CONFERECE ABSTRACT

Better care for people with multimorbidity: needs identified in three European health systems. Initial results of the CAREMATRIX project

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Introduction: As life-expectancy increases and populations age rapidly, Multimorbidity – defined as the co-occurrence of two or more chronic conditions, is becoming a huge challenge for healthcare providers across the EU. It has been estimated that up to 65% of people aged over 65 years may be affected by multimorbidity. It can affect younger people too. And people from deprived areas are at higher risk of complex conditions, with less access to care, which results in poorer health outcomes.

In order to provide solutions to that challenge, the European Commission has funded a project called Carematrix (https://carematrix.eu ) by a consortium of 3 public procurers and 4 supporting organisations, among which: Innovation Skane, Norway health tech, Bioef and IFIC. CareMatrix is a European H2020 Pre-Commercial Procurement (PCP) project for integrated care solutions designed to challenge the health market to develop innovative technology for People with Multimorbidity (PMM).

Objective: The first phase of the project comprised the identification of needs from the main stakeholders involved in the care for people with multimorbidity (mainly from primary health care and hospital care, but also from patients’ organisations and social care).

Methods: The members of the consortium organised three parallel workshops (one in each procurers’ Member State) and 8 in-depth interviews. The workshops included a total number of 59 persons and among those: health professionals (doctors and nurses from primary and hospital care) healthcare managers, IT experts, patients’ representatives and social worker. The workshops were organised following a predefined and agreed structure and were jointly analysed.. In addition, an overview of previous PCP projects and a comprehensive international literature review were also performed.

Results: The identified needs/areas for improvement were classified in five interrelated Building Blocks: 1) Early and comprehensive assessment with a preventive approach; 2) Interdisciplinary
collaboration/Interdisciplinary team; 3) Individualised and patient centered care; 4) Continuity of care: communication, coordination and proactive follow-up; and, 5) Patient and caregiver participation and empowerment. For communication purposes, these Building Blocks were ordered along a theoretical care pathway, starting with an “Assessment and Identification” phase, following with the “Care Planning”, and continuing with the actual provision of “Integrated care”. All along this process, ensuring “Patient and caregiver participation and empowerment” was identified as a key Building Block. Among identified needs, some could be addressed through Information Technology solutions, while others would require changes in the organisation of care and thus, could be seen as proposals for improvement.

**Conclusions:** The results from the needs’ identification phase were consistent with the findings in the literature and the recommendations in clinical practice guidelines and models for improved care for PMM. In the real world the different phases and Building Blocks overlap with each other and are closely interconnected. The proposed Phases should therefore be seen as a continuous process. The improvement of care for PMM would require progress in all the five identified Building Blocks.