OPTIMA FORMA – Towards a patient-centred multimorbidity approach for chronic disease management in primary care

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Background and purpose: To reduce the burden of chronic diseases on society and individuals, European countries implemented chronic Disease Management Programmes (DMPs) that focus on management of a single chronic disease. However, (i) the scientific evidence that DMPs reduce the burden of chronic diseases in terms of health-related quality of life or costs is not convincing, (ii) patients with multimorbidity may receive overlapping or conflicting treatment advice, and (iii) a single disease approach may be conflicting with the core competencies of primary care, i.e. medical generalistic, person-centred, and continuous care. In the project OPTIMA FORMA we aim to develop and evaluate an holistic, person-centred and integrated approach to manage patients with chronic diseases and multimorbidity in Dutch primary care.

Methods: OPTIMA FORMA comprises 3 phases, following the MRC Framework for development and evaluation of complex interventions. In PHASE1 we developed the intervention, including competency-based training modules, supportive ICT and a payment model. In PHASE2, we pilot the intervention in general practices. In PHASE3, we further implement the adjusted intervention and evaluate its effects using quadruple aim outcomes. We have recently finished PHASE1 in which we conducted a mixed-method study to develop the patient-centred approach. The stepwise development ran from March 2019 to July 2020 and was conducted in three large primary care cooperatives in the Netherlands. First, we performed a scoping review to identify key elements and construct a theoretical model for delivering patient-centred integrated care. Second, 6 national experts on DM, CVD, and COPD and 52 local healthcare professionals, e.g. general practitioners, practice nurses, physiotherapists, and welfare workers, commented on the model using online surveys. Third, 9 patients with chronic conditions commented on the approach in telephone interviews. Last, the preliminary model was presented to the involved primary care cooperatives and finalized after processing their comments.

Results: The scoping review identified several key elements: using a case manager; assessing integral health status, including disease burden, treatment burden and medication use; establishing patient preferences and priorities for care; and using a care plan. In the online surveys, most healthcare professionals agreed with the vision and structure of the care approach. Suggestions for improvement were given for the method of patient assessment and choosing interventions. Overall, the interviewed patients were positive towards the approach, specifically the integral health status, use of individual care plans, and cooperation with their healthcare providers.
Conclusion: Using scientific literature and input of stakeholders, we developed a software-supported holistic, person-centred and integrated approach for the management of patients with chronic diseases and multimorbidity in primary care. The approach includes (i) assessing patients’ integral health status using a (web-based) questionnaire and physical measurements; (ii) discussing the results in a semi-structured way with a case manager, after which (iii) personalized treatment goals are formulated, suitable interventions in the primary care network are selected and an evaluation is planned. This approach is being tested in a pilot study until the end of 2021 and will be evaluated in a cluster randomized controlled trial from 2022 to 2024.