Proposal to optimize the care model for people with chronic diseases and multimorbidity in Uruguay

Key messages

- The stratification process of patients with non-communicable chronic diseases (NCCD) according to their health risk provides indicative results for decision-making by health providers.

- Case management as a strategy of care for complex multimorbid patients would enable a focus on the improvement of the patient's quality of life and improve patient safety by minimizing the risk of readmissions and drug interactions in polypharmacy. At the same time, it enables the release of resources to be allocated to improvements in the quality of care and case management.

- In Uruguay, there is an adequate platform for the implementation of a sound patient-centered care model. However, each of the components of this platform offers ample room for improvement, with strong implications for quality of care, safety of patients with chronic conditions, and the efficiency of the service provision system.

- The care model in the five selected highly prevalent Non-Communicable Chronic Diseases (NCDs) also presents ample room for improvement with respect to the extension in which the specific components of the person-centered care model are applied; and in seeking and promoting the institutional development for the integration of care teams that systematically identify multimorbidity and apply common criteria for care and follow-up. This is important, as the lack of comprehensive care for these patients represent a high individual risk of serious chronic disease and mortality, and a burden to families and society.

- The expenditure with patients with multimorbidity in Uruguay is high. Persons with five or more of diseases represent 8.44% of the total patient population, but their care accounts for 42.07% of the total expenditure, and 50.48% of the expenditure on medications.

- The optimization of care model is an effective strategy. It takes into account the developments that have taken place in the country and the availability of resources and processes, and proposes improvements based on the gaps identified in relation to international models that that seek to address the challenges of multimorbidity.
**Introduction**

The importance of chronic diseases in Uruguay have been widely reported and analyzed in multiple studies and reports. Their impact on mortality and high cost have been determining factors in the development of various health promotion and primary and secondary prevention strategies. However, beyond measures to include specific programs and benefits for the care of chronic illnesses and the organization of health services guidelines to respond to the spontaneous demand generated by these diseases, there have been few initiatives aimed at reevaluating existing models of care for chronic diseases and, especially, for the problem of multimorbidity.

**General objective**

To formulate a stratification scheme for patients with Non-Communicable Chronic Diseases (NCDs) according to their health risk, which would allow for the identification of multimorbid conditions, and to propose a model for addressing multimorbidity based on international experience and Uruguay’s implementation capacity.

**Methodology**

In order to fulfill these objectives, the work was developed in three phases:

i) Stratification of the population with chronic diseases in Uruguay based on the grouping of patients into levels of care using the methodology proposed by Kaiser Permanente;

ii) Identification and evaluation of care models for NCDs and multimorbidity in Uruguay through a descriptive and exploratory study carried out from a qualitative methodological approach; and

iii) A proposal for the optimization of the model of care, which took as an analytical basis the results of the previous phases and current international experiences in addressing the same problem, focusing on the development of a comprehensive model of care for multimorbidity.

**Results**

**Resolving problems**

The model seeks to provide a progressive solution to the main problems that patients face and the factors that trigger destabilization, including:

- Difficulties in managing their disease, with problems adhering to treatment and lack of practicing more appropriate lifestyles.
- Fragmentation of care, with different actors of the health system acting individually, without incorporating the needs perceived by the patient.
- A lack of convergence in healthcare and social support actions, with each developing its healthcare programs almost autonomously.

**Objectives to be achieved with the model**

The following objectives, common to international strategies, were defined for this proposal of a general approach to NCDs:

- To improve the quality of life of people with multimorbidity, stabilizing the course of NCDs and delaying, as much as possible, the appearance of complications.
- To develop a more efficient model of care based on prevention and early action in periods of clinical deterioration, all aimed at reducing and avoiding hospital admissions and readmissions and emergency care, and with a focus on the quality of care and patient safety.
- To replace a model of care that treats each disease individually for a model focused on the needs of patients and on the inevitably personalized equilibrium of the morbidities suffered by them.
- To reconcile prescribed medication for the care of various diseases, balancing polypharmacy, and reinforcing adherence to treatment.
- To improve management of complex, fragile, high disease load, and high risk of destabilization cases, through early interventions, almost daily in some cases.
- To involve professionals in the new care model through teamwork and the delegation of power within the team.
Elements of success in stable patients

The challenge focuses on intervening, not when the clinical deterioration begins, but in periods of stability, developing actions that have proven useful in preventing relapses such as:

1. **Identification and stratification of the population** to detect complex patients and predict care needs.

2. **Creation of multidisciplinary groups to care for fragile patients** to establish a coordinated care personalized to their needs, with the creation of the figure of the care coordinator/case manager, who acts as an intermediary in all the patient’s needs in their interactions with the health system and is in charge of coordinating the individualized care plan.

3. **Patient involvement in the management of their disease** by taking the role of an active health agent with the capacity to act to stabilize their disease and prevent the rise of complications and relapses.

4. **Individualized care plan**, including social needs aimed at achieving stability of the disease; anticipation of potential problems; the delay in the progression of the disease, and the appearance of complications and the prevention of relapses.

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**Main transformations that position the perspective for the future**

Theses can be disaggregated in three components focusing on the patient, the care model, and the health system:

**Patient**

- **Active expert in the management of their disease and maintaining a healthy lifestyle:**
  - Knows about their diseases and their determinants.
  - Wants to know about all possible therapeutic alternatives.
  - Takes part in the decision-making that affects their disease.
  - Is actively involved in the management of their disease (self-care).
  - Interested in establishing a relationship of trust and commitment with their doctor.
  - Connected through digital health to intervene in the management of their disease and willing to network as an agent of the healthcare system.

**Model of Care**

- **Collaborative teams focused on prevention and anticipation of patients’ needs, using new forms of non-face-to-face care:**
  - Multidisciplinary teams of professionals organized in collaborative groups that agree on ways of doing things and communicate with each other.
  - Preventive activities and anticipation of destabilization cycles.
  - Non-face-to-face actions and/or remote follow-up to stabilize the course of the disease.
  - Promotion of healthy lifestyles using various channels of interaction, including mental health support.

**Healthcare System**

- **A health system that rigorously evaluates health outcomes and encourages best practices:**
  - Collaborative work based on agreements and operating through integrated networks of care across intra- and inter-service levels.
  - Payment of benefits per capita that promotes a preventive and proactive person-centered care model in the management of the disease.
  - Health evaluation systems based on robust indicators validated by international experience.
  - Decentralization of commitment, responsibility, and clinical leadership (clinical management).

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Source: The authors
5. Use of information and communication technologies to create interface networks through non-face-to-face mechanisms, sharing the same electronic medical record; and remotely monitor the patient’s clinical status and intervene early.

Central elements of the proposal
The following are required to optimize the model of care for NCDs in Uruguay and move towards a comprehensive model that is person-centered and oriented towards multimorbidity care, according to international experience:

- Self-care
- Periodic comprehensive assessment of the patient and their needs
- Population stratification
- Specific models for chronic disease management
- Collaborative space between professionals
- Care units for the care of frail patients
- Remote patient follow-up
- Creation of integrated PHC/hospital provider networks
- Support technology
- Cross-cutting focuses, oriented to quality of care and patient safety

Source: The authors