D.5. Workshop

Integrated care: A roadmap for Europe to innovative patient centred chronic disease care

Friday 21 November 2014

14:40-16:10

Room 'Gala'

Organizers

Dr Iveta Nagyova, President EUPHA section on Chronic Diseases, PJ Safarik University, Kosice, Slovakia
Dr Judith De Jong, President EUPHA section on Health Services Research, NIVEL, The Netherlands

Rationale

In the time of financial crisis, an ageing population and a growing burden of chronic disease healthcare systems are under great pressure. In recent years much political attention has been given to chronic diseases, resulting in initiatives such as the Political Declaration of the 2011 UN High Level Meeting on the Prevention and Control of Non-Communicable Diseases in New York, the WHO Ministerial Conference on Non-Communicable Diseases in Ashgabat 2013, or the recent EU Summit on Chronic Diseases 2014 in Brussels.

Chronic diseases are interrelated, have common risk factors and are largely preventable. Yet, in Europe 9 people out of 10 die of a chronic disease. Chronic diseases carry significant human costs - human suffering, social exclusion, health inequalities; they depress wages, earnings, workforce participation and labour productivity, as well as increasing early retirement, high job turnover and disability. As a consequence 70-80% of healthcare costs are spent on chronic diseases. This corresponds to 7oo billion EUR in the European Union and this numbers is expected to rise in coming years. Given this background, policy-makers across Europe are increasingly searching for new innovative interventions and strategies to tackle chronic disease that better respond to those with complex health need and are initiating new models of service delivery.

The aim of this workshop is to accelerate improvements in care and support for people with long term illnesses or at risk of such illness and to define future implementation research priorities. The workshop provides an overview of most recent European initiatives regarding innovations in chronic illness care.

Workshop structure

After the first introductory presentation, summarising the evidence base on approaches to managing care for people with chronic condition and providing examples of approaches that have been implemented across European countries resulting mainly from the DISMEVAL project, three related topics will be presented. The second presentation deals with the DAWN2 initiative providing a new global scientific platform for the advancement of global and local partnership action for person-centred chronic illness care for people with diabetes. The third presentation, the EMBRACE project, illustrates the effectiveness of the promising and well-fitting integrated care model for the elderly using randomized control trials and business case model to calculate the costs and savings. The fourth presentation reports on innovative solutions of patients centred multidisciplinary care programmes for multi-morbidity patients carried out within the framework of the ICARE4EU project. An audience discussion concludes the workshop.

PROGRAMME

14.40 – 15.00

Managing care for people with chronic conditions: an overview of evidence and experiences

Ellen Nolte
RAND Europe, UK

15.00 – 15.20

Results from the global DAWN2 study and national action priorities to improve person-centred diabetes care

Søren E. Skovlund
Novo Nordisk A/S, Bagsvaerd, Denmark

15.20 – 15.40

Embrace: a population based Integrated Elderly Care model showed improved results and saves costs

Klaske Wynia
University Medical Center Groningen, University of Groningen, the Netherlands

15.40 - 16.00

ICARE4EU: the availability of integrated care programmes addressing multi-morbidity in 31 European countries

Mieke Rijken
NIVEL, the Netherlands

SPEAKER BIOGRAPHIES

Ellen Nolte

Ellen Nolte, MPH, PhD; Director Health & Healthcare, RAND Europe. Her background is in public health; she holds a PhD from London University and a master's degree in public health (MPH). Her expertise is in health systems research, international healthcare comparisons and performance assessment. She combines this expertise with experience in the systematic analysis of population health indicators across European countries, including the application of demographic and epidemiological approaches to understanding factors contributing to population health outcomes, including the assessment of health inequalities within and between populations. Before joining RAND she held a prestigious Career Scientist Award from the National Institute for Health Research at the London School of Hygiene & Tropical Medicine to undertake a five-year programme into chronic diseases, which involved a major study international study on chronic care. She leads on a programme of work on international healthcare comparisons that provides intelligence on new developments in other countries for the Department of Health. She has published widely on health system performance assessment and quality.

Søren E. Skovlund

Søren E. Skovlund, PhD; is a behavioural scientist with academic degrees in neurobiology and psychology. He has worked internationally in academia, the World Health Organisation and the industry for the advancement of patient-centred chronic illness care for more than 15 years. He is currently the global director of patient research, advocacy and support of Novo Nordisk A/S. His areas of responsibility include corporate strategies, partnerships and guidelines for advancement of patient-centred healthcare and scientific oversight of major multi-national studies focusing on understanding patient's and other stakeholder's unmet needs in relation to improved involvement of patients in healthcare and sustainable healthcare innovation. He has published numerous papers and is a frequent lecturer at international meetings. Søren Skovlund is recognized as a long-standing advocate for multi-disciplinary collaboration to improve healthcare policies and national care strategies with a focus on the patient's central role and the integration of psychosocial and medical factors in chronic illness care.

Klaske Wynia

Klaske Wynia, PhD; is assistant professor of the department of Health Sciences of the University Medical Centre Groningen (UMCG), University of Groningen, the Netherlands. She is experienced in developing patient centered and integrated care models for vulnerable populations, and in examining the impact of these models on patient outcomes, quality of care, service use and costs. She developed a patient advocacy case management model for the chronically ill.

Mieke Rijken

Mieke Rijken, PhD is Head of NIVEL's research programme on care needs of people with chronic illness or disability, the Netherlands. She is also managing the EU Health Programme project 'Innovating care for people with multiple chronic conditions in Europe' (ICARE4EU), which aims to contribute to the innovation of care for European citizens with multiple chronic conditions. In addition, she participates in the 'Joint Action on Chronic Diseases' (CHRODIS-JA), also financed by the EU Health Programme in collaboration with the MoHs of member states. For this Joint Action, she is specifying target groups of multi-morbidity patients with high needs and studying care pathways for multi-morbidity patients and approaches for medication management. Rijken's national research projects focus on healthcare organization and quality of care from the perspective of chronically ill or disabled people, their self-management and support needs as well as their healthcare use and quality of life.

Downloaded from http://eurpub.oxfordjournals.org/ by guest on February 22, 2016

D.5. Workshop: Integrated care: A roadmap for Europe to innovative patient centred chronic disease care

Organised by: EUPHA section on Chronic Diseases and EUPHA section on Health services research
Contact: iveta.nagyova@upjs.sk

Chairpersons: Iveta Nagyova, Slovakia and Judith De Jong, The Netherlands

In the time of financial crisis, an ageing population and a growing burden of chronic disease healthcare systems are under great pressure. In recent years much political attention has been given to chronic diseases, resulting in initiatives such as the Political Declaration of the 2011 UN High Level Meeting on the Prevention and Control of Non-Communicable Diseases in New York, the WHO Ministerial Conference on Non-Communicable Diseases in Ashgabat 2013, or the recent EU Summit on Chronic Diseases 2014 in Brussels.

Chronic diseases are interrelated, have common risk factors and are largely preventable. Yet, in Europe 9 people out of 10 die of a chronic disease. Chronic diseases carry significant

human costs - human suffering, social exclusion, health inequalities; they depress wages, earnings, workforce participation and labour productivity, as well as increasing early retirement, high job turnover and disability. As a consequence 70-80% of healthcare costs are spent on chronic diseases. This corresponds to 7oo billion EUR in the European Union and this numbers is expected to rise in coming years. Given this background, policy-makers across Europe are increasingly searching for new innovative interventions and strategies to tackle chronic disease that better respond to those with complex health need and are initiating new models of service delivery.

The aim of this workshop is to accelerate improvements in care and support for people with long term illnesses or at risk of such illness and to define future implementation research priorities. The workshop provides an overview of most recent European initiatives regarding innovations in chronic illness care.

After the first introductory presentation, summarising the evidence base on approaches to managing care for people with chronic condition and providing examples of approaches that have been implemented across European countries resulting mainly from the DISMEVAL project, three related topics will be presented. The second presentation deals with the DAWN2 initiative providing a new global scientific platform for the advancement of global and local partnership action for person-centred chronic illness care for people with diabetes. The third presentation, the EMBRACE project, illustrates the effectiveness of the promising and well-fitting integrated care model for the elderly using randomized control trials and business case model to calculate the costs and savings. The fourth presentation reports on innovative solutions of patients centred multidisciplinary care programmes for multi-morbidity patients carried out within the framework of the ICARE4EU project. An audience discussion concludes the workshop.

Key messages

- The growing recognition of care fragmentation is causing countries to explore new approaches to healthcare delivery that can bridge the boundaries between professions, providers and institutions.
- Integrated care programmes are proposed as a mean to reduce cost and to improve health outcomes. Despite intuitive appeal and growing numbers of evidence progress has been slow in implementing these.

Downloaded from http://eurpub.oxfordjournals.org/ by guest on February 22, 2016

Managing care for people with chronic conditions: an overview of evidence and experiences

Ellen Nolte

E Nolte
RAND Europe, Cambridge, UK
Contact: enolte@rand.org

Background
The rising prevalence of chronic illness poses considerable challenges to health systems globally. Part of this challenge is that chronic conditions create a spectrum of needs that require multifaceted responses over extended periods from a range of professionals as well as active patient engagement. The need to develop coordinated or integrated approaches to service delivery has been widely recognised but it has been difficult to reach conclusions as to the best model for doing so, given that models are highly context-dependent and scientifically rigorous evaluations have been lacking. The aim of our research was to support this process through identifying and validating evaluation methods and performance measures for disease management and to make recommendations to policymakers, programme officials and researchers on best practices that are both scientifically sound and operationally feasible.
Methods
The policy context for, and approaches to, chronic disease management have been reviewed across countries within the European Commission funded project - DISMEVAL (Seventh Framework Programme, Grant agreement No. 223277) as well as other research projects.
Results
Drawing on the outcomes of the DISMEVAL project and author's earlier work on chronic care, disease management, and integrated care, this paper summarises the evidence base on approaches to managing care for people with chronic conditions and provides examples of approaches that have been implemented across European countries. It argues that disease management produces improvements in process measures that may sometimes be related to outcomes, although studies varied widely in the quality of evidence and the size of an effect. The strongest evidence for the effectiveness of disease management was for depression, heart failure and poorly controlled diabetes.
Conclusions
For complex patients there are no single interventions that appear to make a dramatic difference to outcomes, and interventions which combine a number of different approaches appear more promising, albeit small. Given the modest but positive effects of interventions designed to integrate or coordinate care, particular attention should be paid to changes in health services which are likely to fragment care.

Downloaded from http://eurpub.oxfordjournals.org/ by guest on February 23, 2016

Results from the global DAWN2 study and national action priorities to improve person-centred diabetes care

Soren Eik Skovlund

SE Skovlund
Novo Nordisk A/S, Bagsvaerd, Denmark
Contact: sesk@novonordisk.com

Background
The increasing prevalence of diabetes worldwide – coupled with the broad impact diabetes has on all aspects of life – calls for a new and collaborative approach, in which self-management and psychosocial issues are managed as an integral part of team-based chronic illness care, involving people with diabetes, their family members, healthcare professionals and the healthcare system, and the wider community in the process. The DAWN2™ (Diabetes Attitudes Wishes and Needs) initiative provides a new global scientific platform for the advancement of global and local partnership action for person-centred diabetes care. The study objectives were to enhance understanding of the unmet needs of people with diabetes and their families, to facilitate national partnership action, and involving people with diabetes to specifically improve on nationally prioritised aspects of person-centred diabetes care.
Methods
The DAWN2™ study, with the first results published in June 2012, represent opinions from more than 15,000 people living with, or caring for people with diabetes in 17 countries across four continents and highlights important improvements the past decade as well as significant specific gaps in availability of person-centred diabetes care.
Results
Globally, 44.6% of people with diabetes and 39.6% of family members reported diabetes related emotional distress, 13.8 % of people with diabetes reported likely depression. Only 49% of people with diabetes, and only 23% of family members had ever participated in a diabetes education programme. Only 24% of people with diabetes reported their healthcare team had asked them how diabetes affects their lives, while 52% of health professionals stated that they do ask this question. 19% of all people with diabetes had experienced discrimination due to their diabetes. Availability of psycho-social support from multiple sources was associated with diabetes outcomes.
Conclusions
The DAWN2™ study allows for cross-national benchmarking on indicators of person-centred diabetes care at individual, healthcare delivery, and policy level which enables national

Downloaded from http://eurpub.oxfordjournals.org/ by guest on February 23, 2016

multi-sector and multi-disciplinary committees to identify best practices and common priorities for local improvement.

Downloaded from http://eurpub.oxfordjournals.org/ by guest on February 23, 2016

Embrace: a population based Integrated Elderly Care model showed improved results and saves costs

Klaske Wynia

K Wynia[1,2], BPH Kremer[2], SLW Spoorenberg[1], RJ Uittenbroek[1], SA Reijneveld[1]

[1]University of Groningen, University Medical Center Groningen, Department of Health Sciences, Community and Occupational Medicine, Groningen, The Netherlands

[2]University of Groningen, University Medical Center Groningen, Department of Neurology, Groningen, The Netherlands

Contact: k.wynia01@umcg.nl

Background

Embrace is a population based Integrated care model for elderly people living in the community, and is a combination of the chronic care model (CCM) and the Kaiser Permanente (KP) triangle.

Methods

Embrace was designed by translating all CCM key elements to the Dutch situation and by specifying these elements for elderly people. The KP- triangle was used to identify risk profiles and care intensity levels. The model was put into practice since January 2012. A randomized controlled trial (RCT) in combination with two qualitative studies was performed to examine the effectiveness of Embrace. A business case was developed to calculate a reliability indicator for the costs and savings.

Results

Elderly care teams supported 1500 elderly who were divided into three risk profiles: robust (64%), frail (16%), and complex care needs (20%). Results of the RCT will be available soon. Qualitative studies showed that, due to the structural contacts, elderly people felt save and secured and had the confidential to be able to stay in place longer, while the case managers were better able to organize appropriate and coherent care and support, and to prevent escalations. Evaluations among elderly participants in the self-management support and prevention program' reported that the information and activities offered helped them to remain independently for longer. The business case indicated annual savings due to Embrace.

Conclusions

Embrace is a promising and well-fitting Integrated care model. Embrace is one of the good practices in the three star reference site of the University Medical Centre of Northern Netherlands. In 2014 the number of participating elderly will rise to about 4000. Health care insurance companies and municipalities are searching for structural Integrated financing of Embrace.

Downloaded from http://eurpub.oxfordjournals.org/ by guest on February 23, 2016

ICARE4EU: The availability of integrated care programmes addressing multi-morbidity in 31 European countries

Mieke Rijken

M Rijken[1], V Struckmann[2], E van Ginneken[2,3]
[1]The Netherlands Institute for Health Services Research (NIVEL), Utrecht, The Netherlands
[2]Berlin University of Technology, Berlin, Germany
[3]The Observatory on Health Systems and Policies, Brussels, Belgium
Contact: M.Rijken@nivel.nl

Background
Innovation in chronic illness care is urgently called for, since most care delivery models are not adapted to the needs of the growing number of people with multi-morbidity. Moreover, innovation is necessary to provide good quality care with limited financial as well as human resources. Integrated care models have the potential to meet the complex needs of people with multi-morbidity, while making efficient use of resources.

Methods
The Innovating care for people with multiple chronic conditions in Europe (ICARE4EU) project (2013-2016) aims to describe, analyze and disseminate innovative solutions of patient centered multidisciplinary care programmes for multi-morbidity patients in 31 European countries. Data about innovative care programmes and country specific information is collected from expert organizations in all countries with online surveys.

Results
Preliminary results show that out of 31 countries in 17 countries at least one integrated care programme can be identified. First survey results will be presented, including estimations regarding the availability of integrated care programmes addressing multi-morbidity in 31 European countries. Furthermore, first observations will be made about their context, shape and variation (e.g. in terms of definitions, care sectors/providers involved, financing).

Conclusions
Although several countries are experimenting with integrated care models addressing multi-morbidity, many European countries only have few programmes while some countries do not have programmes at all. The potential to scale up successful programmes seems considerable, as currently existing programmes may not meet the demand for the growing numbers of patients with multiple chronic diseases.

Downloaded from http://eurpub.oxfordjournals.org/ by guest on February 23, 2016