# Multimorbidity
# JA-CHRODIS

Vienna, 10th of November 2016

CHRODIS
ADDRESSING CHRONIC DISEASES & HEALTHY AGEING ACROSS THE LIFE CYCLE

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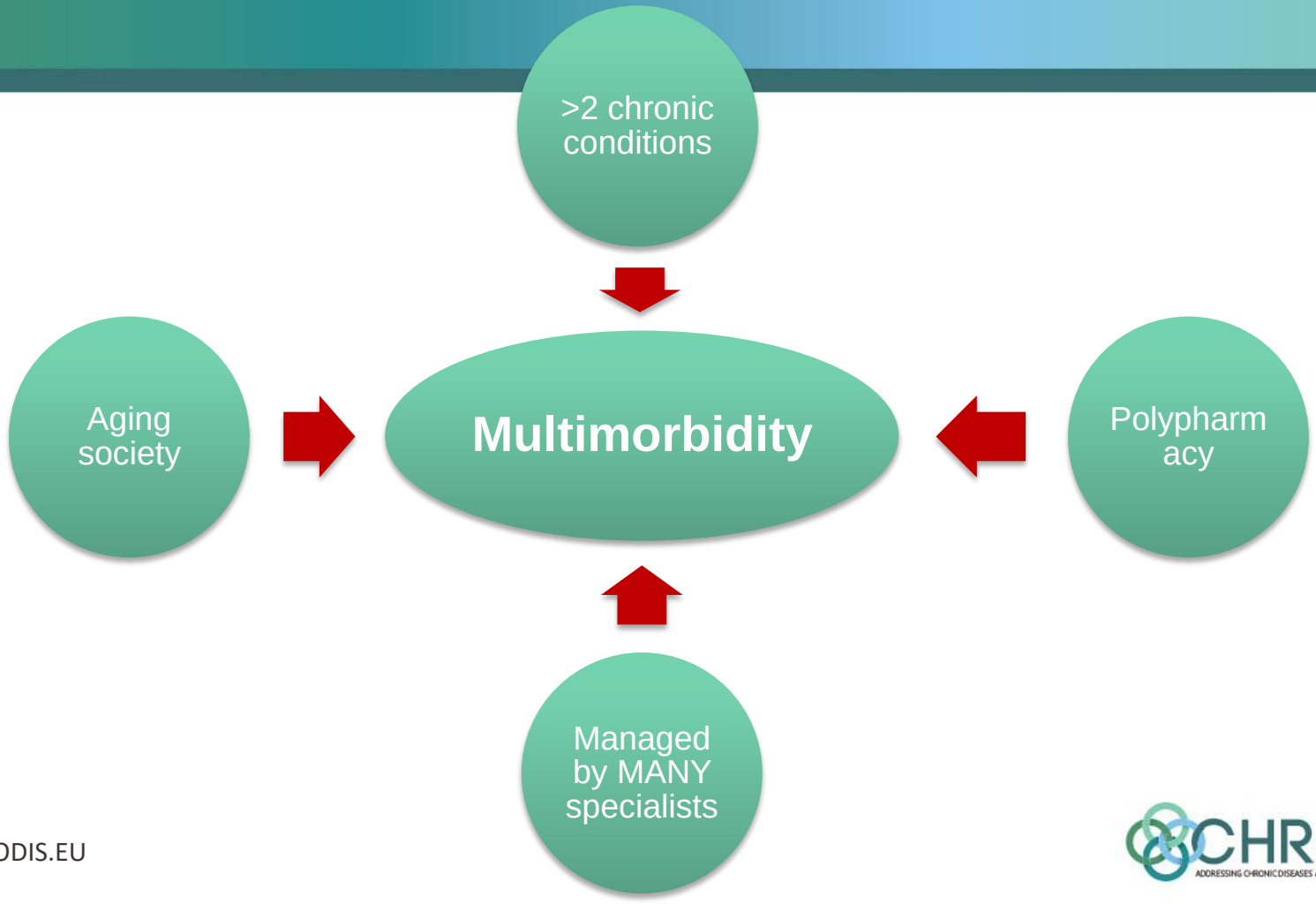
# COMPLEXITY OF MULTIMORBIDITY



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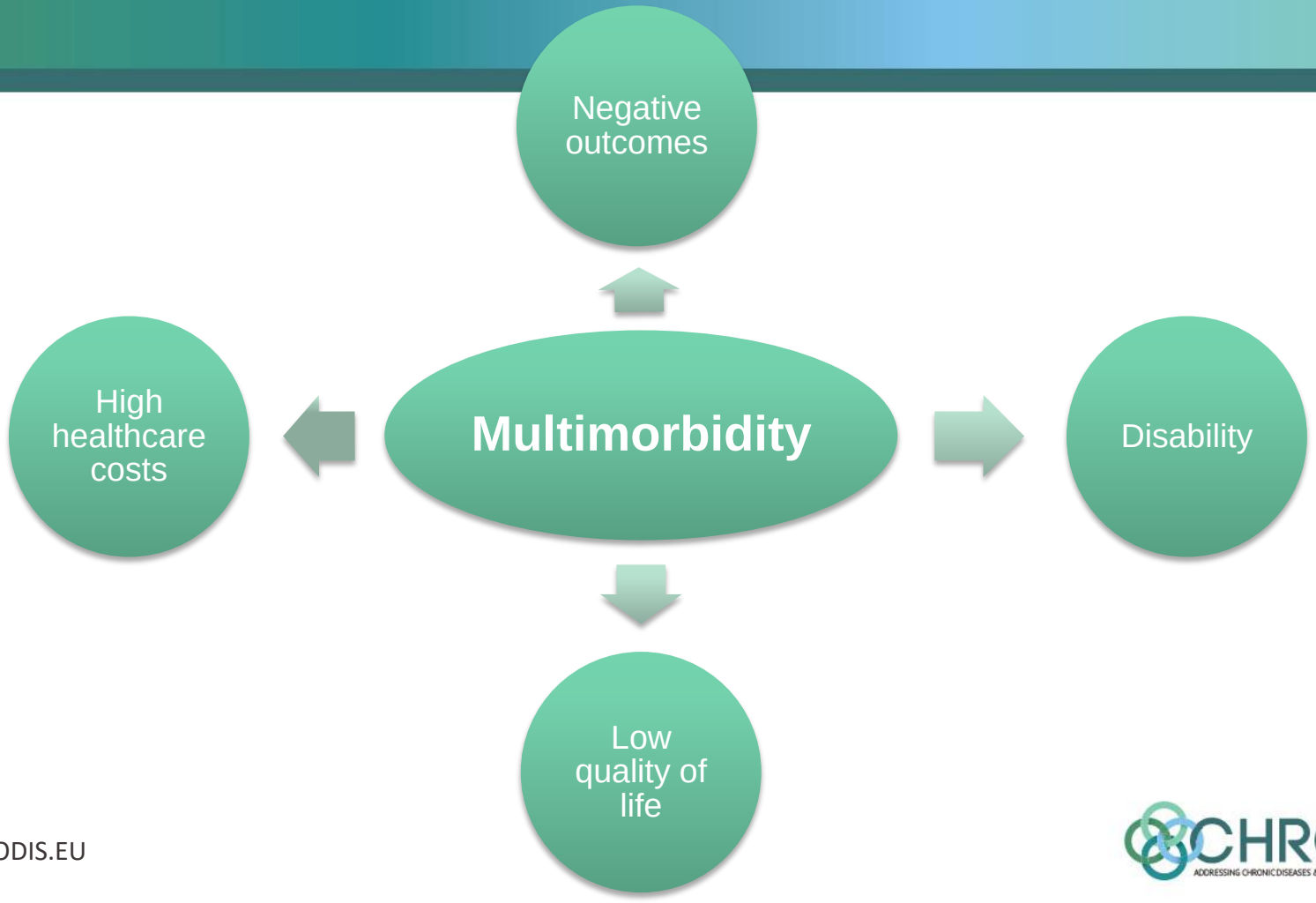
# SCALE OF THE PROBLEM



# TASKS OF WP6-MULTIMORBIDITY

T1. **Identify targets** of potential interventions for management of multi-morbid patients **(M 1-12)**
T2. **Review existing care (pathway) approaches** for multi-morbid patients **(M 1-12)**
T3. **Assess and select good practices** on management of multi-morbid patients **(M 13-24)**
T4. **Define** multi-morbidity case management **training programmes (M 25-36)**

# TASK 1 (Leader AIFA)

- **Onder G** Time to Face the Challenge of Multimorbidity. A European perspective from the Joint Action on Chronic Diseases and Promoting Healthy Ageing across the Life Cycle (JA-CHRODIS).
- **Hopman P** Health care utilization of patients with multiple chronic diseases in The Netherlands: differences and underlying factors
- **Navickas R** Multimorbidity - is this a special condition, or just another chronic disease? National multimorbidity overview based on Lithuanias' national database
- **Alonso-Moran E** Health-related quality of life and multimorbidity in community-dwelling telecare-assisted elders in the Basque Country
- **Forjaz J** Chronic conditions, disability and quality of life and in older adults with multimorbidity in Spain
- **Alonso-Moran E** Multimorbidity in people with type 2 diabetes in the Basque Country (Spain): prevalence, comorbidity clusters and comparison with other chronic patients
- **Wikstrom K** Risk Factors, Hospitalization, And Mortality Related To Multimorbidity 10-year follow-up of Finnish population-based cohorts 1982-2012
- **Calderon A** Global health care use by patients with type 2 diabetes: does the type of comorbidity matter?

# TASK 2 (Leader NIVEL)

- Literature review **(Task 2.1)** *20 publications/studies were selected evaluating* ***19 comprehensive care programmes*** *for multi-morbid patients.* ***Different components of the intervention were identified***
- *ICARE4EU* data collected and summary produced **(Tasks 2.2 and 2.3)**

Multimorbidity in general 59
Specific diagnosis* with a variety of co-morbidities 27
A combination of specific diagnoses 14

* mainly diabetes, ischemic heart disease, heart failure, renal disease, hypertension, asthma, COPD, depression

# TASK 3 (Leader VULSK)

**Report on care pathways** approaches for multi-morbid chronic patients, including existing good practices

**Expert meeting** - 28th of October, 2015, Brussels (Multimorbidity Care Model)

# ORIGINAL LIST OF COMPONENTS IDENTIFIED BY SYSTEMATIC REVIEW

**Delivery of system design:**
- ✓ Regular comprehensive assessment
- ✓ Multidisciplinary team
- ✓ Individualized care plans
- ✓ Appointment of a case manager

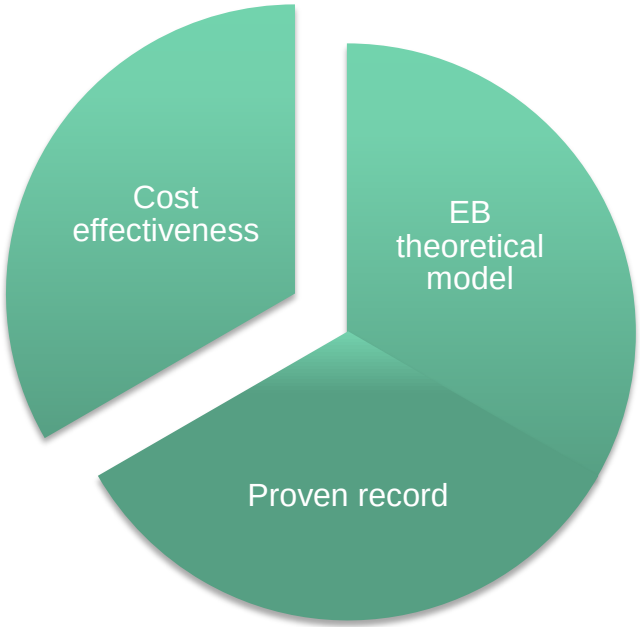
**Decision support:**
- ✓ Implementation of evidence-based medicine
- ✓ Team training

**Clinical information system :**
- ✓ Electronic patient records and computerized clinical charts
- ✓ Exchange of patient information
- ✓ Uniform coding of patients' health problems
- ✓ Patient platforms allowing patients to exchange information with their care providers

**Self-management support** :
- ✓ Training of care providers to tailor self-management support for patients
- ✓ Providing options for them to improve their health literacy
- ✓ Patient education
- ✓ Involving family members and family education
- ✓ Offering approaches to strengthen patients' self-management and self-efficacy
- ✓ Involving patients in decision-making
- ✓ Training patients to use medical devices, supportive aids and health monitoring tools correctly

**Community resources:**
- ✓ Access to community resources
- ✓ Involvement of social network
- ✓ Psychosocial support

# From Evidence Based Medicine to Expert consensus




**JA-CHRODIS WP6 Experts**

+

**Good clinical care components**

→

Guidance on MM care model



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# DELIVERY OF THE CARE MODEL SYSTEM

- Regular comprehensive assessment of patients
- **Multidisciplinary, coordinated team**
- Professional appointed as coordinator of the individualized care plan and contact person for patient and family (“case manager”)
- Individualized Care Plans

# DECISION SUPPORT

- Implementation of evidence based practice
- **Training members of the multidisciplinary team**
- Developing a consultation system to consult professional experts

# SELF MANAGEMENT SUPPORT

- Training of care providers to tailor self-management support based on patient preferences and competencies
- **Providing options for patients and families to improve their self-management**
- Shared decision making (care provider and patients)

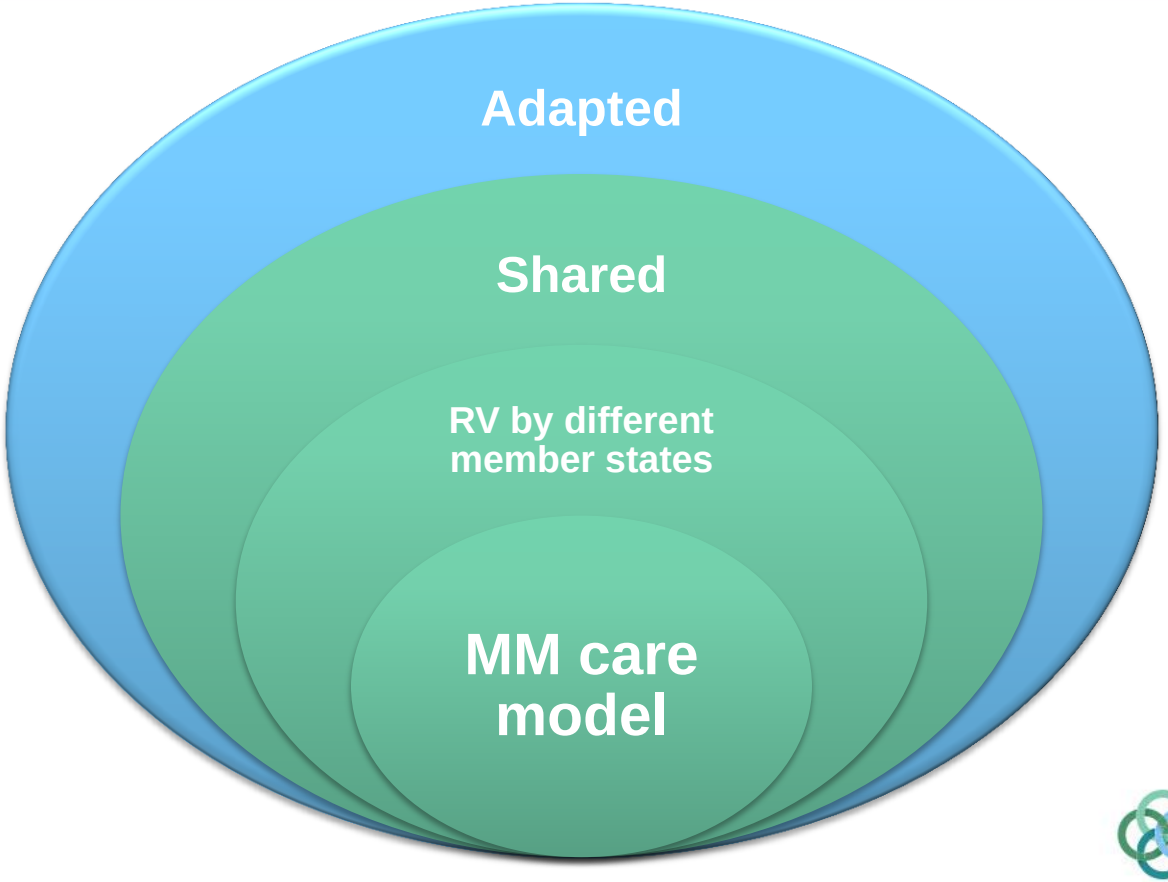
# INFORMATION SYSTEMS AND TECHNOLOGY

- Electronic patient records and computerized clinical charts
- **Exchange of patient information** (with permission of patient) between care providers and sectors by compatible clinical information systems
- Uniform coding of patients' health problems where possible
- Patient-operated technology allowing patients to send information to their care providers

# SOCIAL AND COMMUNITY RESOURCES

- Supporting access to community- and social-resources
- **Involvement of social network** (informal), including friends, patient associations, family, neighbours

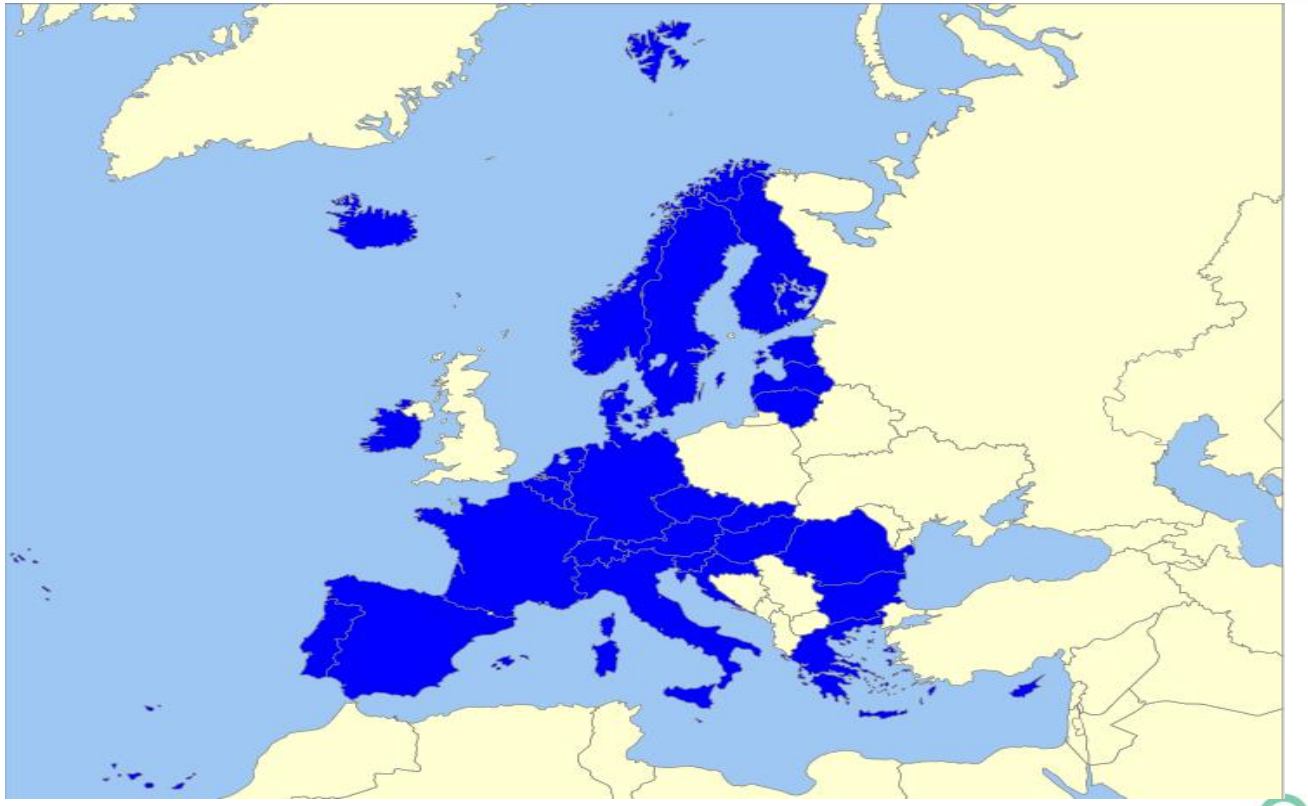
# THEORY TO PRACTICE



# MULTIMORBIDITY CARE MODEL APPLICABILITY ASSESSMENT

- A **questionnaire** (16 components) approaching different specialists from different countries;
- **Target audience**: patients, care providers, physicians specialized in different specialties, epidemiologists, psychologists, representatives from patient organizations and JA-CHRODIS Governing Board members;
- The aim of the assessment was to assess if the **components** of the multimorbidity care model **are applicable across different member states and to what level**.

# EXPERTS' GEOGRAFICAL DISTRIBUTION



# APPLICABILITY ASSESSMENT - RESULTS

- 21 responses received;
- Belgium, Bulgaria, Cyprus, Croatia, Estonia, Finland, Germany, Greece, Iceland, Italy, Luxembourg, Netherlands, Norway and Portugal;
- 3 anonymous responses;
- 4 questionnaires were filled out by the Governing Board members from Cyprus, Croatia, Belgium and Estonia
- All but Bulgaria, Cyprus and Greece confirmed, that there are **no non-applicable components**;
- The average **applicability score varied between 5 and 7** depending on the criteria .

# CONCLUSIONS OF THE APPLICABILITY REPORT

- The Multimorbidity Care Model is **applicable across EU**, except of few countries with limited applicability of few criteria (please see the country figures).
- From the comments, provided by the experts involved, the criteria are being spoken about and in most cases **some work has already been done.**
- However, without a **coherent way of merging those criteria while providing care for every patient**, there is a difficulty to experience the full benefits of the suggested care model.
- Some countries started **implementation pilots**, however it is too early for assessing the outcomes.

# TASK 4 (Leader AIFA)

- **Questionnaire on training programmes** (12 responses received: Austria (n.1), Bulgaria (n.1), Croatia (n.1), Italy (n.2), Netherlands (n.2), Slovenia (n.1) and Spain (n.3).

- **Expert meeting** – 4th of November, Treviso (Report on Case Management Training Programs)

# CORE COMPONENTS OF THE TRAINING PROGRAMME

- Regular comprehensive needs assessment of patients
- Working in multidisciplinary teams and/or care coordination
- Development of Individualized Care Plans – including planning ahead for expected crises
- Implementation of evidence based practice
- Strategies to support self-management based on patient competencies including use of technology to enable care and self management, management of polypharmacy and adherence
- Strategies to support shared decision making (together with patients)
- Use of electronic health records and computerized clinical charts
- Appropriate coding of patients' health problems
- Knowledge of community- and social-resources and strategies to support access to community and social resources
- Strategies to improve the involvement of members of a patient's social network (informal), including family members, friends, patients' associations, neighbours
- Current legislative framework for health, social care and welfare services

# The Joint Action on Chronic Diseases and Promoting Healthy Ageing across the Life Cycle (JA-CHRODIS)*

# Thanks for your attention!

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* This presentation arises from the Joint Action addressing chronic diseases and healthy ageing across the life cycle (JA-CHRODIS), which has received funding from the European Union, under the framework of the Health Programme (2008-2013).



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