Improving the delivery of integrated care for people with multimorbidity

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On behalf of all ICARE4EU partners:
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• National Institute of Health and Science on Aging (INRCA), Italy
• Technical University Berlin (TUB), Germany
• University of Eastern Finland (UEF), Finland
Out of silos!

Leading the right process

See Holmberg-Marttila 2014
Concrete examples how to develop care through integration

- POTKU Project (Patient on a Driver’s Seat), Finland
- Clinic for Multimorbidity and Polypharmacy, Silkeborg, Denmark
- The Strategy for Chronic Care in Valencia Region, Spain

Patient segmentation
Care path for people with multimorbidity
Multiprofessional teams
Case managers
Segmentation of patients (Valencia)

Valencian Community
4,700,000 inhabitants

- Highly complex chronic and palliative patients
  Case management

- Moderate complexity chronic patients
  Disease management

- Risk factors / Low complexity patients
  Self-care

- Healthy population
  Health promotion
Segmentation of patients with MM (Finland)

Degree of difficulty of the disease
Complexity of treatments and services

4 customer strategies

- Community customerships
- Network customerships
- Self-managing customerships
- Co-operation customerships

Ability to cope in everyday life
Family's resources

Low
High

Difficult
Easy

Koivuniemi & Simonen 2011, Holmberg-Marttila 2014
# Care path for people with multimorbidity (Finland)

<table>
<thead>
<tr>
<th>Support</th>
<th>Aims of treatment</th>
<th>Focus of the treatment plan</th>
<th>Mode of making appointments</th>
<th>Tools</th>
<th>Responsibility for coordination of care</th>
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</thead>
<tbody>
<tr>
<td><strong>Self-managing clientship</strong>&lt;br&gt;The patient has good resources/capacity?, and the implementation of treatment is clear</td>
<td>To support patient’s self-treatment (self-care) and her/his own know-how, to replace face-to-face contacts with more suitable modern health services</td>
<td>Self-treatment plan&lt;br&gt;Focus on early stage guidance</td>
<td>The patient books an appointment her/himself, through internet&lt;br&gt;By using text messages laboratory can be forwarded to the patient, or s/he can be reminded about appointments agreed</td>
<td>Electronic contact&lt;br&gt;Health coaching&lt;br&gt;Health library&lt;br&gt;Health navigator</td>
<td>Personal doctor (=family doctor)</td>
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<tr>
<td><strong>Network clientship</strong>&lt;br&gt;The patient has poor capacity, the treatment is complicated and challenging</td>
<td>Enhancing or maintaining functioning ability, clear coordination of care</td>
<td>Formulating and monitoring&lt;br&gt;Personal plan for rehabilitation and personal service plan</td>
<td>Service coordinator books appointments/invitation procedure/home visits</td>
<td>Prepared practice&lt;br&gt;Multiprofessional care team&lt;br&gt;Joint care plan (primary care, social services, secondary care)&lt;br&gt;Including next-of-kin in care</td>
<td>Appropriate social or health care professional = service coordinator and rehabilitation coach in secondary care</td>
</tr>
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Clinic for Multimorbidity and Polypharmacy  
(Silkeborg, Denmark)

• Same-day service

• Comprehensive assessment

• Multidisciplinary team
  – consisting of medical doctor, nurse, pharmacist, physiotherapist, occupational therapist and relevant physicians from nine different specialities, including psychiatry

• Aim is to support GPs
Two case managers’ model in Valencia, Spain
Conclusions

• Several different promising tools and practices have been developed and implemented to improve the care for people with multimorbidity

• Many of these practices cover only part of the care sector

• More concrete connections needed
  • between primary care and secondary care
  • between health and social care
  • between formal and informal care

• Organizational arrangements form a basis for integration, attention also on competencies and collaboration skills of professionals
References

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