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Improving the delivery of integrated care for people with multimorbidity

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On behalf of all ICARE4EU partners:
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- University of Eastern Finland (UEF), Finland

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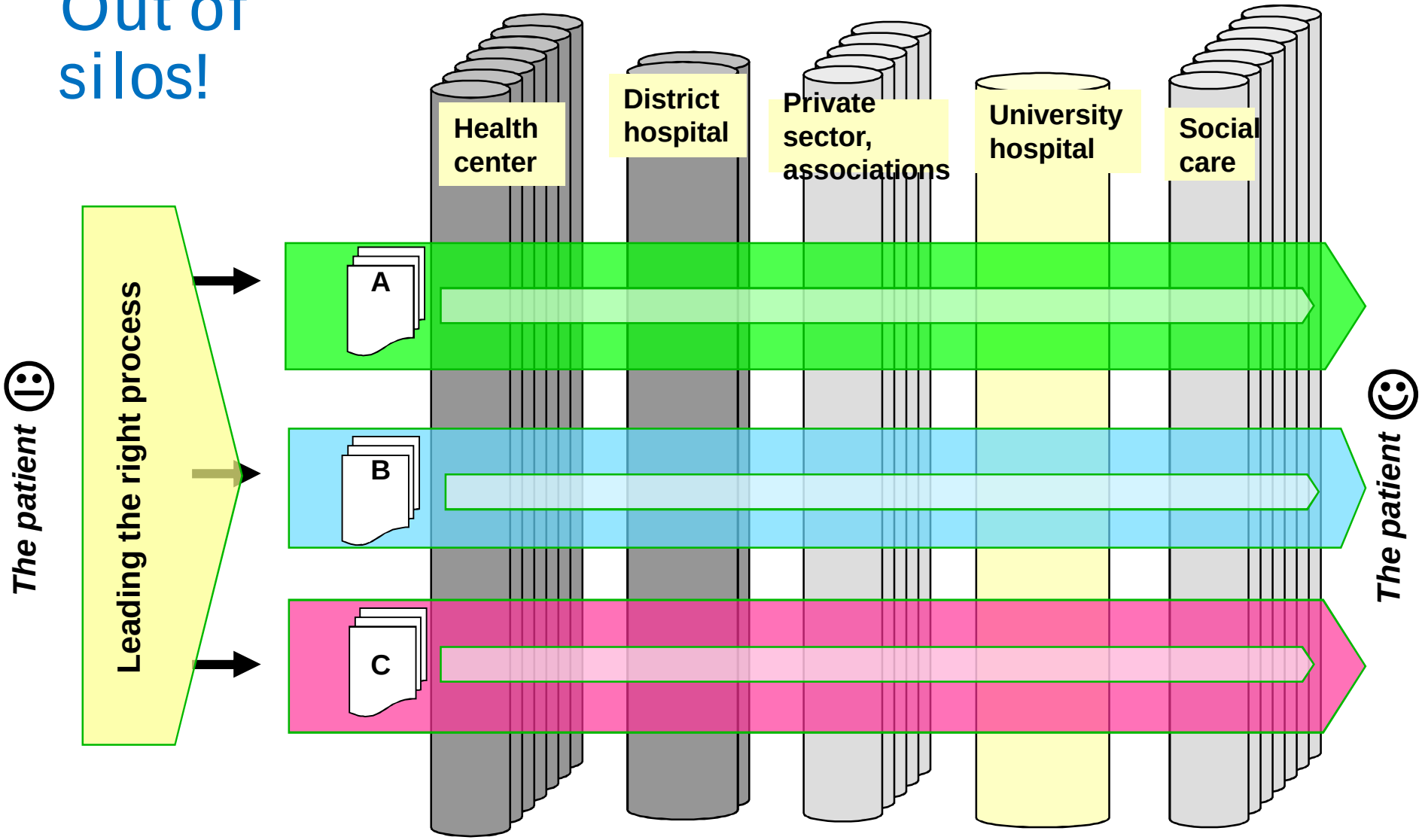
Out of silos!



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

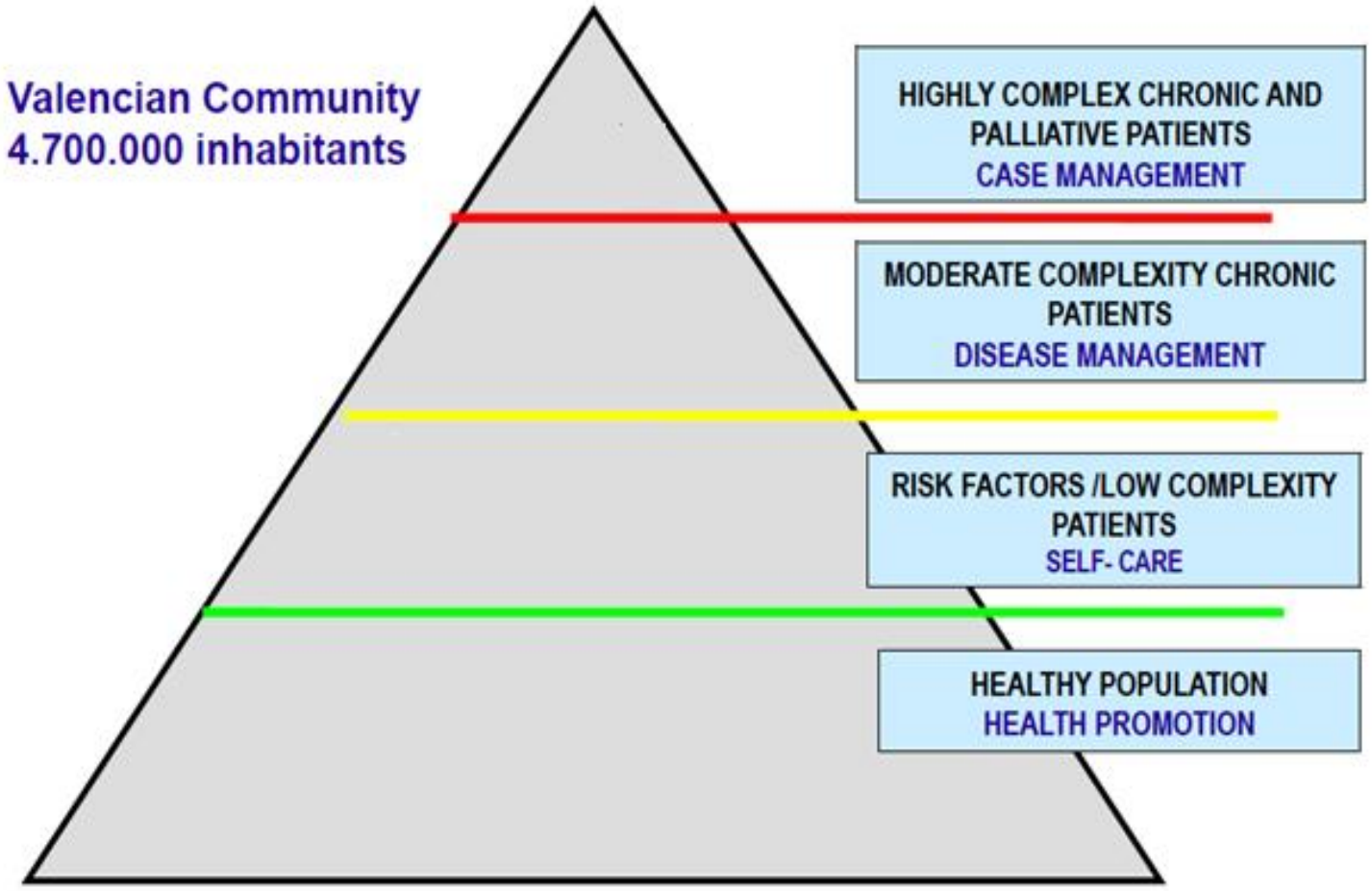
Patient segmentation

Care path for people with multimorbidity

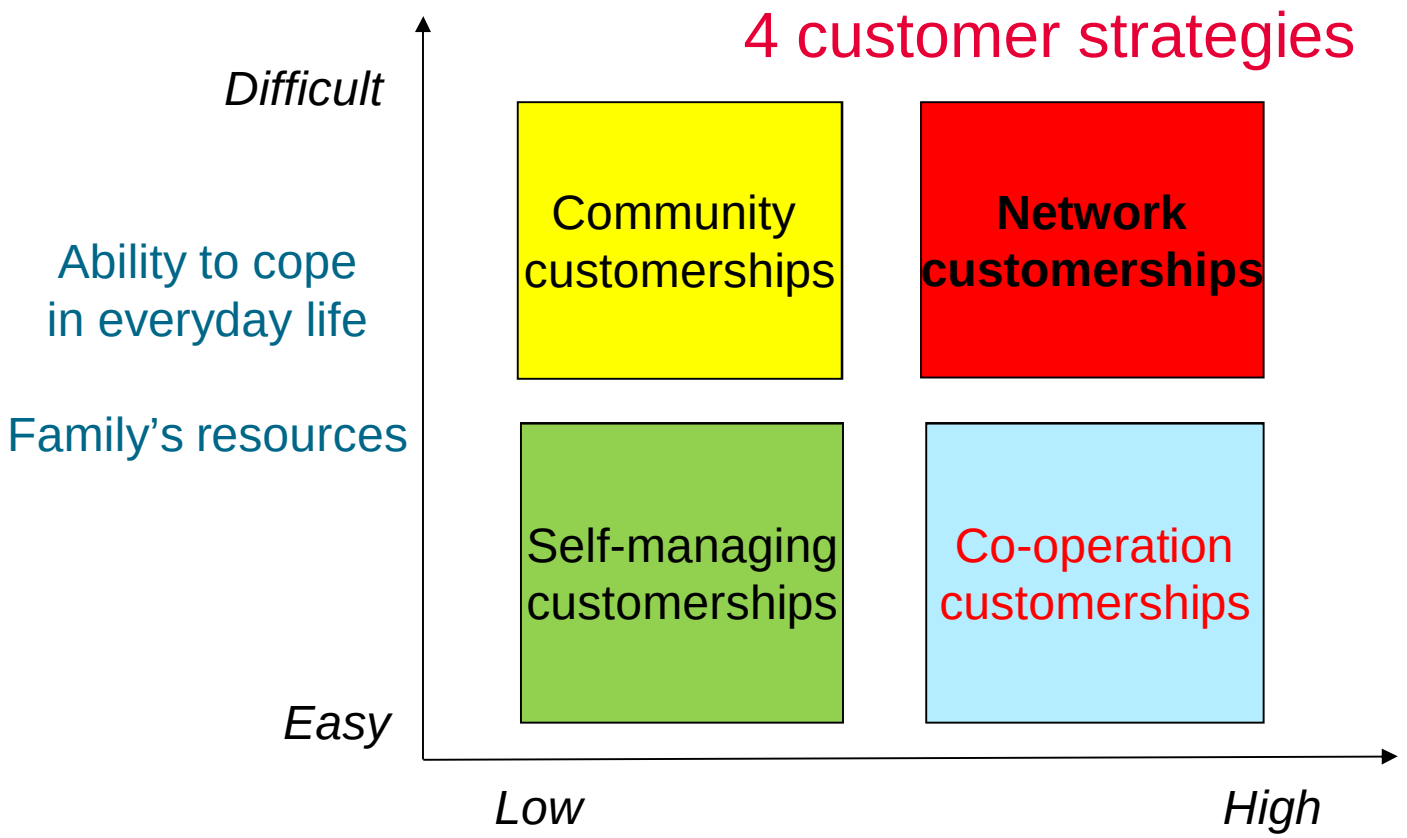
Multiprofessional teams

Case managers

Segmentation of patients (Valencia)



Segmentation of patients with MM (Finland)



Koivuniemi & Simonen 2011,
Holmberg-Marttila 2014

Care path for people with multimorbidity (Finland)

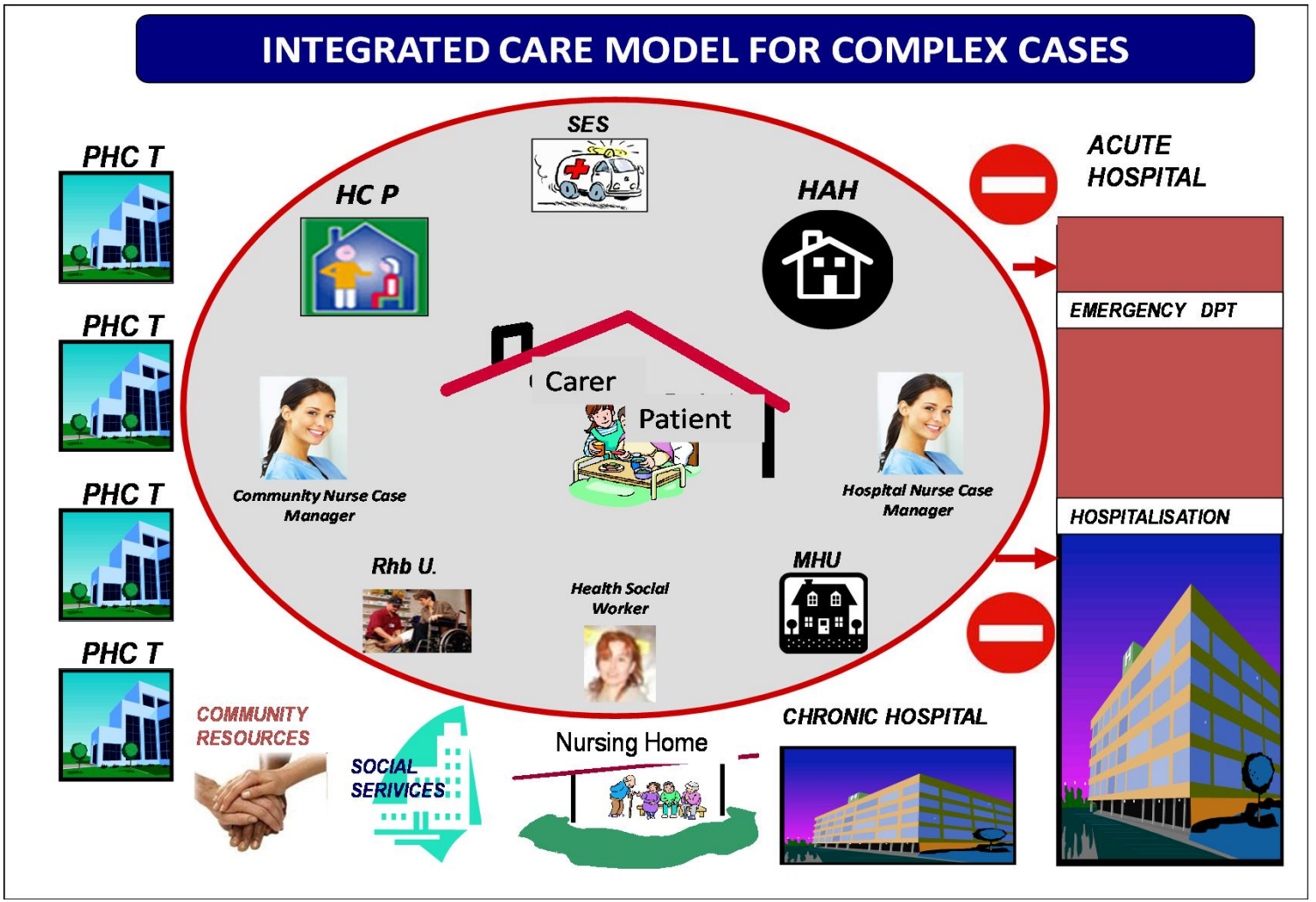
Support	Aims of treatment	Focus of the treatment plan	Mode of making appointments	Tools	Responsibility for coordination of care
Self-managing clientship The patient has good resources/capacity?, and the implementation of treatment is clear	To support patient's self-treatment (self-care) and her/his own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

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

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