MANAGE-CARE *project*

The EU-funded MANAGE-CARE project aims to create a shift from disease management to chronic care management. It combines applicable approaches through change in care delivery and through partnering for change, addressing in particular older patients with multiple chronic conditions and using innovative business modelling.

Starting with diabetes as a chronic care example, MANAGE-CARE developed an innovative chronic care model applicable also to other chronic diseases. This model adequately includes the needs, especially of elderly populations but also including the young populations, which are increasingly affected by chronic disease, as well as challenges given by the changes in the health care systems and financing structures in the European countries.

Unlike most of the current treatment models and treatment guidelines, this model is a care-focused, instead of a disease-focused model. The model covers both health- and well-being-related aspects in the treatment and care of the ageing patient and is based on Wagner's chronic care model. The main aim of this model is to ensure an integrated, team- and patient-centred approach to the complex treatment and care of elderly with T2DM and associated comorbidities as an example for the development of chronic care models for other chronic conditions.

the MANAGE-CARE *model*

The MANAGE-CARE Model consists of seven dimensions. It summarises diversified outcomes to provide individual measurements to evaluate the productive and targeted interaction. The model is based on the following three requirements:

- The MANAGE CARE Model includes **health promotion and all kinds of prevention**, without being limited to citizens who have risk factors, but also people who have a chronic disease and who will benefit by adapting to a more preventive lifestyle.
- The model includes an **individualised planning, treatment and evaluation process**. The MANAGE CARE Model is based on the requirement that care should be initiated by individualised assessment of personal needs of the patient. Planning, monitoring and evaluating treatment regimens have to be dynamically adapted to the individual health competence, readiness to change lifestyle and individual preferences of the individual.
- **Successful treatment and improved outcome** is not only evaluated based on singular medical parameters, it also includes individual lifestyle, awareness, as well as psychological and social components and everyday competences.

A technical handbook representing this innovative MANAGE CARE Model has been developed. A detailed scientific publication is currently being prepared by the MANAGE CARE Consortium.

MANAGE CARE summarises its findings in *11 recommendations* on how to improve chronic care management. These recommendations (overleaf) are a roadmap to improve existing disease management models.

This leaflet arises from the project Manage Care which has received funding from the European Union, in the framework of the Health Programme

chronic care standard *recommendations*

MANAGE CARE

1	**Education**	Continuing literacy and need-adjusted education is essential for both patients and health care providers. Promote and apply diabetes self-management care through patient education, empowerment and shared-decision making. Patient motivation support for lifestyle behavioural change and their compliance to therapy should be an integral component of care.
2	**Individual needs**	Chronic care must address individual patient needs and preferences as much as medical treatment objectives. Patient needs, risks and comorbidities have to be assessed, addressed and regularly monitored.
3	**Prevention & Health Promotion**	Prevention activities are integral to chronic care management. Activities must be measurable, sustainable and needs oriented. Contribute actively to prevention focusing on target groups. Prevention products must primarily address individual needs. Contribute actively to awareness campaigns and health promotion focusing on target groups. Provide tools which primarily address individual needs for preventive education and empowerment. Provide the most effective policy action to cater for screening and early detection.
4	**Social support & Community Engagement**	A supportive social environment must accompany chronic patients at all levels, settings and phases of care. One peer or counterpart is the minimum to provide this support. Create and support community care approaches to improve care access of vulnerable target groups (minorities, disabled, etc.).
5	**Accessibility**	Evidence-based chronic care must be available and affordable to patients. Provide easy and timely access to care. Ensure continuity between different levels of health system and involve municipalities in prevention and treatment activities. Access must include 24/7 minimum services for crisis and exacerbation, especially for patients with diabetes and other co-morbidities who could be in a complex condition with health and potential social care needs.
6	**Cooperation/ coordination**	Cooperative systems are conducive to better chronic care management, including care navigation, care planning and risk stratification. Promote multidisciplinary cooperation and exchange between health care providers, formal and informal care givers around primary care by data exchange and quarterly meetings. Different kinds of instrumental operative items should be implemented to facilitate and guarantee a coordinated and integrated care environment at local level.
7	**Sharing information**	Personal data is owned by the patients. Anonymised patient data are a public health asset for policy-making. All stakeholders relevant to patient care must have timely access to patient data. Integrate individualised shared decision-making, promote cooperation and exchange between health care providers, formal and informal care givers by data exchange and quarterly meetings. This data could be used to facilitate good calculation of indicators (diabetes-related or management-related indicators such as hospital rates utilisation, etc). This aggregate information derived from different data sets (Primary care, hospital, long term care facilities, mental health and social care) related to the same patient could facilitate not only calculation of indicators but also stratification algorithms to classify the patient according to the level of complexity.
8	**eHealth**	Use eHealth technology with a clear medical objective to address individual patient need. Facilitating virtual collaborative work and care between primary care and secondary care can be supportive.
9	**Fairness**	Chronic Care Management must practice fair collaboration, concepts, processes and strategies between all health model related stakeholders with focus on individual patient needs.
10	**Business**	A chronic care business model must be sustainable and address patient needs. Monitoring of treatment targets and cost-effectiveness should be part of the business considerations.
11	**Evaluation**	Implement measures for evaluation of the efficacy, effectiveness, quality and feasibility of the model. Predefined *Shared Outcome Frameworks* to regularly evaluate outcome measures without being limited to medical outcomes will anchor evaluation in individualised chronic care.

www.managecare-project.eu

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