



European
Commission

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Which priorities for a European policy on multimorbidity?

WHAT ARE THE PRIORITIES WHEN TACKLING MULTIMORBIDITY?

50 million European citizens suffer from multimorbidity. Health professionals, interested parties and patients groups met in Brussels to define policy priorities to ease the plight of multimorbid patients.

More than 100 delegates attended the "Which priorities for a European policy on multimorbidity?" conference, which took place in Brussels on October 27th.

Following an opening speech from Xavier Prats Monné, Director-General DG SANTE, setting out the European

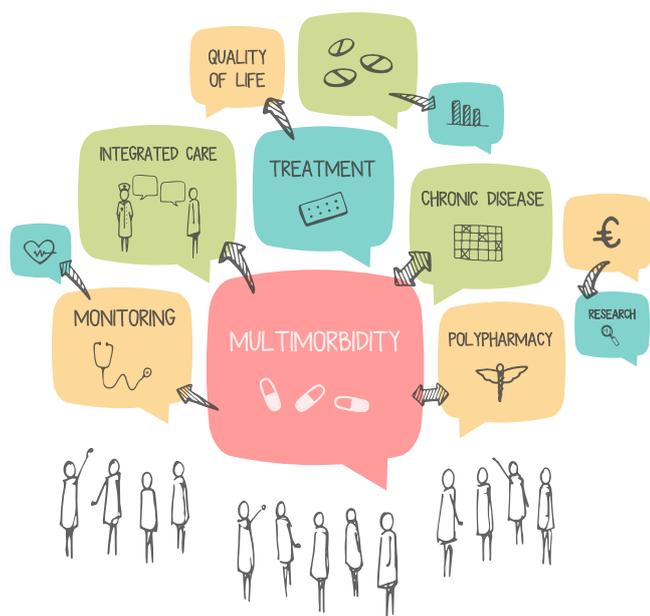
Commission's expectations for the event, participants heard from four story tellers – experts in various aspects of multimorbidity – who shared their experiences on encountering, tackling, assessing and managing projects on numerous multimorbidity issues.

Delegates, who had been encouraged to engage in active listening, then split into discussion groups in order to capture the key learnings from the four stories. The knowledge from the stories was enhanced by attendees' own experiences in the field of multimorbidity, in feedback sessions reflecting on the current evidence base, successes, challenges and gaps.

Further to the reflexion on the current knowledge base, participants engaged in interactive discussions in a World Café setting to define the vital elements they felt were necessary to construct a common framework on multimorbidity from the research, healthcare organisation, cost-effectiveness and financing and patient engagement perspective. Each group documented their proposals, which were shared when all attendees came back together.

In a final Open Space setting, guided group exercises gave attendees the opportunity to recommend their priorities. What topics, actions and activities would they advise to be prioritised in addressing the challenges of multimorbidity?

The conference ended with closing remarks from Martin Seychell, Deputy Director-General of DG SANTE, who said he was inspired by the depth of the conversation and the evident determination to reach common goals to tackle multimorbidity. He confirmed the willingness of the European Commission to follow up the reflexion on how to better address multimorbidity in order to improve patients' quality of life and health care system sustainability.



[Booklet with patients' testimonials and speakers' biographies](#)



MULTIMORBIDITY IS A CHALLENGE EUROPE IS DETERMINED TO MEET

Opening Speech by Xavier Prats Monné - Director General DG SANTE

Opening the 'Which priorities for a European policy on multimorbidity?' conference in Brussels on 27 October, Xavier Prats Monné, Director General DG SANTE, stated that multimorbidity 'is a very long road hiding very long suffering' in which patients face a journey through specialists who insist on dealing with conditions separately, rather than dealing with them holistically.

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There are not just a few sufferers of multimorbidity,' Monné noted. '50 million Europeans are affected by this. It is not enough to raise awareness of multimorbidity; what we want to do is look at new ways to tackle it.' He declared that the conference should be 'a participatory event which draws on the experience and knowledge of attendees.'”



There is a need to address how Member States exchange best practices and facilitate inter-disciplinary approaches to those affected by multimorbidity, Monné indicated. There is clearly much to achieve if we are to increase the care and improve the well-being of 50 million citizens; more effective and resilient health care treatments have to come into being. We have to ensure we have more sustainable health care systems which work in close partnership with our welfare regimes.

"This was the first time," he said, he had seen "such a diverse gathering, so interested and knowledgeable on multimorbidity".

In conclusion, Monné stated: "It is important that we do not squander this opportunity. We have to make the most of all the experience and knowledge we have here in this room. It is important that we have a productive conference, as multimorbidity presents Europe with a key challenge which we are determined to meet."

"There needs to be a change in the way the medical profession works," claimed Monné. "Putting patients at the heart of the medical process is essential, and it has been shown to work." What is needed, he said, are more sophisticated inter-disciplinary tools which work from the perspective of the patients, rather than the current silos of expertise.





TELLING A STORY – WHAT DO WE REALLY KNOW ABOUT ADDRESSING MULTIMORBIDITY?

If you are deeply immersed in tackling multimorbidity, you will have a story to tell. Four authorities in the field share their experiences of facing challenges at the multimorbidity coal-face.

Following the opening speech, moderators set the scene for participants to share existing knowledge on multimorbidity. This was facilitated by four experts delivering short stories on how their institutions or projects had encountered and addressed a variety of problems relating to multimorbidity, and how systems, processes and interventions in local projects had tackled chronic illnesses and multimorbidity.

The story-tellers provided a catalyst to encourage conference attendees to share their own experiences of multimorbidity, either in terms of challenges or solutions.

FOUR STORY TELLERS: SHARING EXISTING KNOWLEDGE

1. The first story-teller, **José María Valderas of Exeter University and Hospital** presented the experience of his hospital in dealing with multimorbidity in primary care.



The lack of a standardised approach to address multimorbidity in routine general practice led Exeter Hospital to devise a system by which patients with multiple conditions (any combination of the following conditions was considered: asthma, COPD, heart failure, diabetes, osteoarthritis and depression) would be administered instruments to measure quality of life in relation to these conditions in view of an annual review.

His research team not only recorded quality of life features in patient reported files (“patient reported outcomes”) but also used individualised measures or patient-generated indexes which take into consideration patients’ priorities, their overall health conditions, their goals and their expectations regarding outcomes. These two pieces of information were then fed back to both patients and clinicians.

The research has piloted projects in a number of GP practices in Devon, giving a better understanding of how clinicians and patients interact. Over ninety per cent of the patients and clinicians involved in the research say they want this closer engagement and information exchange to take place on a regular basis.

In terms of obstacles, the incompatibility of information systems and databases challenges this model; also, traditionally, information systems have been developed to be understood and used by clinicians, not for patients. The way medical data is currently collected can also be a hindrance, claimed the researcher.

2. Story number two, told by **Mieke Rijken of the Netherlands institute for health services research (NIVEL)**, focused on the Finnish Potku project, which has developed a model-based patient-centred chronic illness care as part of the ICARE4EU project, partly funded by the Third Health Programme.

The Potku project aims to improve the treatment of those suffering from chronic illnesses in the region of Mid-Finland. According to Rijken, ‘the Potku project puts the patient in the driver’s seat’ when it comes to improving patient-centred care. Pushing the metaphor a little further, she said:

“**The patient not only drives the car, they decide in which direction it travels.**”

While the project focused on improving the treatment of those struggling with chronic illnesses, Rijken is convinced that the project is relevant to and has many important lessons for tackling multimorbidity.



The focus on individualised care planning places patients at the centre of developing their health care plan – patients are encouraged to document their functional problems, not just their medical problems. The self-assessment examines how their chronic conditions are impacting on their lived lives. The project creates innovative ‘citizenship profiles’ incorporating patients’ self-definition of their conditions and an element of self-management as part of their care plan.

The Potku project also strengthens team work by involving GPs and nurses since the very beginning of the process and setting nurses as “care managers” for patients. It is also very important to make sure that the patient is a core member of the team. Finally, the role of the network citizenship has proved to be effective in supporting a holistic approach and continuity of care in patients’ daily life.

Those involved in the project are convinced it has improved patient-centred care in the Mid-Finland region, making a real difference to how health care plans are now developed. Patients who contributed to their health care plans report that they experienced better and more effective care for the range of their chronic illnesses. There was an increase in the number of phone calls to nurses and a decrease of GPs visits.

A key observation of the project is that improving patient-centeredness does not mean that more time should be spent with the patient; what is important is that the patient knows they have regular access to their care team, whether by phone or online. Developing a care plan in the ways the project recommends does take time but it also leads to fewer visits to medical facilities in the long-run.

The assumptions for a successful project are however the possibility to have compatible information systems on the one hand, and strong leaders within the health care system who provide a supportive environment on the other hand.

3. The third story was delivered by **Graziano Onder of CHRODIS**, the Joint Action on Chronic Diseases project running between 2014 and 2017 as part of the sixth Work Programme. It has 63 partners, including numerous ministries of health and health authorities from 25 Member States.

This story focused on the project’s aim to improve the management of the chronic diseases which go to make up multimorbidity. One of their key tasks is to develop a common guidance and methodology for core pathways for multimorbid patients. Onder stated that one of the primary tasks of the project was to identify appropriate targets for possible interventions in the management of multimorbid patients. In order to achieve this, there is a need to identify patients who are at the highest risk of multimorbidity, so that they can become the main targets for intervention.



The project is reviewing existing literature covering multimorbidity disease patterns, both as individual diseases and as combinations of diseases. So far 36 articles have been reviewed which explore the high degree of risk factors and risk stratification associated with multimorbidity.

However, Onder noted that ‘a good deal of the data collected is heterogeneous and so not comparable’, which makes developing pan-European conclusions difficult.

Studies also show that those suffering from multimorbidity tend to have a lower socio-economic status, either being in a low income bracket or struggling with poor social support systems. So multimorbidity outreach needs to be more comprehensive if it is to target care where there is the greatest need.

Onder admitted that so far most of the literature presented a mixture of mostly multi-dimensional data containing different data components which are difficult to compare.

The project will seek to develop a common model for multimorbidity management that can be applied and repeated in different settings. It continues to explore multimorbidity interventions in terms of delivery system designs, mechanisms supporting decision making, clinical information systems, patients’ self-management and maximising the usage of community resources.



EMPOWER PATIENTS
THROUGH INFORMATION SHARING, EQUAL
ACCESS & INCREASING MEDICAL LITERACY



4. The fourth and final story in this session was told by **Regina Roller-Wirnsberger of the EU Geriatric Medicine Society**. She illustrated the real clinical case of an eighty-seven year-old lady living in assisted housing, who turned up at a hospital's emergency ward alone.

Her primary health emergency was that she was suffering from a high fever, but it emerged that she was also suffering from hypertension, incontinence, arthritis, severe dizziness, and also had problems walking. As she was alone; there was no input from her family on her conditions or on what health care she was receiving.

She was diagnosed with pneumonia, prescribed antibiotics and fluid replacements. 12 hours later, as she was being considered for discharge, she nevertheless became agitated, very upset and was either unable or unwilling to communicate with the medical staff.

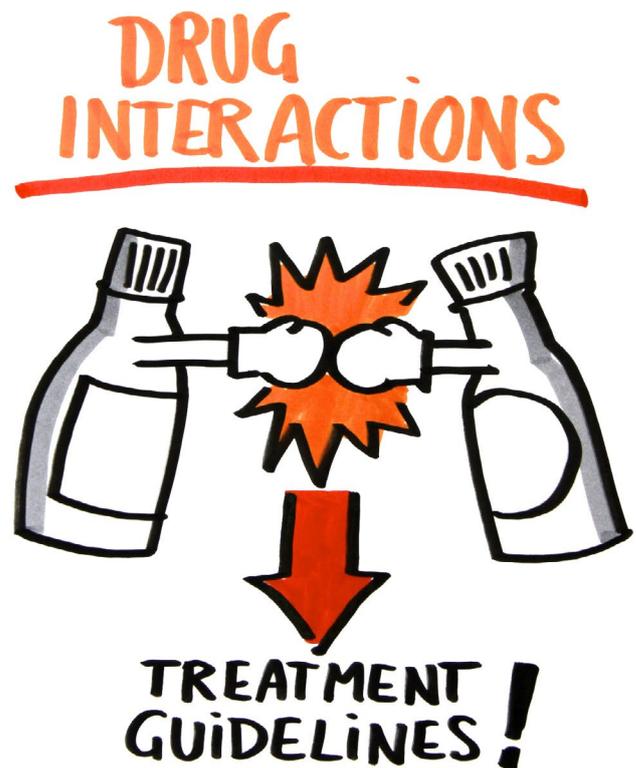
A young doctor then prescribed her benzodiazepine to calm her down. Further examination showed that her kidneys were deteriorating and her blood pressure was rising. At this point she was prescribed insulin.

Only after this point, a geriatrician intervened and pulled together all the medical professionals who had treated the patient. A multimorbidity approach was applied to her case and the health care focused on what was causing her deterioration and what would be the best way to progress. It transpired that in all her time in hospital no one had asked her what was most impeding her functionality, how she was feeling and what she wanted to happen.

Roller-Wirnsberger noted that this case showed that health care professionals need more guidance on recognising and dealing with cognitive impairments and geriatric symptoms. Health care professions need to take on board the patient's wishes and work towards a single goal.

This story also raised the question of how health care providers can create an integrated care package which helps the patient become or remain resilient. It shows that in order to develop

integrated multimorbidity health care packages for geriatric patients, a strong documentation system is necessary to enable health care professionals to know their patients better and understand all the issues and conditions which need addressing to bring about a better outcome in the overall health of their patients.





WHAT HAVE YOU LEARNT FROM THE STORIES?

Conference attendees, clearly inspired and moved by the stories, set about gathering the knowledge gained from their active listening, to which they added their own experience.



PROBLEMS FACED BY THE CURRENT SYSTEMS:

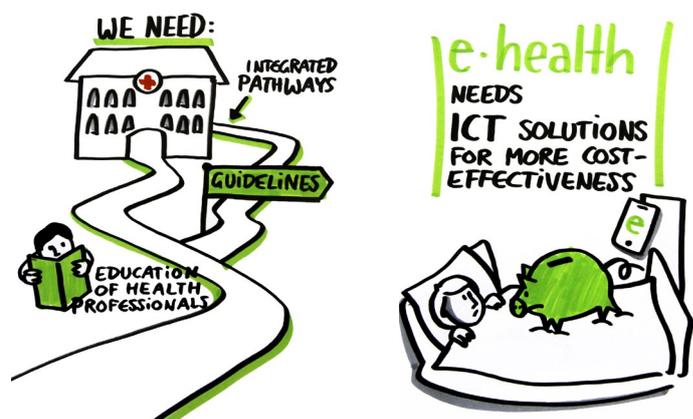
- > Current system hard to navigate, fragmented, focused on diseases and not on the patient
- > Need for a change of paradigm from a medical problem-solving to a patient-centred approach
- > Not enough evidence on how to understand and deal with multimorbidity patterns
- > Services not integrated within the health system
- > Lack of coordination between health and social care
- > Lack of communication and transmission of patient health information among health care professionals (HCP)

POSITIVE IMPACTS OF MULTIMORBIDITY INTERVENTIONS ON PATIENT HEALTH OUTCOMES

- > Reduction of mortality rates
- > Reduction of drug interactions and adverse drug events
- > Increased continuity of care
- > Increased patient-centeredness, it is with patients and not about patients
- > Outcomes should be on all perspectives in life not only on health perspectives
- > Disease management in the treatment of multimorbidity
- > Time dedicated to listen to patients can be time consuming at the beginning but turns out to be time saving in the end

POSITIVE IMPACT OF MULTIMORBIDITY INTERVENTIONS ON HEALTHCARE SYSTEMS

- > Reduction of visits and hospitalisations
- > Increased effectiveness in the use of health care resources (e.g. increased responsibilities for other healthcare profiles as nurses and pharmacists)
- > Importance of geriatric assessment
- > Standardised outcomes are needed to address multimorbidity, while having the possibility to tailor them on specific cases
- > The relationship between performance and cost effectiveness needs to be further addressed
- > Better ICT solutions and transfer of data is a fundamental condition to further improve outcomes





OBSTACLES, CHALLENGES AND GAPS TO BE ADDRESSED TO FULLY DEPLOY INTERVENTIONS

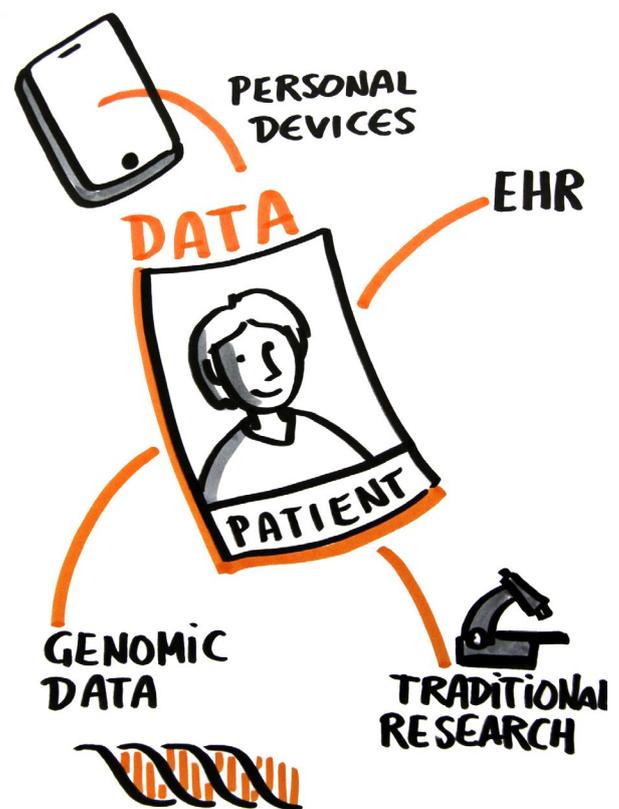
- > Health systems do not connect and so should be reorganised in order to better integrated services
- > Complexity of working in multidisciplinary teams across HCP, communication and collaboration between different healthcare professions is not optimal



- > Education of health care professionals should include a patient-centred approach
- > Limited time availability of health care professionals
- > More research on how diseases interact is needed
- > Guidelines built on evidence are needed to help health care professionals, but can also be an obstacle if they differ too much in different Member States
- > Absence of interoperability between ICT systems
- > Lack of standardisation of care models
- > Lack of evidence-based good practices
- > Lack of patients' health literacy and understanding of their diseases can prevent the to take full advantage of their treatment
- > Cognitive impaired patients are not sufficiently taken into consideration when developing multimorbidity care plans
- > Lack of leadership and change management support by managers
- > Some health care professional profiles are not fully exploited to improve the integration of care (nurses, pharmacists)
- > Quantifying data of multimorbid patients is different from collating data of single morbidity, and this has to be recognised
- > There is a lack of standardisation in collecting data throughout Europe which prevents comparable studies and interventions
- > A platform needs to be created which allows health care professionals and medical facilities to share their experiences on dealing with data surrounding multimorbidity

SUCCESS ELEMENTS THAT SHOULD GUIDE THE WAY WE WORK ON MULTIMORBIDITY:

- > Adapting the care system to multimorbid patients instead of fitting the patient into the current system
- > Using the « Chronic Care Model » as a starting point
- > Using risk stratification tools
- > Introducing individualised care plans
- > Training health care professionals to form multidisciplinary teams
- > Setting up clear defined responsibilities
- > Promoting higher involvement of patients and families
- > Setting up a “reference person” increasing accessibility to health care services





MEANINGFUL DISCUSSIONS IN A WORLD CAFÉ SETTING TO BUILD A COMMON FRAMEWORK ON MULTIMORBIDITY

By taking part in an interactive World Café, delegates concentrated on building a common framework on multimorbidity.

Breaking up into groups through three rounds of separate conversations, attendees had the opportunity to engage in a series of lively and informed discussions. These fluid groups focused on priorities in different fields including how health care systems are organised, financing multimorbidity efforts more cost-effectively, encouraging patients' engagement and gaining better understanding through research.

HEALTH CARE ORGANISATION



It is hard to make the case for re-organising a system, when there is a lack of hard empirical data on what a possible re-organisation might achieve. Speaker after speaker agreed that unless there is hard evidence that change would be beneficial

it would be difficult to push through major re-organisations of Europe's health care systems. **Evidence-based care models also need to be adapted to national and regional specifications.**

Placing personalised patient-centred care at the heart of individualised health care plans was viewed as an important way or creating catalysts for change and encouraging re-organisation. The integrated care pathways are seen as the key element to successfully address multimorbidity, starting from the "Chronic Care Model".

Any re-organisation would involve building **better Information Communication and Technology (ICT) systems, enabling a better exchange of information** throughout any newly re-constituted organisation. Doubts were expressed regarding the availability of funds from health authorities to make significant investments in new ICT systems.

Improving the training of health care professionals will be important in any effort to re-organise a health care system. For example, if more nurses are going to take on the role of case study managers, they will need additional training in order to build their skill base.

Whether experts from different specialists' fields will be willing to engage in meaningful discussions in order to facilitate a re-organisation is of concern. Even though cross-specialisation discussions would make their health care system more responsive to multimorbidity.

If a health care system re-organisation is to be successfully re-organised then GPs, nurses, experts from a range of specialist fields, community workers, ICT specialists and health care managers will all have to have a significant change in mind-sets.

Policy makers still need to be convinced of the value of any re-organisation, not just in terms of whether it will improve medical practices but also whether it will benefit society as a whole.

Decision making and risk stratification tools, need to be developed in order to tailor interventions to patients' needs.

PATIENT ENGAGEMENT/MANAGEMENT



Patients need to be placed at the centre of a more effective response to multimorbidity. However, as the session unfolded, it became clear that very significant changes in terms of attitudes, culture, systems and relationships

would have to take place before meaningful patient centred health care systems could emerge.

A re-design of the medical model is wished, bringing about a **re-distribution of responsibilities between health professionals and patients**. The levels of trust between the medical profession and patients' needs to be increased, and it was said that a great deal of motivational energy, communication and training - on both sides - would be needed in order to change current attitudes and structures in terms of patient-doctor relationships.

It was noted that GPs' workload often does not give them enough time to consult all the different experts and specialists that would lead to a more satisfactory response to multimorbid patients, so GPs invariably make decisions on their own, based on the primary ailments which are presented.

Training doctors to be more sensitive to all aspects of multimorbidity, including **placing patient input at the centre of any treatment plan, is viewed as a key aspect in improving patient management** and encouraging patient engagement.

Placing patient data at the heart of decision-making when it comes to accessing conditions and creating individual health care programmes is another way to encourage patient empowerment. More user-friendly ICT systems will encourage patients' to provide data and access existing data.

The role of pharmacists should also be re-visited, as they play a valuable role in engaging with patients. If they can be trained to have greater awareness of multimorbidity and engage with their customers around the issue, an increase in patient engagement is likely to follow. Giving patients more information on the options they have to change their behaviours and lifestyles in order to minimise the likelihood or impact of chronic illness, is an important way to promote patient engagement.



COST EFFECTIVENESS AND FINANCING



Greater efforts need to be made at EU level, through the European Commission and at Member State level, to encourage the commissioning of more research on the cost-effectiveness of interventions addressing multimorbidity.

Some preliminary evidence already indicates that the proactive care of multimorbid patients - with greater professional interaction between the different medical specialists - is more cost-effective. Money is probably wasted by each professional repeating tests or aspects of health care, which could be avoided if a co-ordinated approach to multimorbidity were enacted.

However, **more empirical financial evidence is needed on how much money would be saved by the effective treatment of multimorbid patients:** the financing systems and medicines might be more sensitive to multimorbid issues. There is a lack of on the ground experience among health professionals in assessing the cost effectiveness of treatments around multimorbidity.

It can be indeed difficult to measure cost-effectiveness in terms of improving the overall quality of human life. Models need to be developed to show that addressing multimorbidity more efficiently carries social benefits to the society at large, including cost savings.

Evidence needs to be gathered on which specific economic and financial models are the best ways to support integrated health care that effectively addresses multimorbidity. Do there need to be health payment systems based on outcomes? Will they be linked to personal health budgets? Can financial incentives be developed to empower patients? What might these look like? The possibility of the private sector playing a greater financial role in tackling multimorbidity also needs to be considered.



BETTER UNDERSTANDING AND RESEARCH



In order to set up efficient interventions to address multimorbidity, additional knowledge and understanding of several aspects of it need to be further enquired.

First of all, although the current WHO definition ("co-occurrence of two or more chronic conditions in one person" - WHO) is broad and general enough to define the concept, a narrower operational definition would help guide policy and research including elements such as severity and complexity (risk stratification of patients), taking into account the impact of acute conditions on chronic diseases, further defining patterns of disease or considering including mental conditions and the burden of symptoms.

In addition to this, **further research is needed at an epidemiological level to better understand the risk factors, determinants and patterns of multimorbidity; on drug-drug interaction and polypharmacy in multimorbid patients or on risk stratification tools** that target sub populations. Additionally, more evidence is needed on clinical practices and interventions which have shown to be cost-effective or have had good patient related outcomes. Finally, it was suggested that clinical trials should also seek to include patients with multimorbidity.





WHERE TO START WORKING ON MULTIMORBIDITY? THE OPEN SPACE DISCUSSION

Following the previous discussion which focused on the priorities expected to be set for different areas of work, attendees were then proposed to go more in depth into some of them in order to document a set of proposals for action in future collaborative programmes.

The conference continued with a final interactive session, where a few participants freely proposed to discuss ten topics which they believed should be considered as priorities by all decision makers seeking to improve the EU's response to multimorbidity. The rest of the participants could choose to which discussion(s) to participate and contribute.

The groups came up with a series of proposals for action that could both guide the debate on future responses to multimorbidity and encourage future collaborations. It is envisaged that there will be future collaboration not just among attendees of the conference, but also in the wider world of multimorbidity,

as attendees go back to their places of work and share the proposed initiatives hammered out throughout the day.

Each group was guided in its efforts by a template encouraging them to address each topic in terms of themes, such as the rationale for working on the topic, which stakeholders they expected to engage in their activities, what would be the short, medium and long-term proposals for action and what will their work hope to achieve. A final feedback session wrapped up the contributions of participants, ending a series of fruitful, intense and rewarding discussions.

PROFESSIONALS TEAM UP



Here is the list of the topics discussed during the Open Space session:

- > Building trust between stakeholders
- > How to help multimorbid patients to formulate their goals/preferences
- > Sharing big data / how to design a EU study on multimorbidity
- > Clinical practice guidelines
- > Care models in multimorbidity
- > Evidence based knowledge resources for clinicians and the public on key diseases clusters
- > Involvement of patients' organisations at all levels of decision making and research
- > How to promote a multistakeholder approach and a mind-set change
- > Build upon existing evidence based and experiences of last two years in research
- > Financing and remuneration



WORKING TOGETHER TOWARDS A COMMON GOAL

Closing Remarks by Martin Seychell, Deputy Director General DG SANTE

Closing the 'Which priorities for a European policy on multimorbidity?' conference, Martin Seychell, Deputy Director General DG SANTE, noted that it had been a very productive day, full of inspiring discussions:

responsibilities among healthcare professionals, promoting the support of nurses, pharmacists, and social care for the patient.

The Deputy Director General said that the European Commission is convinced of the importance of working on multimorbidity. It plans to follow-up on the work conducted at the conference and take into account all the relevant inputs. 'The discussions held today will be put into our policy thinking,' Seychell confirmed.

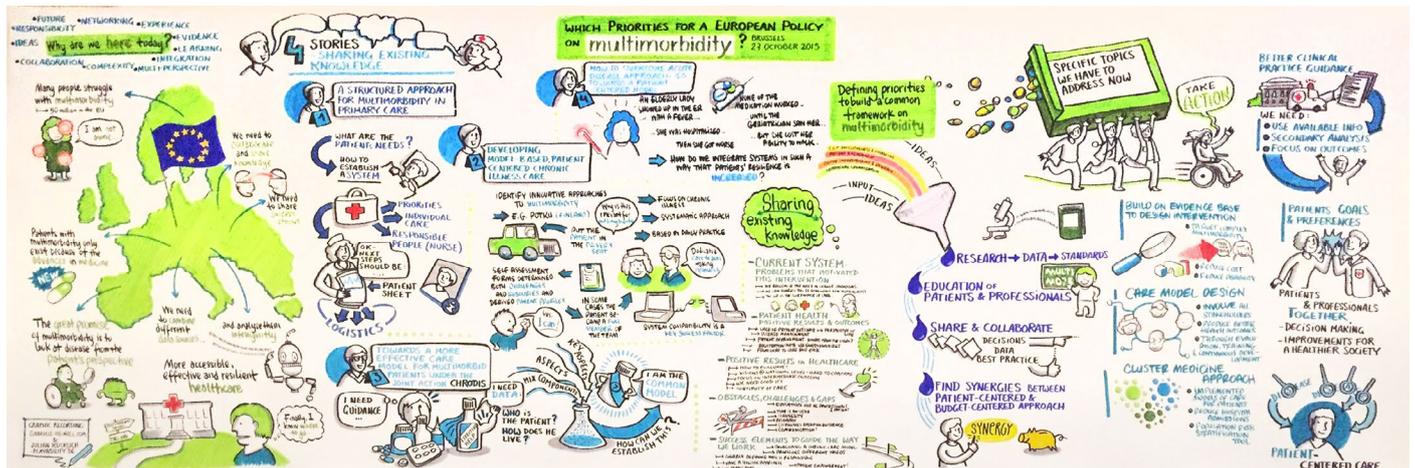
“ I have seen the great interest you have in working on multimorbidity. I have also seen your willingness to work together towards a common goal: to establish a common framework on multimorbidity. ”

[Conclusions of the conference: inputs and highlights put forward by the participants](#)

There is growing evidence, which this conference affirmed, according to the Deputy Director General, that interventions lead to better health outcomes when 'the patient is treated in an integrated approach and is part of the decision-making of his or her treatment.' Such an approach also leads to patients showing a higher level of adherence to medical plans, higher satisfaction levels and a reduced number of adverse drug events, leading to fewer consultations and hospitalisations.



Seychell reflected that there is a need to 'measure the effectiveness of the interventions we implement and place the patient at the centre of the system'. An integrated approach to multimorbidity also has a positive impact on health system performance and cost-effectiveness, thanks to a more effective use of healthcare resources – for instance by reorganising



Graphic Recording by Gabriele Heinzel & Julian Kücklich