



**IAGG-ER Symposium: Innovating
care for people with multiple
chronic conditions in Europe**

Caring for people with multiple chronic conditions in the Netherlands: policy and practices

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Multimorbidity care in the Netherlands

An insight, focusing on the care delivery for older people.

The challenge of multimorbidity in the Netherlands

- Dutch population ±16,7 million
- In 2050 expected 25% of population 65+
- 37% of 55+ suffers from multimorbidity¹
- Health care cost increased 3.7% to 92,7 billion mostly due to LTC
- Growing financial burden working age population

Costs untenable: reforms are necessary!

Chronic illness care

- National strategy on chronic disease management launched in 2008²
- Chronic illness care mainly is provided in primary care
- Experiments for improvement of care delivery: integrating primary and secondary care, but also social and community services
- Adopted health care standards for DM2, CVD, COPD
- Introduction of bundled payment

Approach mostly disease oriented, not suitable for patients suffering from multimorbidity!

Reforming LTC, happening right now!

→ Emphasis on activation and empowerment³.

Four policy assumptions:

- older people want to live independently for as long as possible
- they are willing and able to pay for care and support
- informal care can substitute professional care
- technology will help older people to stay more independent

People need to be activated more in taking responsibility for their own health. However, differences between elderly are greater than policy suggests!

NIVEL shows that ¼ does not match with this profile.

Innovative approaches are key

More people to care for, at the same time, restraints in expenditures!

1. Prevention
2. Using available resources as efficiently as possible

Disease oriented approaches are not sufficient, especially concerning multimorbidity, patient centered integrated care approaches are key.

Developments occur all over Europe: in stead of inventing the wheel over and over, lets learn from each other!

This is the focus of ICARE4EU!

An example from the Netherlands

The Utrecht Proactive Frailty Intervention Trial⁴

Aim:

1. Improve identification and monitoring of general practice patients aged 60+ at high risk of (developing) frailty. (U-PRIM)
2. Improve care for these patients in order to prevent/reduce negative patient outcomes, health care consumption and high cost. (U-CARE)

(Cost-)effectiveness studied in cluster RCT (U-PROFIT)

U-PRIM

U-PRIM: software application to identify potentially frail older patients

Potentially frail is described as:

- **Multi-morbidity:** score above threshold on a Frailty Index of 50 potential health deficits, derived from ICD-coded symptoms and diagnoses, and/or
- **Polypharmacy:** chronic use of five or more different medicines listed according to ATC-coding), and/or
- **'Consultation gap':** not having consulted the general practice in the past three years = potential care avoiders

Routine care data registered in patients' EMRs is used.

U-CARE

U-CARE: multi-component care program delivered by trained practice nurses

Components:

1. Individual assessment (GFI, bio-psychosocial needs)
2. Comprehensive Geriatric Assessment conducted by nurse
3. Evidence-based tailored care plan developed by nurse and patient
4. Care coordination, involvement of other disciplines & community services.
5. Follow-up visits by nurse

U-PROFIT

U-PROFIT: cluster RCT to test (cost-)effectiveness of U-PRIM & U-CARE

Participants:

Patients aged 60+ from 39 general practices (124 GPs) in urban region of Utrecht. Based on U-PRIM, 7638 (17.3%) potentially frail identified of which 3091 (40,5%) gave informed consent to participate.

Three arms:

1. Only U-PRIM (N=790)
2. U-PRIM +U-CARE (N=1446)
3. care as usual (N=856)

Results

Physical functioning

- Better preservation of physical functioning in both intervention groups compared to control group at 12 months
- U-CARE in addition to U-PRIM did not have more effect

Health care consumption

- No effects on the number of hospital admissions and the number of ED visits at 12 months
- The U-PRIM/U-CARE group consulted the general practice more frequently by telephone than the other two groups

Mortality

- No effects at 12 months

Considerations

1. U-CARE did not have more effect than U-PRIM only: after identification the care provided to U-PRIM group likely changed
2. U-PRIM provides an opportunity to deliver care more proactively, but it requires good registration / complete EMRs
3. U-CARE may not meet the needs of the most vulnerable patients: individualized care planning starting from patients' needs and preferences requires patients to be able to communicate well with their health care providers

A nice example of multi-component programme addressing all CCM components



Thank you!

Stay tuned...

www.icare4eu.org

www.nivel.com

