinary area, not so advanced and profound as to match that of the specialist (to whom this figure does not intend to replace), but such as to face the problem of the patient with greater competence and offer an additional high quality service [12].

Role of General Practitioners

GPs in question could put their expertise to good use in the Complex of Primary Care Units and Territorial Functional Aggregations, reducing the costs of the health service. In this way, they would often avoid unnecessary consultations, with the reduction of waiting lists, thus being able to favor the diffusion of knowledge in the respective subjects among general practitioners, also through field education and training. And even solve some problems in the patient's primary care setting and accelerate the formulation of diagnosis without prejudice to the holistic vision that characterizes primary care. The areas where it would be possible to activate the presence of these doctors are varied and, in particular, the psychiatric area, the area of pain control, palliative care, the cardiovascular and metabolic [13].

An organic approach to the management of the multi-problematic patient in the territory must be firmly anchored to the recognition of the elements of complexity that connote both the individual with his phenotype and his specific needs, and the context in which he places himself and interacts with people, services and healthcare and social facilities. On this basis acquires value the concept of medical generalism, where knowledge of the person as a whole and its needs, the continue vision of healthy (not only) events of each subject - integrate with the knowledge straight determine evidence - determine the most appropriate and feasible choices for the individual patient (evidence based practice), characteristics that precisely frame the role of the GP.

Conclusions

An aging population and the rise of complex elderly patients is a major challenge for national health systems committed to addressing the demographic and epidemiological changes in a context of limited resources and technological development and rising expectations. The complex elderly patient is by definition a fragile

subject with specific needs that can be satisfied through a careful multidimensional evaluation.

Therefore, extending the perspective, any health systems addressing the critical issues of chronic patient management should engage in the definition of diagnostic-therapeutic-rehabilitative pathways in order to provide a path of care and taking care of as personalized as possible, which puts at the center the patient and at the same time provide a good cost / effectiveness ratio.

The chronic patient suffering from multiple co-existing diseases presents a resulting clinical phenotype that is determined and influenced not only by biological factors (disease-specific), but also by determining non-biological (social and family status, economic, environmental, accessibility of care etc. .). Those factors interact with each other and with disease-specific ones in a dynamic way so outlining the typology of the "complex patient".

Optimal care cannot be separated from the physician's ability to investigate and recognize the phenotype and in perspective the genotype-phenotype association through a complex pattern of clinical-anamnestic parameters in order to manage the patient's health path with a holistic vision.

Last, but not least, recognize causal factors of possible errors, as well as of the latent gaps in the system, to build a risk management process that allows a high quality of care [14].

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