

A novel Horizon2020 project on integrated care for multi-morbidity

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Content



- Collaborating countries
- * Aim
- Methods
- * Conceptual framework
- * Selected integrated care programs for multi-morbidity

Collaborating countries

The Netherlands

Erasmus University Rotterdam, Institute of Health Policy and Management

Germany

Berlin University of Technology, Department of Health Care Management

Austria

Institute for Advanced Studies

Norway

University of Bergen, Department of Economics

institute of Health Policy & Management



Hungary

Syreon Research Institute



United Kingdom

University of Manchester, Center of Health Economics



Croatia

Agency for Quality and Accreditation in Health Care and Social Welfare



Spain

Consorci Institut D'Investigacions Biomediques August Pi i Sunyer









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Aims



- * Taxonomy of promising, patient-centred, prevention-oriented, cost-effective, economically sustainable ICC models for multi-morbidity
- * Matching financing/payment schemes that provide adequate financial incentives to support their implementation
- * Empirical evidence about the impact on a wide range of outcomes
- * Performance-monitoring tool based on MCDA methods and new indicators particularly relevant for multi-morbidity
- * Implementation and transferability strategies (esp. CEE)

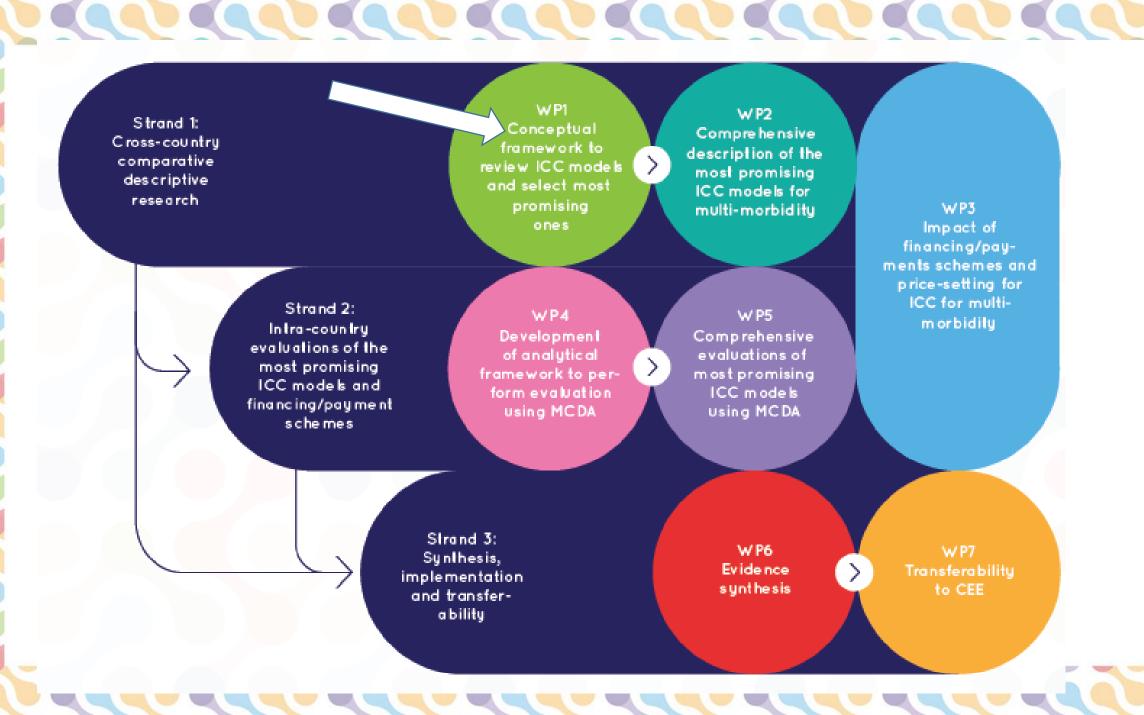
Methods

* Qualitative

Quantitative

- Thick descriptions
 - Document analyses
 - Interviews

- Multi-Criteria Decision Analysis
 - Assess performance on multiple outcomes;
 - Obtain relative importance **weights** from 5Ps
 - Weights via DCE, AHP
 - Combine performance scores and weights into overall assessment from each perspective
- Impact of financing/payment schemes
 - Within ICC programs
 - On routine data (Difference-in Difference, Time Series Analyses)
- * Adequate price-setting methodology



Methods to develop framework



- * Scoping review of scientific/grey literature + previous projects
 - * PubMed, Scopus, Embase, PsycInfo, Cochrane, Web of Science, Sociological Abstracts, and Social Services Abstracts > 93 papers
 - Data extraction: key features of integrated care for multi-morbidity, existing models/frameworks/theories/concepts
- * Expert discussion
 - * All SELFIE consortium partners
 - * (Inter)national stakeholder meeting
 - * 5Ps: Patients, Partners (informal carers), Providers, Professionals, Payers

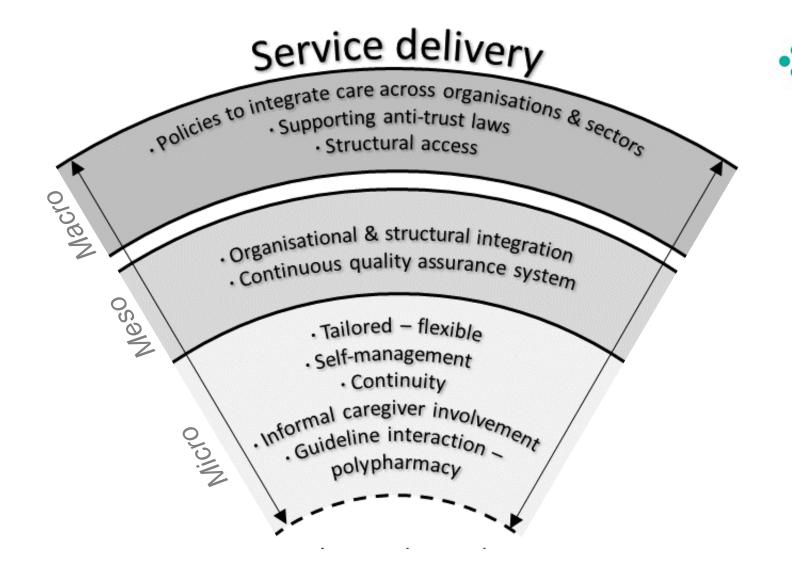
Service delivery Framework . Organisational & structural integration Information . Continuous quality assurance system . Tailored - flexible Self-management Continuity r governance . Informal caregiver involvement Guideline interaction Registration polypharmacv · Shared individual level decision-making Person-centred care · Individual risk Holistic understanding prediction Coordination Individual with tailored multi-morbidity Monitoring to complexity Health, well-being, capabilities, Micro Meso Micro Meso Macro. self-management, needs, preferences Financial Community · EMRs & / · Multi-disciplinary Housing Environment Transport patient portal Assistive · Core group Named coordinator technologies Remote medical products Technologies &. monitoring tools responsibilities · Coverage reimbursement Out-of-pocket costs · Incentives to participate · Incentives to collaborate · Secured budget Health- and social care systems Stimulating investments in innovative care models **Financing**



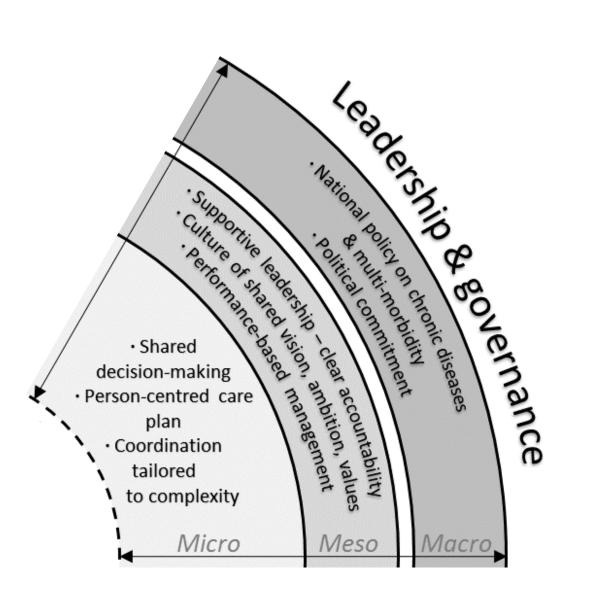
Heart



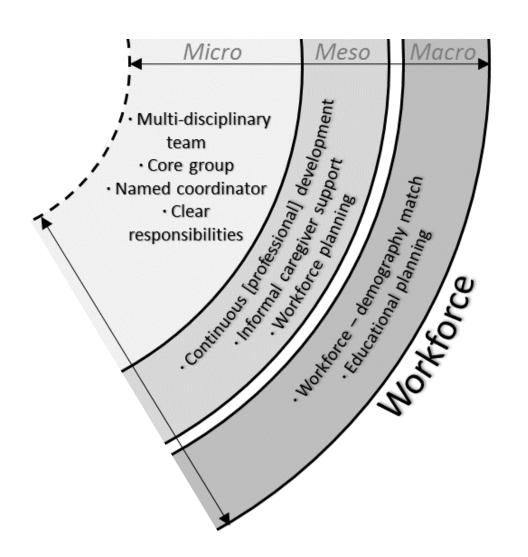
Holistic understanding **Individual with** multi-morbidity Health, well-being, capabilities, self-management, needs, preferences Financial Community Housing Environment Transport Social Welfare network services



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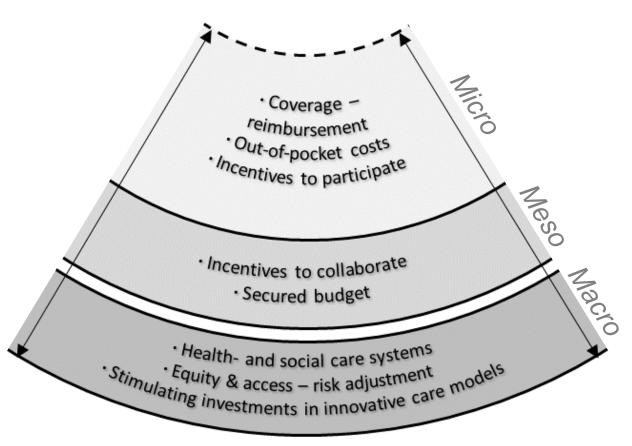




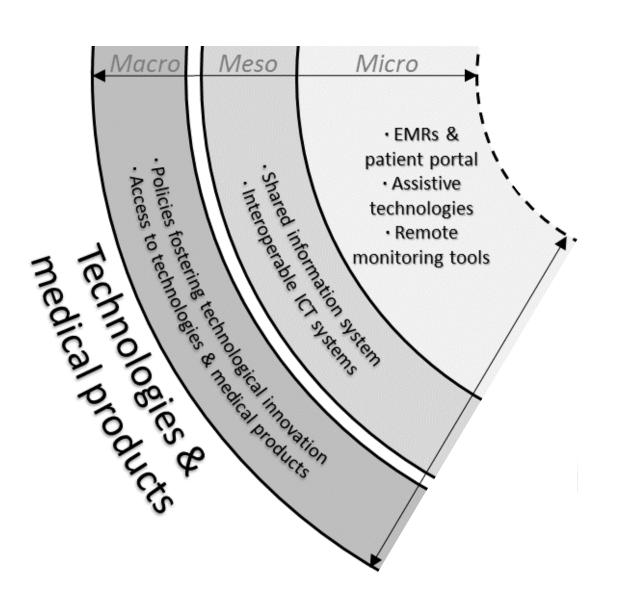




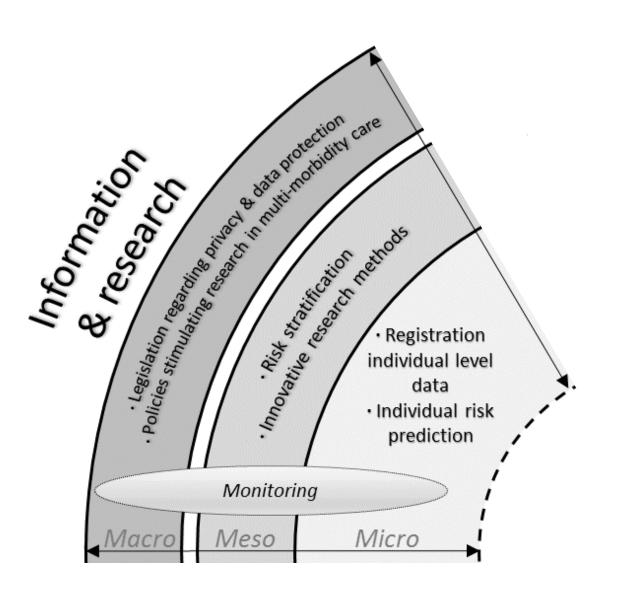




Financing









Criteria program selection



Essential

Multi-morbidity (broad definition incl. vulnerable groups)

Multidisciplinary integrated care

Innovative in country's context (e.g. intersectoral integration, population health management)

Patient-level data on triple aim available or collectable

Ongoing for at least the next 2 years

Additional:

- Does the patient have an active role?
- Is the program **goal-oriented**?
- Does the program ensure continuity of care?
- Are informal caregivers actively involved?
- Was the program a bottom-up initiative?
- Can the program be scaled-up and is it transferable?
- Variability across selected programs

Programs (preliminary)

| UK | South Somerset Symphony Program The Torbay Model |
|----|--|
| ES | Badalona Serveis Assistencials Deployment of Integrated Care Services for Chronic Patients Supported by Information and Communication Technologies Barcelona-Esquerra (AISBE) (NEXES project) |
| NL | Better together in Amsterdam North (BsiN) Implementation of U-Profit approach for frail elderly Care Chain Vulnerable Elderly (formerly KOMPLEET) |
| DE | CasaplusGesundes Kinzigtal |
| AT | Health Network TennengauSociomedical Centre Liebenau |
| NO | Learning network for new users of home nursing services or short-term stays in nursing homes Medically Assisted Rehabilitation Bergen for adults with opioid addiction (LMAR) |
| HU | Onconetwork Palliative Care Consulting Service (Mobile) Team in Pécs |
| HR | GeroS (System to detect/evaluate health needs and functional capacity of geriatric patients) Palliative Care System |

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Disclaimer



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Website: http://www.selfie2020.eu/