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# ICARE4EU: IMPROVING CARE FOR PEOPLE WITH MULTIPLE CHRONIC CONDITIONS IN EUROPE

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**Summary:** Currently, an estimated 50 million people in the European Union live with multiple chronic diseases, which deeply impacts on their quality of life. Innovation in chronic illness care is urgently called for. First, most current care delivery models are disease-specific and therefore are not adapted to the needs of the growing number of people with multi-morbidity. Second, chronic illness care places a high burden on financial and human resources. The ICARE4EU project, a major new European initiative co-funded by the Health Programme of the European Union, wants to improve care for people living with multiple chronic conditions by identifying, analysing and disseminating innovative patient-centred multidisciplinary care programmes to address multi-morbidity.

**Keywords:** Multiple Chronic Conditions, Multi-morbidity, Integrated Care Strategies, Innovation, ICARE4EU

## Introduction

As in previous years, the 2013 Gastein Forum has put non-communicable diseases (NCDs), or chronic diseases\*, high on its agenda and for good reason. Chronic

diseases are the leading cause of mortality and morbidity in Europe.<sup>1</sup> Therefore, it is not surprising that several European countries are now developing disease management programmes to improve care for patients living with chronic diseases. Yet, such programmes have not adequately addressed the problem of multi-morbidity<sup>2</sup>

\* Some definitions may not equate NCDs with chronic diseases.

even though in the European population alone, an estimated 50 million people live with multiple chronic diseases.<sup>1,2,3</sup> In this article we will discuss the challenges facing health systems and provide some examples of promising innovative care models for patients with multiple chronic conditions. Lastly, we will introduce an important new initiative co-funded by the European Union's Health Programme 2008–2013, called ICARE4EU, which will help improve, analyse and disseminate innovative patient-centred multidisciplinary care programmes for chronic comorbidity.

### Innovative solutions required

The challenges facing health systems are many. Not only will the number of chronically ill people increase, their needs for care will also increase and become more complex because of ageing and multi-morbidity. Until now, multi-morbidity and its sub-concepts – like comorbidity – are ambiguously defined. Yet its significance in care and service systems has been acknowledged widely. European health and social systems will need to manage the very complex and substantial burden arising from continuous multidisciplinary care. Yet, also from a patient perspective, improvements in the organisation and quality of care, for instance, as well as their own involvement in the care process are important. Therefore, innovations for chronic illness care are urgently needed for two key reasons.

First, most current care delivery models are disease-specific or structured around acute episodes; therefore, they are not adapted to the needs of the growing number of people with multiple health problems. For people with multi-morbidity, single-disease programmes incorporate the threat of too narrow a focus on their health and social problems (the focus is on the disease that the programme has been designed for), lack evidence regarding treatment and subsequently lack decision support (clinical practice guidelines may contradict each other and do not sufficiently address aspects of multi-morbidity). There may also be a greater chance of inadequate coordination of care and the possible interference of self-care

(even if advised by a doctor) for a single disease with the care of multiple co-existing diseases.<sup>4,5</sup>

“single disease programmes are too narrowly focused”

Second, chronic illness care puts a high burden on financial and human resources. Increasing health care expenditures and shortages, as well as disparities in the supply of health professionals raise concerns about health system sustainability in many countries. About 70–80% of health care costs are spent on chronic diseases, which corresponds to €700 billion in the European Union.<sup>6</sup> Innovation is necessary to provide good quality care with limited resources. Patient-centred multidisciplinary care, integrating health and social care, using new technologies to support self-management, improving collaboration with family caregivers, and fluid care processes all have the potential to meet the complex needs of people with multiple chronic conditions, while making more efficient use of resources. Such integrated care models respond to the nature of multi-morbidity, as they prioritise and integrate treatment and support across the whole range of care and services. New models and integrated care programmes for people with multiple chronic conditions are now being developed, implemented and evaluated. **Box 1** contains two examples.

However, De Bruin and colleagues<sup>7</sup> recently published a systematic literature review of so-called comprehensive care programmes for people with multiple chronic conditions. Their search identified few European programmes: of the 28 programmes described, only four were implemented in European countries (Italy, Netherlands, Norway and the UK). The lack of European programmes identified may be due to the restriction of searching for only English language

papers. In addition, recent initiatives may not have been described in scientific literature yet.

It is more likely, however, that many such programmes remain unidentified since a current and comprehensive overview of European integrated care programmes addressing multi-morbidity is not available. The provision of such an overview, including an analysis of their characteristics is essential and would allow swift adoption of good practices. Moreover, regular updates need to be ensured as they create an important step to enhance the quality and sustainability of multi-morbidity care for chronic multi-morbidities in Europe.

“70–80% of health care costs are spent on chronic diseases”

### ICARE4EU: A major new European initiative

Against this background, the management of multi-morbidity is increasingly considered to be an important issue by policy-makers and researchers. The ICARE4EU project wants to improve care for people living with multiple chronic conditions in various ways and on several levels.

First, data from 30 European countries will be compiled to provide an insight into the ‘state of the art’ of integrated care for people with multi-morbidity and the strengths and weaknesses of care programmes, their inputs, processes and outcomes. Information about the availability and variation in the dissemination of integrated care programmes in (parts of) European countries will help policy-makers and stakeholders to plan, decide and advocate integrated care for people with multiple chronic conditions.

Second, the project will identify best practices from four perspectives: patient-centred; management practice and professional competencies; use of e-health technology for older people; and financing systems. In-depth analysis will provide information on their features, success in terms of outcomes, costs and sustainability, as well as management and implementation strategies. Best practices are particularly valuable for policy-makers, care managers and other stakeholders as exemplars for a wider implementation of effective and successful management of multi-morbidity in Europe.

Third, the project will develop a template that can be used (at the least in a simplified version) for future systematic monitoring of developments in multi-morbidity chronic illness care. To ensure sustainability, the aim is to create a link with the Health Systems and Policies Monitor of the European Observatory on Health Systems and Policies ([www.hspm.org/mainpage.aspx](http://www.hspm.org/mainpage.aspx)). Furthermore, by collaborating and building an effective platform for experts from different European countries, ICARE4EU will facilitate the exchange of knowledge and experiences throughout Europe. This will allow better understanding, improved design, wider applicability and more effective implementation of care programmes addressing multi-morbidity around Europe.

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### Box 1: Examples of innovative integrated care programmes for patients with chronic multi-morbidity in Spain and The Netherlands

#### Andalusia, Spain

In the Spanish region of Andalusia, a programme called Polypatology was set up, specifically designed for people with multi-morbidity. The programme started with the development of criteria for 'polypathology' in order to define the target group. According to these criteria, patients are defined as having multi-morbidity when they have chronic diseases that belong to two or more (of eight) disease categories. In addition, the patient with multi-morbidity is defined by a special clinical susceptibility and frailty which entails a frequent demand for care at different levels that is difficult to plan and coordinate. This is a result of exacerbations and the appearance of subsequent conditions that set the patient along a path of progressive physical and emotional decline, with a gradual loss of autonomy and functional capacity. Subsequently, the Andalusian Ministry of Health has designed an organisational process to manage the care of such patients in collaboration with internal medicine specialists, family physicians and nurses. The aim of the programme is to improve continuity of care and thus focuses on professional roles, workflows and best clinical practices, supported by an integrated information system.<sup>10</sup>

#### West-Friesland, The Netherlands

In the West-Friesland region of The Netherlands a programme called CasCo has been developed for type II diabetes patients with comorbid conditions, to improve the delivery of integrated care. The Guided Care (GC) Model was used to design a case management care programme customised to the Dutch primary care setting. Case management is a model to counteract fragmented care for comorbid patients. Practice nurses receive training in case management and act as case managers. The programme aims to coordinate all care involved for patients enrolled in different single-disease management programmes who have to adhere to various treatment protocols. It draws on evidence-based optimal care to systematically manage all existing conditions in a patient, and is tailored to the individual patient's preferences. The programme is currently being evaluated by comparing its added value to a single diabetes management programme in a randomised controlled trial.<sup>11</sup> Similar approaches based on GC principles were piloted with multi-morbidity patients (not necessarily with type II diabetes) in 2011 and 2012 in local primary care practices in other regions of The Netherlands.<sup>12</sup>