JA-CHRODIS: Structure

- **25 Countries**
- **39 Associated Partners**
- **32 Collaborating Partners**
- **7 Work packages**
- **30 Tasks**

Led by: Health Institute Carlos III and Spanish Ministry of Health, Social Services and Equity

**Budget:** 9.2m € (Co-funded EC and Partners)
Objective of JA-CHRODIS

To promote and facilitate a process of exchange and transfer of good practices between European countries and regions

To pave the way for better health policies and interventions to improve the well-being of citizens.
JA-CHRODIS: structure

Horizontal work

WP1 Coordination
WP2 Dissemination
WP3 Evaluation

Core work

WP4 Platform for knowledge exchange
WP5 Good practices in the field of health promotion and chronic disease prevention across the life cycle
WP6 Development of common guidance and methodologies for care pathways for multimorbid patients
WP7 Diabetes: a case study on strengthening health care for people with chronic diseases

Governing Board (Ministries of Health) | Advisory Board
WP 6. Multimorbididity

LEADER
Italian Medicine Agency (AIFA), Italy

CO-LEADER
Vilnius University Hospital Santariskiu Klinikos (VULSK), Lithuania

ASSOCIATED PARTNERS
- Basque Foundation for Health Innovation and Research, Spain
- European Institute of Women's Health (EIWH), Ireland
- European Patients Forum (EPF), Belgium
- Instituto Aragonés de Ciencias de la Salud (IACS), Spain
- Instituto de Salud Carlos III (ISCIII), Spain
- Ministry of Health and Care Services (HOD), Norway
- National Center of Public Health and Analyses (NCPHA), Bulgaria
- National Institute of Health and Welfare (THL), Finland
- National Institute of Public Health and Research (NIJZ), Slovenia
- Technische Universität Dresden (TUD), Germany
- 1st PHA of Attica / "Sotiria" Hospital (YPE), Greece
- CHRODIS
To design and develop innovative, cost-efficient and patient centred approaches for multimorbid patients with chronic conditions

DEVELOPMENT OF COMMON GUIDENCE & PATWAYS FOR MULTI-MORBID PATIENTS
WP 6. TASKS

• T1. To identify targets of potential interventions for management of multimorbid patients
• T2. To review existing care (pathway) approaches for multimorbid patients
• T3. To assess and select good practices on management of multimorbid patients
• T4. To define multimorbidity case management training programmes
Title: To identify targets of potential interventions for management of multimorbid patients

Leader: IT

Aim: to identify population(s) at high and very high care demand (utilization of resources, of negative health outcomes, complexity of their chronic conditions), by a analysis of existing national databases and literature review
WP 6. Task 1 – Strategy

• Analysis of existing databases
• Literature review
Special Issue on Multimorbidity in the Elderly

*European Journal of Internal Medicine, 26 (2015) 157-216,*

*Time to face the challenge of multimorbidity. A European perspective from the joint action on chronic diseases and promoting healthy ageing across the life cycle (JA-CHRODIS)*

Patients with multimorbidity at high risk (target for intervention):

- **Disease patterns**
  - Individual diseases
  - Combination of diseases
- **Low socioeconomical status**
  - low income
  - poor social support
- **Poor physical function**
- **Mental health problems**
  - depression
  - cognitive impairment

NEED OF COMPREHENSIVE AND MULTIDISCIPLINARY ASSESSMENT AND INTERVENTION
Title: To review existing care pathway approaches for multimorbid patients.

Leader: NL

Aim: To provide an overview of care pathway approaches for multimorbid patients in Europe, description of their characteristics and analysis of their efficacy to improve patient outcomes, healthcare use, cost-effectiveness, applicability and replication in other regions/settings.
WP 6. Task 2 - Strategy

- Review of international literature
- Extra data collection and analysis within ICARE4EU project
- Analysis of data available from other relevant European projects
Review (BMJ 2012 Sep 3;345:e5205) → Evidence on the care of patients with multimorbidity is limited… Interventions had mixed effects...

Update → Programs varied … Different components of the intervention were identified (comprehensive programs)

LACK OF EVIDENCE

MIXED INTERVENTIONS

LACK OF STANDARDIZATION
WP 6. Task 2 – Results II

Source: Noordman et al., 2015
Title: To assess and select good practices on management of multimorbid patients.

Leader: LT

Aim: to assess and select good practices on the management of multimorbid patients, to create a care model for multimorbid patient care.
WP 6. Task 3 – Strategy

- Preliminary identification of components
- Expert opinion
- Release of identified components
WP 6. TASK 3 – Results I

16 COMPONENTS WERE SELECTED

For each component:

- Description and aims
- Key characteristics
- Relevance to multimorbid patients
Delivery system design
- Comprehensive assessment
- Multidisciplinary team
- Individualized care plans
- Case manager

Self management
- Tailored self-management
- Option to improve self-management
- Shared decision making

Decision support
- Implementation of EBM
- Team training
- Consultation system

Social & community resources
- Access to community resources
- Involvement of social network

Clinical information system
- Electronic patients records
- Exchange patients infos
- Uniform coding
- Patient operated technology
The care model here outlined needs to be assessed and validated in a real life setting to determine specifically how and to what extent multimorbid patients will benefit from it;

Specific research questions of interest may focus on how this care model can be applied across different settings in various European countries;

Costs and benefits to the patients and families, and practical application of the care model within care and medical setting should all be considered.
“It is more important to know what type of person has the disease, than to know what type of disease the person has.”

Hippocrates
(born c. 460 b.c.- died c. 375 b.c.)
The Joint Action on Chronic Diseases and Promoting Healthy Ageing across the Life Cycle (JA-CHRODIS)*

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