Multimorbidity
JA-CHRODIS
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COMPLEXITY OF MULTIMORBIDITY

>2 chronic conditions

Aging society

Multimorbidity

Managed by MANY specialists

Polypharmacy
SCALE OF THE PROBLEM

Multimorbidity

High healthcare costs

Negative outcomes

Low quality of life

Disability
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)
• 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?

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

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

Guidance on MM care model

Good clinical care components

EB theoretical model

Proven record

Cost effectiveness
• 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

MM care model

RV by different member states

Shared

Adapted
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.
• **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** – 4\textsuperscript{th} 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
Thanks for your attention!

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