Caring for multiple conditions

Overcoming fragmentation and stimulating improvement

Workshop 'Cure Integrate per i pazienti con multimorbilita' nel veneto'

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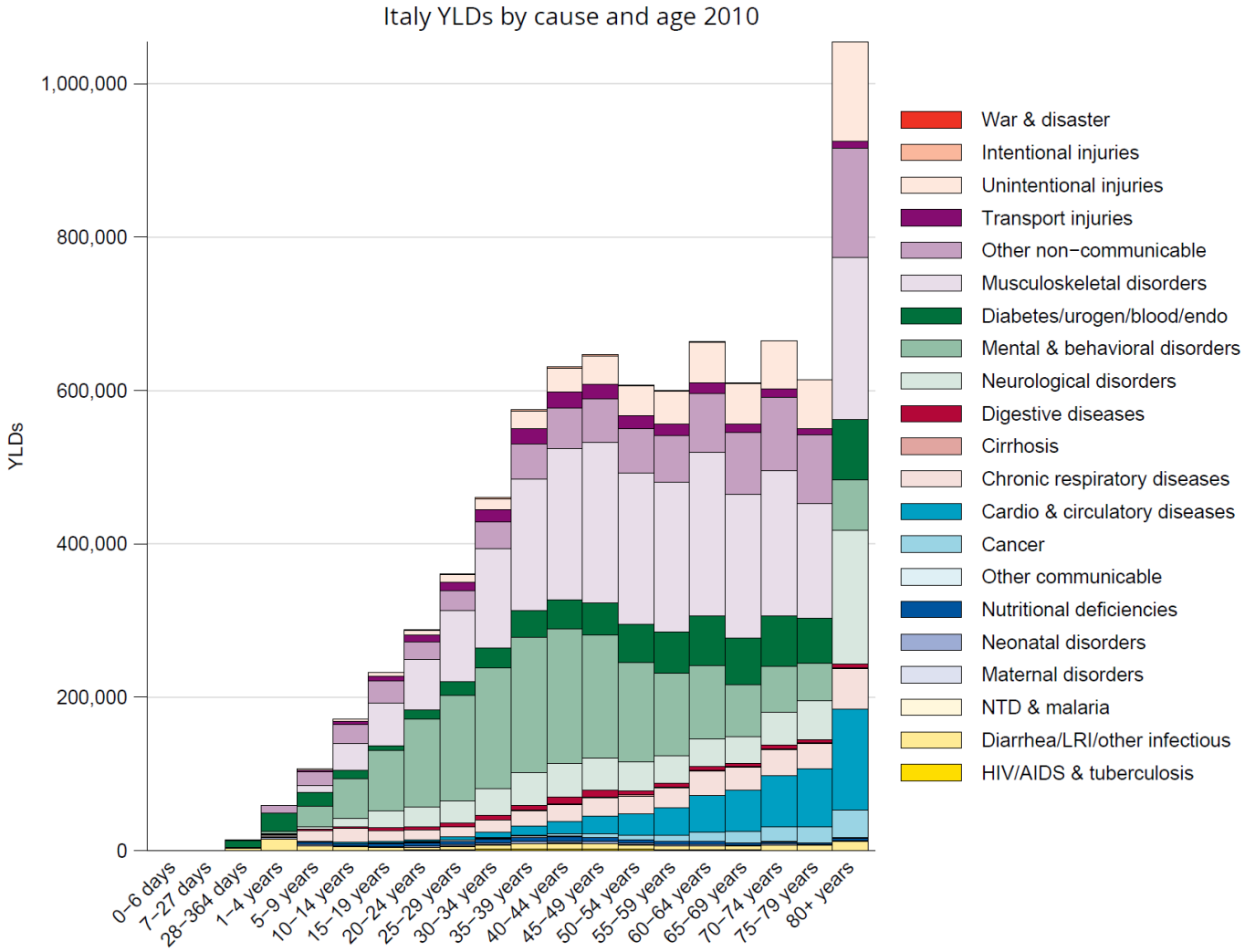
A list of challenges

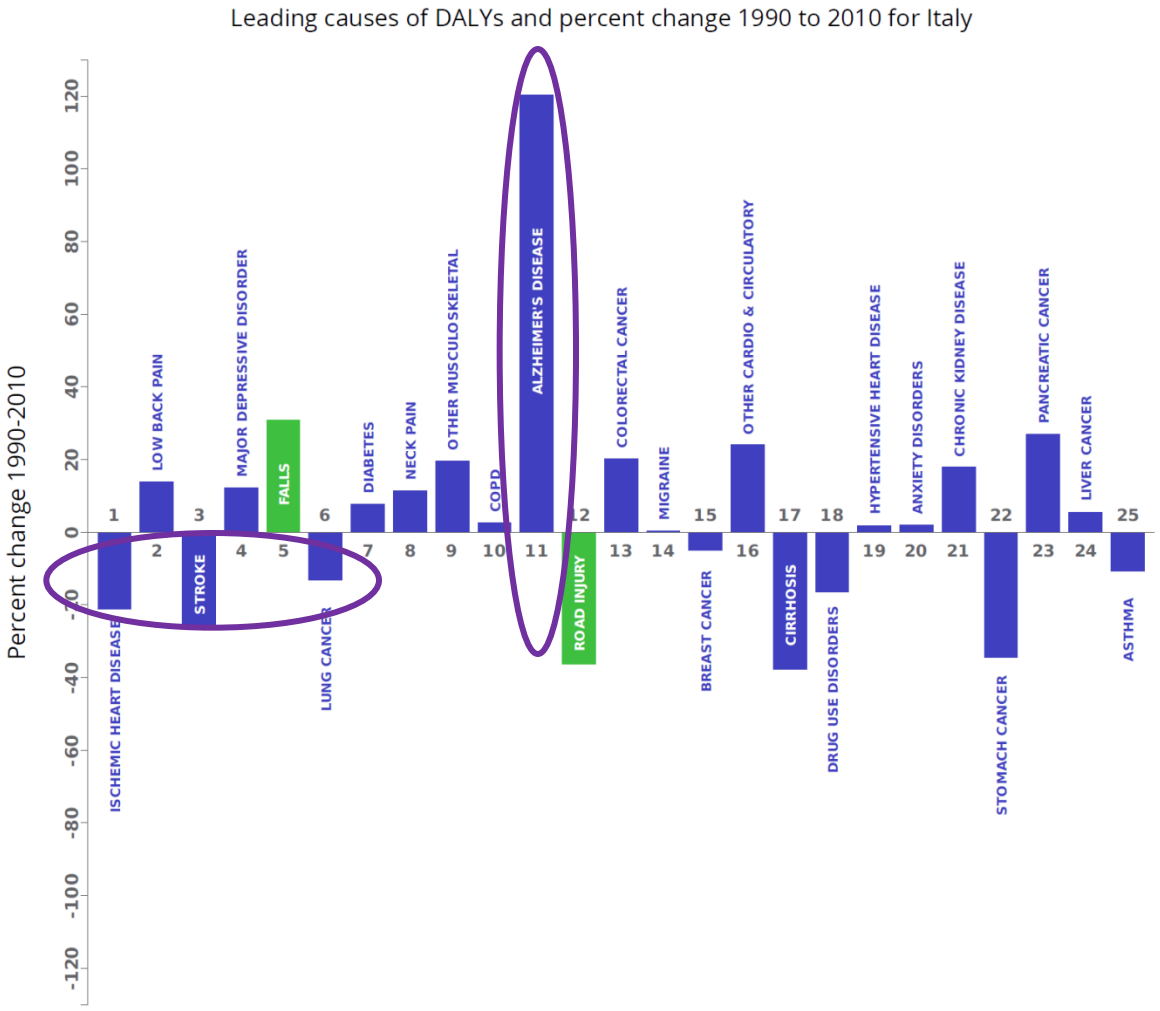
- Advances in health care that keep people alive while controlling their conditions have led to growing numbers of people surviving with chronic illness
- Proportion of older people is rising, increasing the number of those with chronic health problems because of accumulated exposure to chronic disease risk factors over lifetime.
- Accelerated advances in medical technology provide potential for new methods of delivering and organising health care
- Shortages and uneven distribution of health professionals
- Health inequalities and inequities in access to health care
- Financial pressures on economies and health systems

Years lived with disability, Italy, 2010



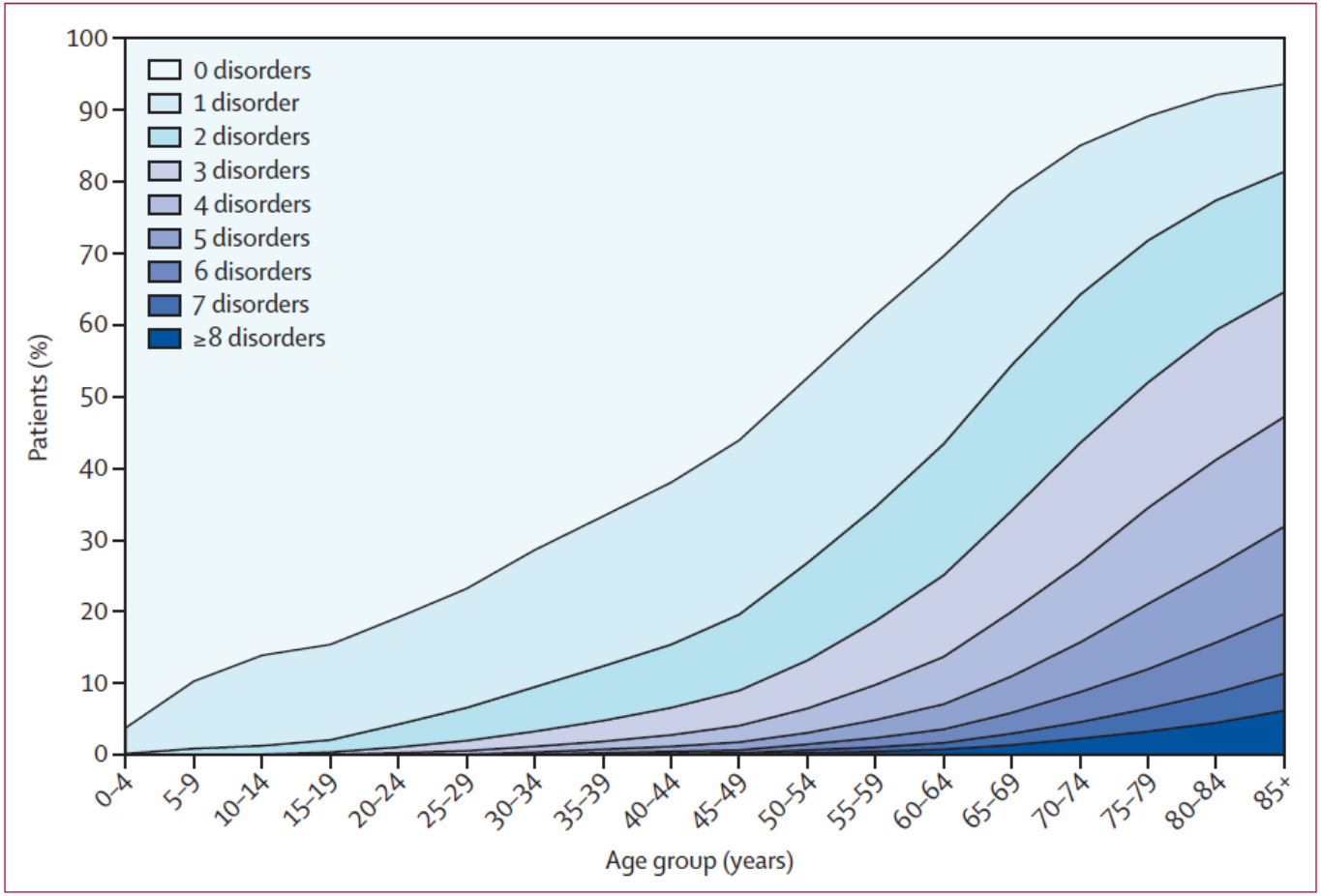
Source: IHME (2013)

Trends in leading causes of DALYs, Italy



Source: IHME (2013)

Multimorbidity is most common among older people (Scottish data)



Source: Barnett et al. (2012)

… but the actual number of people with multimorbidity is higher at younger ages

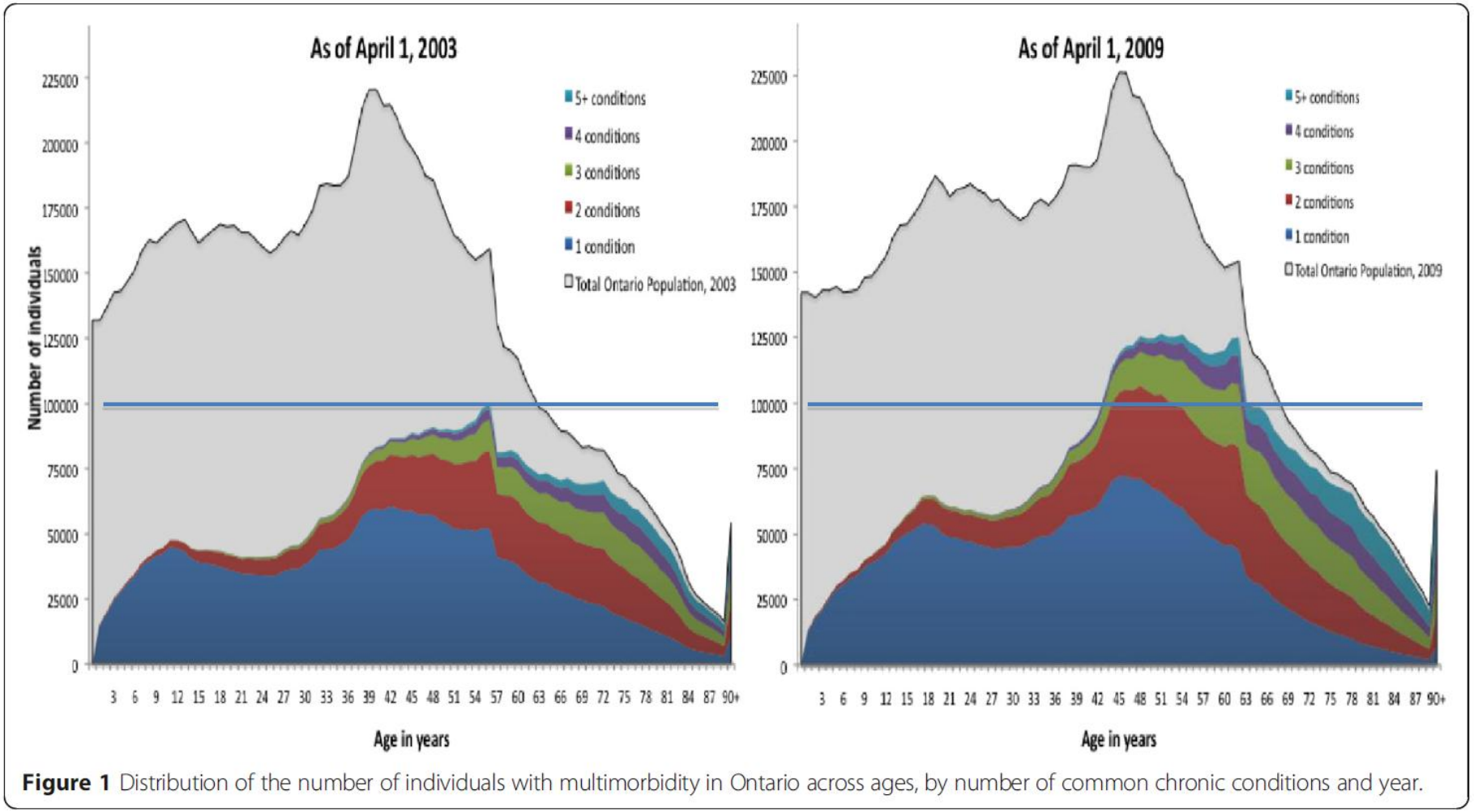
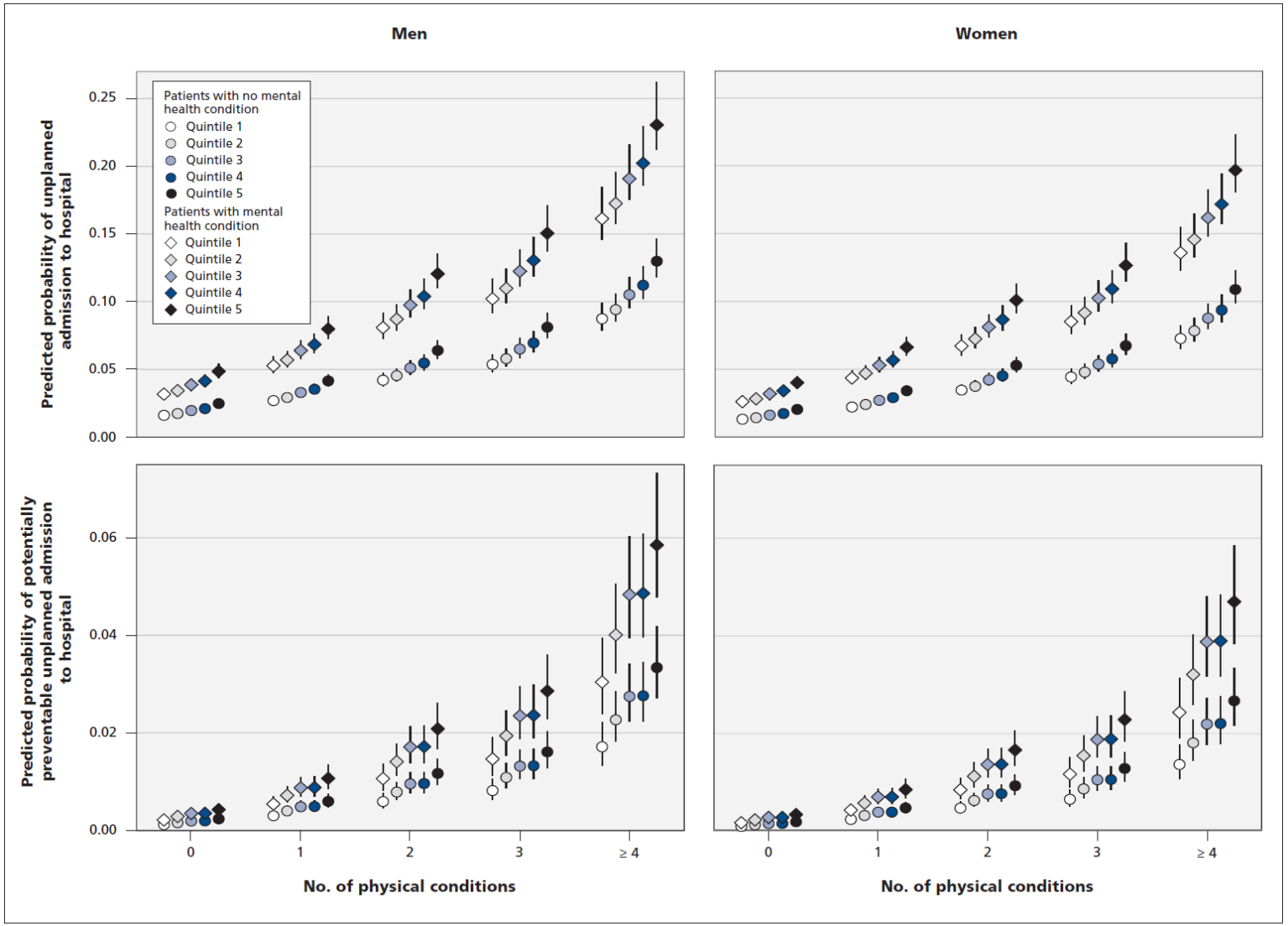


Figure 1 Distribution of the number of individuals with multimorbidity in Ontario across ages, by number of common chronic conditions and year.

Source: Koné Pefoyo et al. (2015)

Multimorbidity is associated with unplanned admission to hospital



Source: Payne et al. (2013)

The nature of chronic conditions requires a different approach to service delivery

	Acute disease	Chronic illness
Onset	Abrupt	Generally gradual and often subtle
Duration	Limited	**Lengthy and indefinite**
Cause	Usually single	Usually multiple and changes over time
Diagnosis and prognosis	Usually accurate	Usually uncertain
Technological intervention	Usually effective	**Often indecisive, adverse effects common**
Outcome	Cure possible	**No cure**
Uncertainty	Minimal	Pervasive
Knowledge	Professionals knowledgeable, patients inexperienced	**Professionals and patients have complementary knowledge and experiences**

Source: Holman & Lorig (2000)

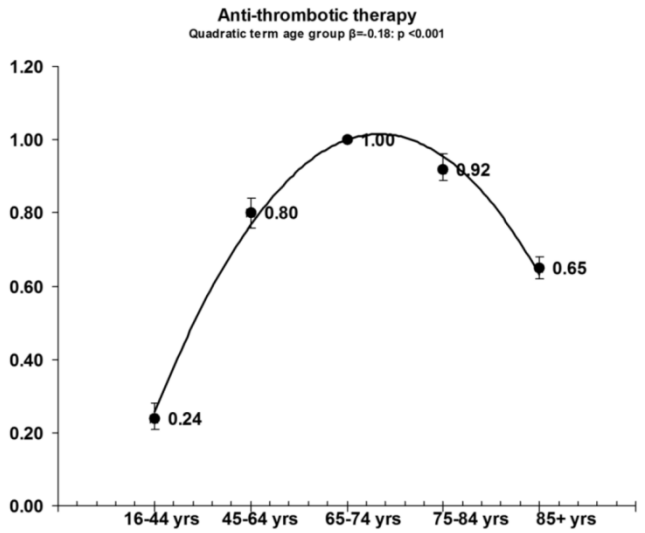
Health care largely built around acute, episodic model of care

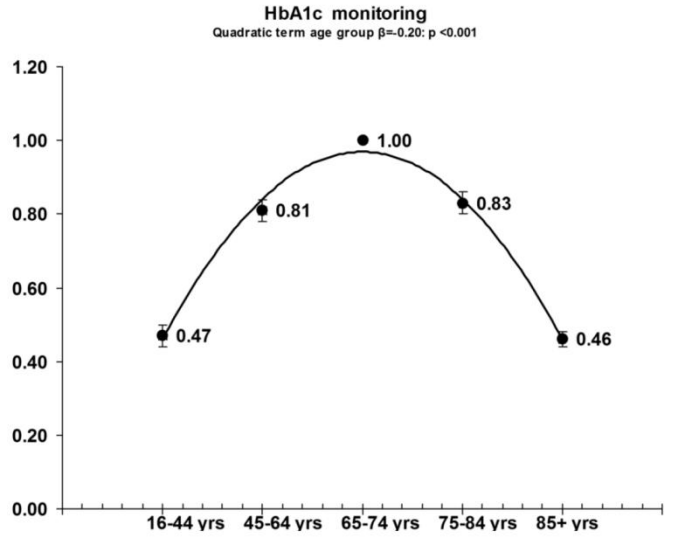
- Health care not well-equipped to meet the requirements of people with multiple or complex care needs
  - complex response over extended period of time
  - co-ordinated inputs from a wide range of professionals
  - access to essential medicines and monitoring systems
  - promotion of patient empowerment

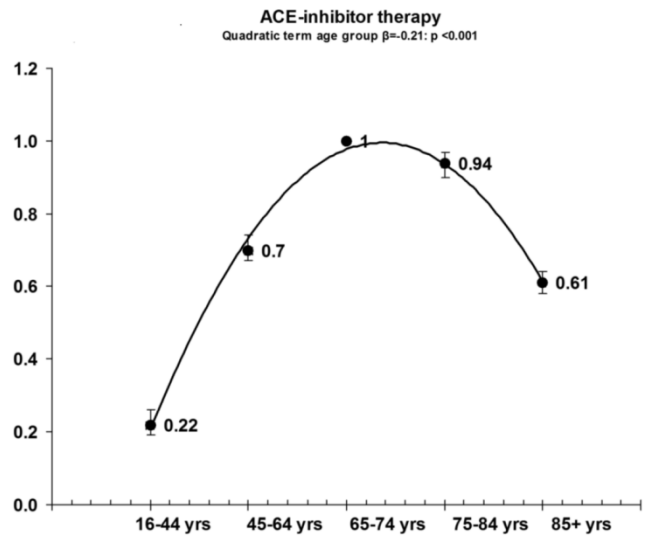
- Fragmentation of services acting as barrier to coordination of services along the continuum of care
  - Patients receive care for a disease from many different physicians or providers
  - They are frequently called upon to monitor, coordinate, or carry out their own treatment plan

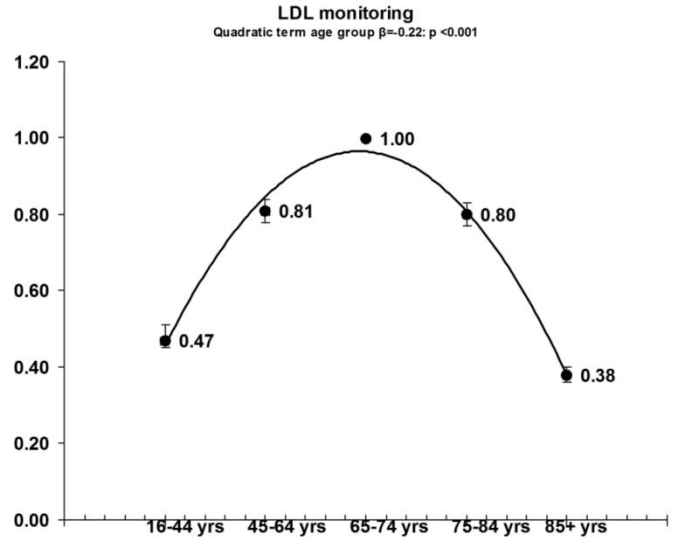
Suboptimal quality of care delivered to those with chronic care needs

Adherence to disease management standards for heart disease and diabetes in 6 regions in Italy (VALORE study)









Source: Buja et al. (2014)

Countries have recognised the need to enhance the coordination of care

- EU-funded project 'DISMEVAL' (Developing and validating disease management evaluation methods for European health care systems)

- Review of approaches and models in place in 13 countries across Europe
  - Social health insurance systems: *Austria, Estonia, France, Germany, Hungary, Lithuania, Netherlands, Switzerland*
  - Tax-based systems: *Denmark, England, Italy, Latvia, Spain*

- Use of the Chronic Care Model as an organising principle

Approaches to enhance coordination frequently focus on specific conditions

Country	Name	Year implemented	Aim/general description	Target	Principal coordinator	Distribution
Austria	'Therapie Aktiv' diabetes disease management programme	2006	To improve the quality of life and	Diab	DMP physician (General practitioner /family physician)	Implemented in 6 of 9 states; 2 states operate separate programmes, one of which is to be integrated into 'Therapie Aktiv'
Denmark	Regional disease management programmes	Ongoing since 2009	An interdisciplinary, intersectoral and coordinated effort using evidence-	Diab	DMP General ctitioner	DMPs for most conditions implemented in several regions (Central Region, Southern Region, Zeeland); anticipated that programmes will cover all targeted patients in the country
France	Sophia diabetes care programme	2002	To improve the coordination, efficiency	Diabetes type 1 and 2	General practitioner, in collaboration with nurse	Experimental phase targeted patients of 6,000 GPs (6.4% of all GPs) in 10 departments; expanded further in 2010 and nationwide in early 2013, has to date provided services to 226,000 patients (12.5% of the eligible population)
Germany	Disease management programmes	2003	Organisational approach to medical care that involves the coordinated ca evidence	Diabetes type 1 / Diab typ	sician	Offered by SHI funds across Germany; in 2010 there were ~2,000 DMPs for each condition; number of participants varies from 126,000 for breast cancer to 3.75 million for diabetes type II (2012)
Nether-lands	Bundled payment contract ('care group')	2007	To facilitate multidisciplinary v	Diab Diabet COPD Vascular risk	General tioner / care giver mined by programme)	There were 97 care groups in March 2010 with bundled payment contract with a health insurer, mostly for diabetes care; there were relatively few care groups for the provision of vascular risk management

Improve quality of life; place patients at centre; reduce hospitalisation

Interdisciplinary, intersectoral & coordinated effort

Improve coordination, efficiency and quality

Coordinated treatment and care across providers

Multidisciplinary cooperation; encompasses prevention, early detection, treatment and rehabilitation

Trend towards strengthening the role of nurses in care delivery and coordination

- Common in systems with tradition in multidisciplinary team working
  - Nurse-led clinics; nurse-led case management *(England, Italy, Netherlands, Spain)*

- Challenging in systems where primary care traditionally provided by doctors in solo-practice and few support staff
  - Enhanced functions in care coordination or case management under development/piloted *(e.g. Denmark, France; Lithuania)*
  - Enhanced functions in patient self-management support and/or selected medical tasks but under supervision of GP/physician *(Austria, France, Germany)*

Approaches that seek to reduce barriers between sectors remain less common

- Typically focus on managing the primary/secondary care and/or secondary care/rehabilitation interface
  - e.g. Provider networks (France); Integrated care contracting (Germany); Stroke service Delft (Netherlands)

- Often (although not always) implemented as pilot projects
  - e.g. (some) Integrated Care Pilots *(England);* Partnership for Older People Project *(England);* Improving intersectoral collaboration (pilot) *(Lithuania);* 'SIKS' project *(Copenhagen, Denmark)*

- Typically available in selected regions only
  - e.g. Multifunctional community centres *(Hungary);* Care Coordination Pilot *(Hungary);* 'From On-demand to Proactive Primary Care' *(Tuscany, Italy);* (some) Reform pool projects *(Austria)*

The implementation of approaches frequently involves financial incentives

- Start-up funding
  - *Supporting payers* (municipalities, Denmark; integrated care pilots, England; integrated care contracts, Germany*)
  - *Supporting providers* (provider networks, France)
- Financial incentives
  - *Incentivise payers* (municipalities, Denmark; DMPs, Germany*)
  - *Incentivise providers* (DMPs, Austria; GPs (diabetes care), Denmark; provider networks, France; DMPs, Germany; some regional projects, Italy; care groups, Netherlands; Quality & Outcomes Framework, UK)
  - *Incentivise patients* (provider networks, France; DMPs, Germany; care groups, Netherlands)

** Discontinued from 2009*

Levels of patient and clinician support vary

- Patient access is typically granted in line with access to usual care
- Many approaches are being implemented in selected geographical regions so potentially limiting access to defined population groups
- The majority provide some form of patient self-management support, although the level and scope of support offered varies
- The use of clinical information systems for chronic disease management tends to be the least developed strategy in most approaches

- Reinhard's presentation

What difference do these new approaches make?

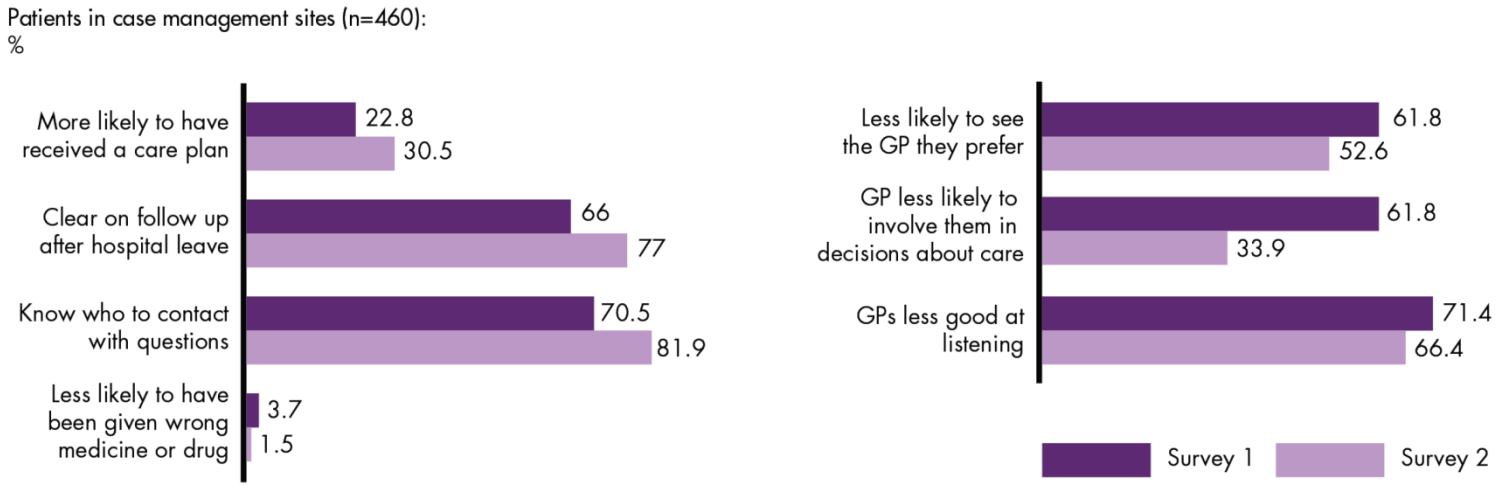
- Improvements reported mainly on process measures (eg eye examinations)
- Evidence of improvement of outcomes less certain
  - Germany
    - Evidence of improved survival of patients in German diabetes DMP => selection?
    - Limited evidence from (few) controlled studies point to improved outcomes (quality of life; mortality)
    - Methodological challenges
  - Some evidence of effect of improved clinical outcomes in Austrian diabetes DMP

Source: **DISMEVAL 2012**

… and to whom?

England

- Evaluation of national Integrated Care Pilot programme (16 pilots) finds wide variation in nature and scope of integration
- Staff were more positive about new ways of working than patients



- There was an increase in emergency admissions (9% in case management sites) but fewer elective admissions and outpatient attendance in the six months following the intervention

Source: RAND Europe and E&Y (2012); Roland et al. (2012)

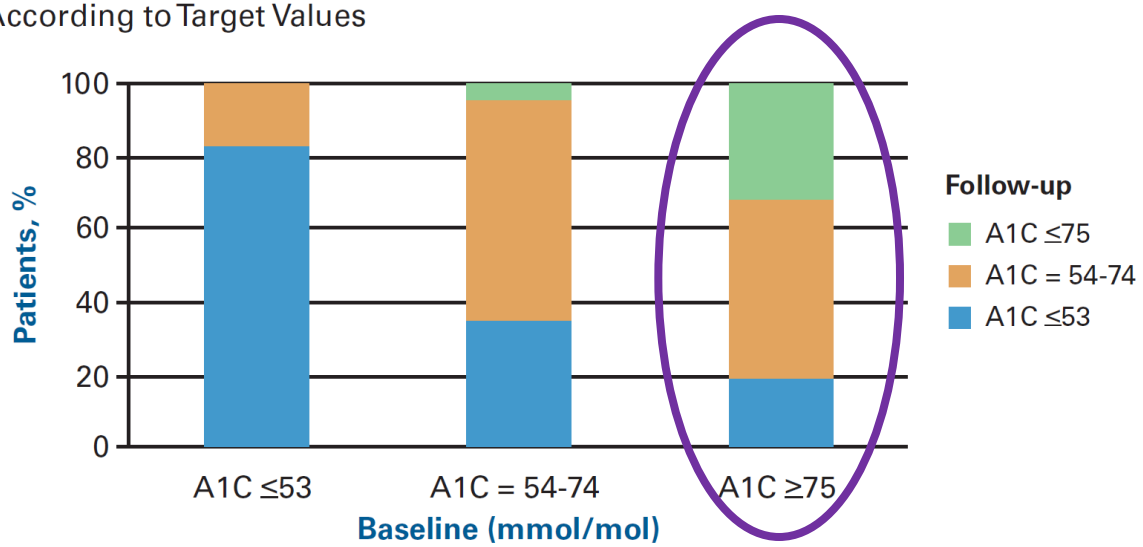
Which way to go?

- Need to better understand differential impacts of new approaches and ‘what works for whom’
  - Need to take account of needs and preferences of service users
  - Need to develop more tailored approaches to care

Source: **Elissen et al. 2012**

Dutch diabetes care groups: Improvements in patients with poor control

Figure 2. Glycemic Control From First- to Second-Year Measurements According to Target Values



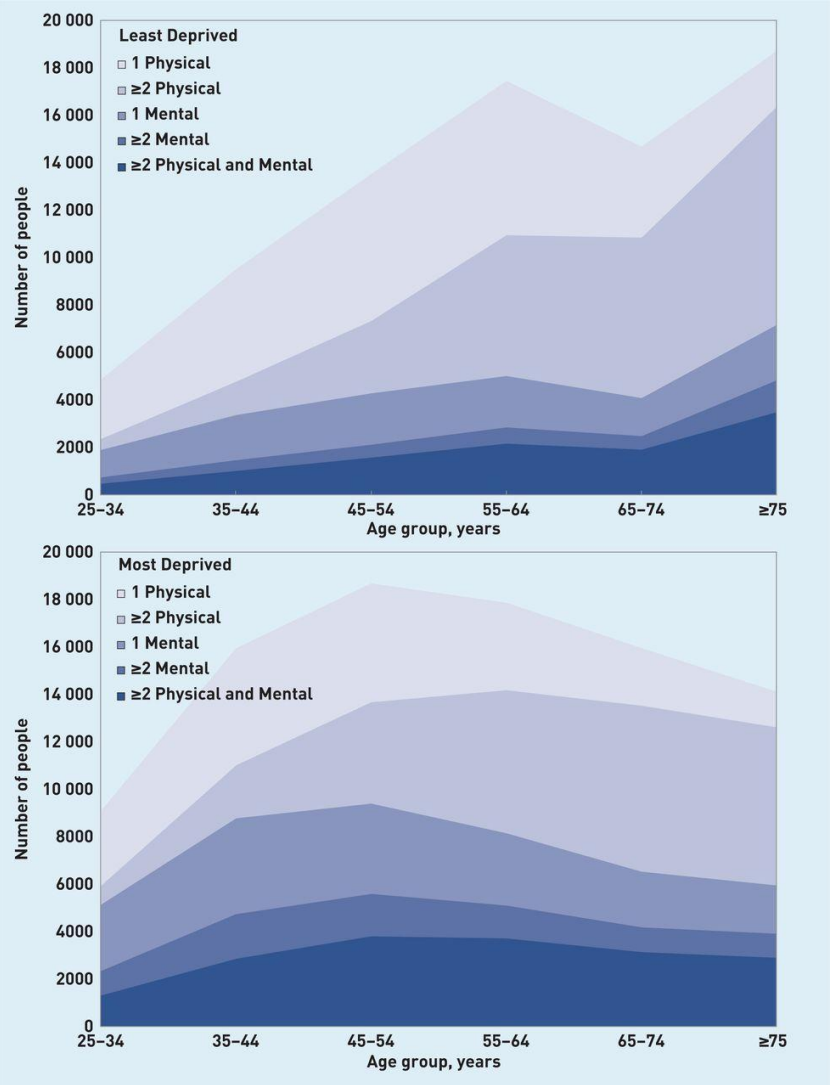
A1C indicates glycated hemoglobin.

Source: Elissen et al. 2012

Which way to go?

- Need to better understand differential impacts of new approaches and ‘what works for whom’
- Much of existing research evidence has focused on the management of a few specific diseases
  - Need to shift focus on individuals with coexisting conditions or multiple health problems

Multimorbidity is more common among those living in deprived areas



Source: Barnett et al. (2012); McLean et al. (2014)

Evidence base for interventions targeting multimorbidity specifically is limited

- Systematic review of controlled studies of management of patients with multimorbidity in primary care/community *(Smith et al. 2012)*:
  - Identified 10 randomised trials (2 on comorbidity; US, UK, Canada)
  - Interventions were multifaceted & complex, including:
    - Care coordination, case management, care plans
    - Multidisciplinary teams, care/nurse manager
    - Professional training/education
    - Patient self-management support
  - Interventions targeted at specific combinations of common conditions or at specific problems for patients with multiple conditions may be more effective
  - Effects on outcomes, especially physical outcomes were mixed

Sources: Smith et al. 2012

Which way to go?

- Need to better understand differential impacts of new approaches and ‘what works for whom’
- Much of existing research evidence has focused on the management of a few specific diseases
  - Need to shift focus on individuals with coexisting conditions or multiple health problems
- Need to use existing evidence to better understand how specific local conditions influence the outcomes of a given programme to inform implementation

What needs to be done?

Providing the (regulatory) context to enable innovation

- Create incentive systems that encourage rather than hinder better coordination among providers and sectors
  - particular attention to be paid to changes in health services which appear likely to fragment care
    - Payment systems: e.g. activity-based payment
    - Service provision: e.g. competition
- Create a policy environment that provides the means for those who are asked to implement change to acquire the actual capacity and competence to do so
- Deliver consistent messages: Policymakers and payers need to be clear about whether their goal is quality improvement or cost reduction

What needs to be done?

Learning from experience

- Systematically assess existing inefficiencies in health service delivery and disincentives for the patient or the provider to receive or deliver the highest quality care (such as access or cost)
- Need to use existing evidence to better understand how specific local conditions influence the outcomes of a given approach to inform implementation

Incorporating the patient perspective

- Support for people with chronic conditions needs to account for the social and cultural context and norms within which they live
  - Need to understand patient preferences and the importance they place on health outcomes
  - Need to be considered partners in the care process that is sensitive to the contexts within they make decisions (e.g. 'experience-based co-design')

Thank you!

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