1st JA-Chrodis WP6 Expert Meeting

MEETING WITH EXPERTS TO ASSESS
ACCURACY OF COLLECTED EVIDENCE AND
SELECT GOOD PRACTICES, IDENTIFY
COMMONALITIES FOR CARE
MANAGEMENT OF MULTIMORDIBITY

CHRODIS
ADDRESSING CHRONIC DISEASES & HEALTHY AGEING ACROSS THE LIFE CYCLE

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Executive Summary/Abstract

Date: October 28, 2015

Time: 9am-5pm

The main achievement during 2015 was the development of a framework for care of multimorbidity patients that can be applied across Europe. First, we identified a list of twenty components across five domains from existing published comprehensive care programs for patients with multiple chronic conditions or frailty. An Expert meeting was held in Brussels on October 28, to discuss the components. Sixteen were selected after discussion. During the meeting the experts discussed the definition of the components, aims, key characteristics, target population and relevance for patients with multimorbidity in order to develop a framework for care of multimorbidity patients, including recommendations for delivery of system design, decision support, self management support, clinical information systems, and community resources.

Output: An article has been produced to detail the results and conclusions of this meeting, and has been reviewed, edited and, coauthored by all the experts, entitled "Multimorbidity care model: Recommendations from the consensus meeting of the Joint Action on Chronic Diseases (CHRODIS)".

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Attendees

LINDSTROM, Jaana: National Institute for Health and Welfare

FORJAZ, Joao: Instituto de Salud Carlos III, Madrid

JUREVIVIENE, Elena: Vilnius University Hospital Santariskiu Klinikos (VULSK)

MUTH, Christiane: Institut für Allgemeinmedizin, Universität Frankfurt

MARENGONI, Alessandra: AIFA

NAVICKAS, Rokas: Vilnius University Hospital Santariskiu Klinikos (VULSK)

ONDER, Graziano: AIFA

PALMER, Katie: AIFA

PRADOS-TORRES, Sandra: University of Zaragoza, Zaragoza,

RIJKEN, Mieke: Netherlands Institute for health services research

ROTHE, Ulrike: Technische Universität Dresden

SOUCHET, Laurène: European Patients' Forum (EPF)

VALDERAS, Jose: University of Oxford

VONTETSIANOS, Theodore: Sotiria General Hospital, Athens,

ZALETEL, Jelka: Slovenian National Institute of Public Health

Points Discussed

A list of twenty components across five domains was identified from existing published comprehensive care programs for patients with multiple chronic conditions or frailty.

Sixteen components were selected after discussion. During the meeting the experts discussed the Description and aims, key characteristics, target population and relevance for patients with multimorbidity in order to develop a framework for care of multimorbidity patients, including recommendations for delivery of system design, decision support, self management support, clinical information systems, and community resources.

-DELIVERY OF THE CARE MODEL SYSTEM

Regular comprehensive assessment of patients, including, i) assessment of the complexity of conditions and/or medical treatment, as well as treatment burden and interactions, and ii) evaluation of patients' preferences and personal resources (e.g. coping skills, health literacy), and social resources (e.g., available social network).

Multidisciplinary, coordinated team. One of the main features of the regular comprehensive assessment is the inclusion of a multidisciplinary team and network to evaluate and deliver treatment and care relating to the patient's functioning, impairments, and social support. The use of a multidisciplinary team aims to address disease specific needs, avoiding fragmentation and ensuring continuity of care. The objectives are to increase efficiency and accessibility of care by providing multidisciplinary care both in terms of different levels of the healthcare profession (nurses, physicians, physiotherapists, social workers etc), and different disease specializations.

Professional appointed as coordinator of the individualized care plan and contact person for patient and family ("case manager"). Patients with complex care needs should be appointed a case manager, who is the primary contact point for the patient and their family, representing a single entry point into the system. The case manager should act as coordinator between patient and various members of the multidisciplinary team to manage care, actively linking the patient to providers, medical services, residential, social, behavioral, and other support services where needed in the most effective way, monitoring continuity of care, follow-ups, and documentation.

Individualized Care Plans. Individualized, coordinated, and integrated plans for the treatment and long-term follow-up of patients should be developed based on the comprehensive assessment by the multidisciplinary team, including a patient-centered approach that considers the preferences of the patients, and the prioritization of cross-disease, holistic approach, including targeting symptoms, functional ability, quality of life, desired patient outcomes etc.

DECISION SUPPORT

Implementation of evidence based practice

Flexible application of disease-specific evidence based guidelines, with consideration of multimorbidity, disease interactions, and drug-drug interactions should be used. Healthcare providers should promote clinical care that is consistent with available scientific evidence and is consistent with patient preferences. As specific disease guidelines do not represent the evidence base for multimorbidity, caution is needed, applying a critical appraisal of the evidence, with critical review by the multidisciplinary team.

Training members of the multidisciplinary team. Training members of the multidisciplinary team is an important element of multimorbidity care, aiming to improve knowledge and skills, focus on the following themes: comprehensive assessment concepts, multimorbidity and its consequences, health outcomes, innovation technologies, implementation of individualized treatment/care plans and goal setting, working effectively as a team, training in the critical appraisal of knowledge and evidence based knowledge, patient-centeredness, patient empowerment, and self-management (see Component 8). Key team members should receive training, as well as any external experts who provide treatment or care to the patient on specific occasions.

Developing a consultation system to consult professional experts. The development of a consultation system to discuss patient care and treatment with specialist with professional experts (e.g. highly specialized medical specialists, but also medical/clinical psychologists with specific expertise, e.g. cognitive problems, frailty).

SELF MANAGEMENT SUPPORT

Training of care providers to tailor self-management support based on patient preferences and competencies. The training of staff to support self-management among patients and their caregivers, via comprehensive training of health care professionals (such as through courses, online training, educational materials). This should also include encouraging patients to increase health literacy and tailored health promotion and prevention strategies.

Providing options for patients and families to improve their self-management. Providing options and support for patients and their families and caregivers to improve the self-management of their conditions, including patient training and support tailored to patients' preferences and competencies. This includes offering approaches (e.g. online courses, group-based courses, individual counseling, dependent on patients' preferences and competencies) to strengthen patients' self-management and self-efficacy, including explaining their diagnoses, diseases, and medical conditions, as well as providing information on medication use, and training patients to use medical devices, supportive

aids, and health monitoring tools correctly (for example, blood pressure and glucose monitoring tools etc).

Shared decision making (care provider and patients). Health care professionals should include the patient (and, where relevant, their family) in making decisions about their care and treatment, including identifying their individual needs as well as deciding on future goals and outcomes to aim for. Individualized care plans should be constructed that represent these shared desires and decisions, and shared with the patient and relevant care providers.

INFORMATION SYSTEMS AND TECHNOLOGY

Electronic patient records and computerized clinical charts. Electronic patient records and computerized clinical charts to allow exchange of patient information (with permission of patient) between the multimorbidity team and other care providers and sectors by compatible clinical information systems. This includes any electronic technology used to enter data and manage the care of patients, to keep track of their medical history, diagnoses, symptoms, hospital visits, health care utilization, care needs, or medications etc, allowing different providers of health and social care to share information about a single patient, preferably using standardized tools and similar diagnostic systems.

Exchange of patient information (with permission of patient) between care providers and sectors by compatible clinical information systems. This component involves different providers of health and social care sharing information about a single patient, preferably using standardized tools and similar diagnostic systems. It is important to have a comprehensive set of information available for all healthcare providers and decision makers because without it updating individualized care plans might be too slow, and therefore any acute care or management of the patient may be compromised. The benefits include increased speed of care and decision making, as well as improved comprehensiveness.

Uniform coding of patients' health problems where possible. : Using the same classification system to evaluate and record symptoms, diagnoses, medication, patient-reported outcomes, individualized treatment/care plans, and aspects of health care utilization between nurses, physicians, and other care providers.

Patient-operated technology allowing patients to send information to their care providers. Patient-operated technology allowing patients to send information (e.g., health monitoring data) to their care providers to complement face to face visits (with consent/desire of the patient). This should include technology tailored to the patient's needs which allows the health care professionals to view, monitor, and react to information directly from their patient via the technology (e.g., glucose levels, blood pressure etc), to compliment face-to-face meetings, aiming to reduce health care utilization and improve clinical outcomes. Potential target populations include patients who live remotely, or those with low social

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support or with reduced mobility. Using telemedicine (telemonitoring), should provide a bridge between self-management and healthcare providers, enabling faster and timely access to healthcare providers.

SOCIAL AND COMMUNITY RESOURCES

During the consensus meeting the experts highlighted that they believe that access to social and community resources are relevant aspects of the care of patients with multimorbidity, but as these are not included in the formal care process and the availability of these services is extremely variable, the following components are difficult to standardized and, thus, only a general description can be provided.

Supporting access to community- and social-resources. Improving patient access to community resources, formal care, and patient associations, support groups, and psychosocial support (including home help, transportation etc), and supporting access to such services.

Involvement of social network (informal), including friends, patient associations, family, neighbours. Involving the patient's informal social network, including family, friends, patient associations, neighbours, with either their treatment or care, and finding ways to increase their social support network.

A report summarizing the recommendations of the experts was written: "Multimorbidity care model: Recommendations from the consensus meeting of the Joint Action on Chronic Diseases (CHRODIS)".

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