



**CHRODIS+**  
IMPLEMENTING GOOD PRACTICES FOR CHRONIC DISEASES



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# CHRODIS PLUS Joint Action

## FROM THEORY TO IMPLEMENTATION

### **Wide scale implementation of the Multimorbidity Care Model: What? How? Why?**

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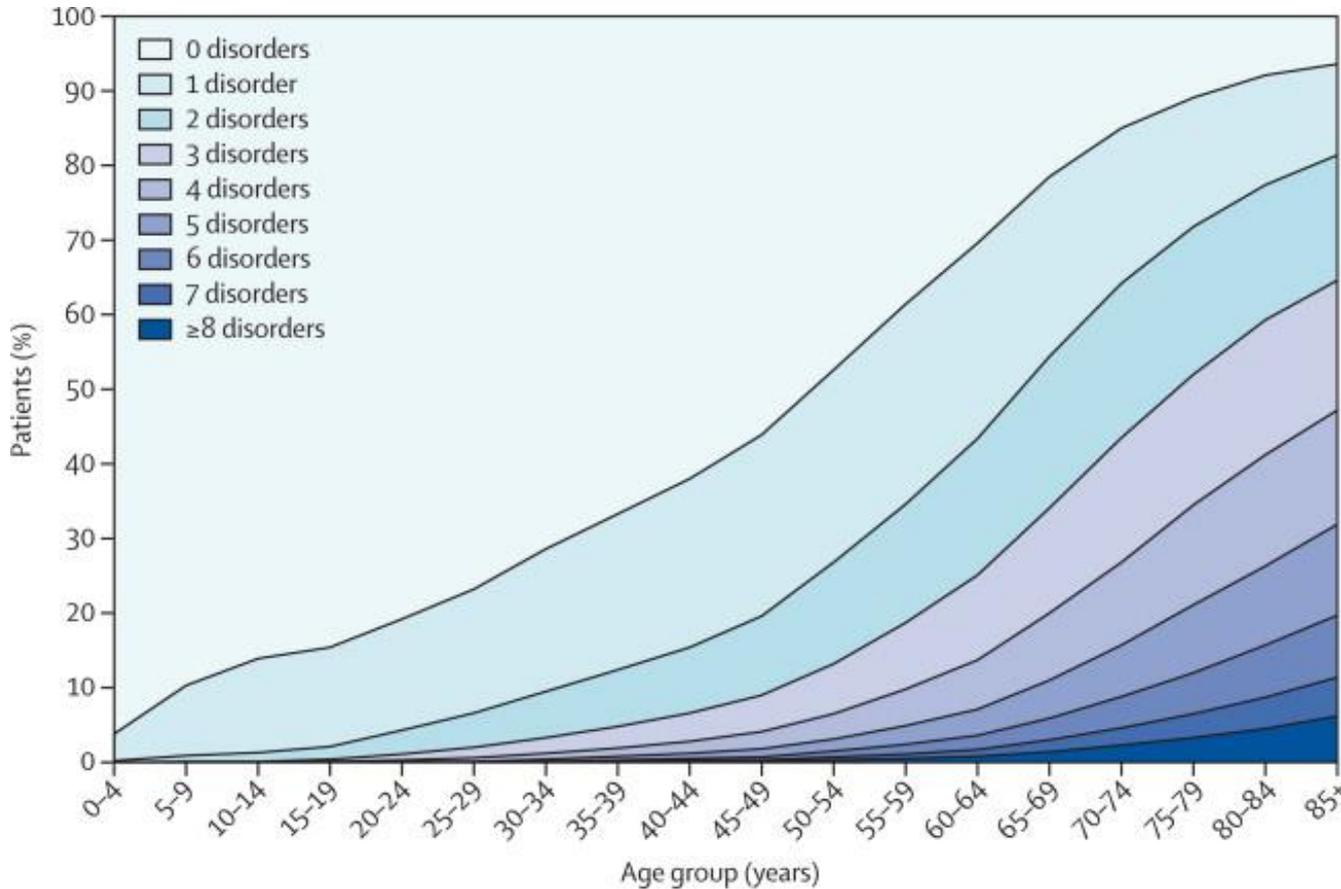
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# Multimorbidity



- Defined as  $\geq 2$  chronic diseases
- Prevalence  $\uparrow$  with age (>60% of people aged  $\geq 65$  y with multimorbidity - 'most common chronic condition')
- Impact on **clinical outcomes** and health care **costs**
- Multimorbidity also affects processes of care and may result in complex care needs
- The **traditional single-disease approach inadequate** for multimorbidity

# Multimorbidity



*Barnett K et al. The Lancet 2012*

**THE LANCET**

# Wide scale implementation of the Multimorbidity Care Model

**What?**

Why?

How?

# WHAT is work package implementing (I) CHRODIS Care Model

## Delivery system design

- Comprehensive assessment
- Coordinated team
- Individualized care plans
- Case manager

## Decision support

- Implementation of EBM
- Team training
- Consultation system

## Self management

- Tailor Self-management
- Options for self management
- Shared decision making

## Clinical information system

- Electronic patients records
- Exchange patients infos
- Uniform coding
- Patient operated technology

## Community resources

- Access community resources
- Involvement of social network



*Palmer K et al. Health Policy 2018*

# WHAT is work package implementing (II) CHRODIS Care Model

16 components identified

For each component:

- Description and aims
- Key characteristics
- Relevance to multimorbidity patients

The model derives from *expert opinion*.

Its applicability should be tested in pilot actions



*Palmer K et al. Health Policy 2018*

# Wide scale implementation of the Multimorbidity Care Model

What?

**Why?**

How?

# WHY is the implementation important (I)

- Scientific literature review + field survey
  - **Programs varied** in the target patient groups, implementation settings, number of included interventions, and number of chronic care model components
  - Different components of the intervention were identified (comprehensive programs)
  - Effectiveness of the programs rarely evaluated



*Hopman et al. Health Policy. 2016*



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# WHY is the implementation important (II)

## Policy makers

- Provide evidence on effective interventions that can represent the basis to inform policy

## Stakeholders

- Provide a cost-effective intervention to be applied in different contexts

## Patients

- Receive comprehensive and patient- centered care

# Wide scale implementation of the Multimorbidity Care Model

What?

Why?

**How?**

# HOW to conduct the implementation (I)

1. Understand target – risk stratification

# Understand target

Patients with multimorbidity at high risk (target for intervention):

- Disease patterns
  - Individual diseases
  - Combination of diseases
- Low socioeconomical status
  - low income
  - poor social support
- Poor physical function
- Mental health problems
  - depression
  - cognitive impairment

*'...the consequences of multimorbidity cannot be arithmetically determined based on the number of clinical conditions the person presents'*  
(WHO)

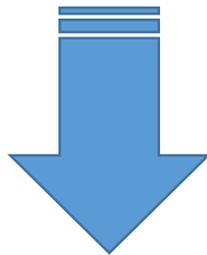
Onder G. *Eur J Intern Med* 2015;26(3):157-9

# HOW to conduct the implementation (I)

1. Understand target – risk stratification
2. Definition of a scope

# HOW to conduct the implementation (I)

1. Understand target – risk stratification
2. Definition of a scope
3. Situation analysis – SWOT



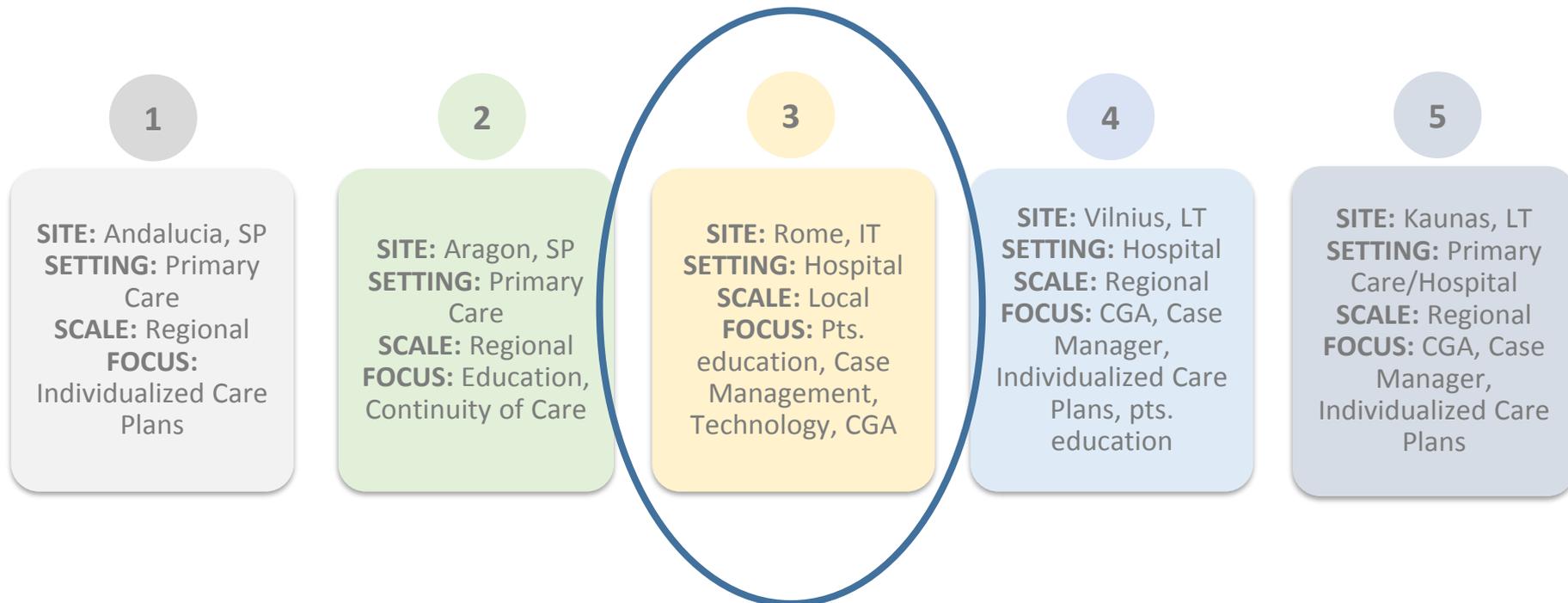
Interventions and solutions CAN NOT be fixed and standardized but should be adapted to the context

# HOW to conduct the implementation (I)

1. Understand target – risk stratification
2. Definition of a scope
3. Situational analysis – SWOT
4. Development of pilot action plans
5. Implementation
6. Assessment - Outcomes

# Implementing sites WP6

## IMPLEMENTATION PROJECTS OF THE WP



# Pilot Action plan - UCSC

SWOT



Action plan



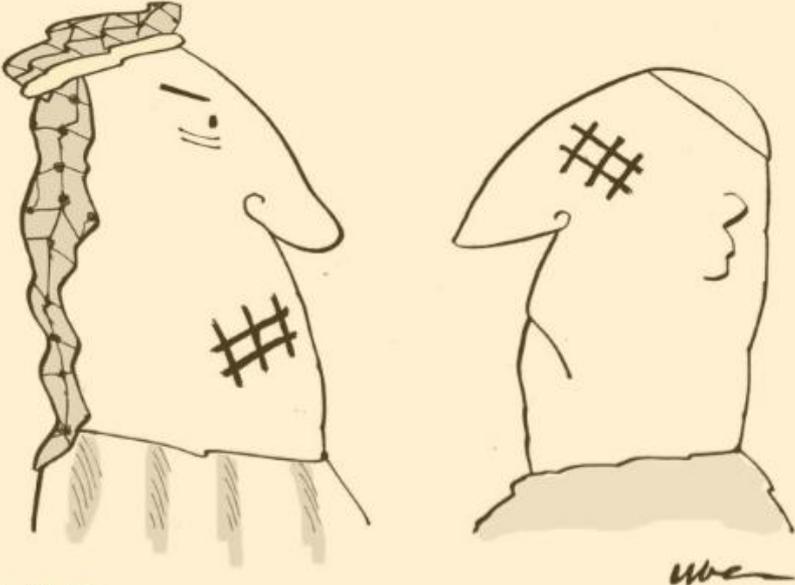
Improvement area(s)	Change Package
Poor case coordination	Case manager
Accessibility of care	Technocare service
Fragmentation of care	Comprehensive Geriatric Assessment
Improve patient self – management	Group meetings and training courses for patients and family members.

# Poor care coordination (1/4) - UCSC

**HOW.**



**GOAL.** Improve communication and coordination of care among members of the health care team and patients.



**SO FAR.** The case manager is successfully coordinating health care team members and patients

**Poor care coordination**  
Patients don't have a reference care provider

# CHRODIS Care Model components implemented - UCSC

## Delivery system design

- **Comprehensive assessment**
- Coordinated team
- Individualized care plans
- **Case manager**

## Decision support

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- **Tailor Self-management**
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*Palmer K et al. Health Policy 2018*

# Barriers to implementation

Changes in political situation and shifts in health priorities

- Unresolved continuity of care between care levels and sectors (eg: social)
- Limited resources (time, personnel, funds), compared to population increasing needs (*sustainability*)
- Information systems not focussing on multimorbidity
- Resistance to organizational changes from the population and professionals
- Guidelines or structured training not always available
- Patient's high expectations, scarce information material, limited self management
- Lengthy approval of studies from Bioethics Committee
- Pressure from the Pharmaceutical Industry

# Posters



1. Personalized Action Plan in Andalusia: supporting the Chrodis-Plus integrated care model for multimorbidity
2. Pilot implementation of CHRODIS Integrated Care Model in a tertiary referral hospital in Italy
3. Pilot implementation of Integrated Multimorbidity Care Model in public and private healthcare sector.
4. Case manager approach managing multimorbidity
5. Pilot implementation of CHRODIS Integrated Care Model for Multimorbidity in Aragón, Spain
6. Applicability of JA-CHRODIS+ multimorbidity care model in European national health systems

# Contact and follow us

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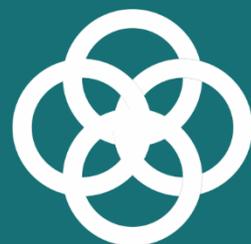
## WP6

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# CHRODIS+

IMPLEMENTING GOOD PRACTICES FOR CHRONIC DISEASES

## Thank you for your attention

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### CHRODIS PLUS

The Joint Action implementing good practices for chronic diseases

This presentation is part of the CHRODIS PLUS Joint Action. This Joint Action addresses chronic diseases through cross-national initiatives identified in JA-CHRODIS, in order to reduce the burden of chronic diseases while assuring health system sustainability and responsiveness, under the framework of the Third Health Programme (2014-2020). The content of this presentation is the sole responsibility of the author. Consumers, Health, Agriculture and Food Executive Agencies cannot be held liable for any use of the information contained within this document.



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