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PCDE
primary care diabetes europe

RETHINKING HEALTH SYSTEMS

Integrated care and empowerment of primary care for people with diabetes

Making the transition from existing models of care poses challenges for health systems, healthcare providers and patients alike. For diabetes care, the degree of difficulty in successfully managing this chronic disease varies from one patient to another. Facilitating integrated care pathways becomes an essential tool in delivering effective healthcare to diabetes patients. But how can healthcare systems consider different patient profiles and perspectives when designing care? What tools and technologies are needed to enhance the communication between providers on one side and between providers and patients on the other side? How can we align care coordination efforts among healthcare providers?

In order to explore these questions and build consensus on possible policy solutions, EFPIA, in collaboration with Primary Care Diabetes Europe (PCDE), convened a multi-stakeholder roundtable to share different stakeholder perspectives on the barriers and opportunities of integrated care empowerment of primary care for people with diabetes. These insights provided the backdrop to a roundtable discussion that engaged all participants to address three core questions:

1. What are the barriers and opportunities presented by an increased focus on integrated care and primary care management of diabetes?
2. How to align and improve care coordination efforts among providers, and enhance communication between providers and patients?
3. How is daily practice supported and empowered by health authorities to identify the right incentives to improve primary care?

1. WHAT ARE THE BARRIERS AND OPPORTUNITIES PRESENTED BY AN INCREASED FOCUS ON INTEGRATED CARE AND PRIMARY CARE MANAGEMENT OF DIABETES?

1.1 The role of leadership

Clinical and political leadership can contribute to improving outcomes for people with diabetes. An absence of leadership can often hinder the benefits of an integrated care approach to managing diabetes. Despite the presence of clinical guidelines, healthcare professionals along all points of the continuum of care often lack adequate clear leadership, communication channels and guidance to provide people with diabetes with comprehensive and tailored care.

Leadership amongst care providers can help direct attention to those patients that require the most support to manage their condition. Taking leadership of patients' outcomes helps care providers to coordinate their efforts in the most efficient and effective manner and motivate a competitive spirit that can drive clinical excellence. This approach is best supported by health data to assist in setting targets, monitoring progress, demonstrating value and efficiencies and ultimately capturing better outcomes for people with diabetes. An absence of health data can hinder the coordination of care between primary and secondary care.

A lack of political leadership can also mean a clear direction for how best to drive better outcomes in diabetes is absent. Once again health data offers an opportunity to inform public health policy and identify good practices and efficiencies that can support and inform health system change. Armed with this evidence, policy makers can make informed decisions to shape the provision of healthcare in their country. A lack of understanding of the importance of primary care and integrated care by policy makers risks governments changing their plans and political priorities, making it hard for the health system to respond and ultimately undermining the long-term outcomes for people with diabetes.

1.2 Supporting a shift in treatment and care

In order for integrated care to encompass a person centric approach to diabetes care and management there should be a shift from a model centred around medical interventions and clinical outcomes to a more a holistic approach. A new model of care should focus on the broader wellbeing of the patient and take into account the lifestyle implications of living with the disease as well as the emotional and psychological needs of people with diabetes. This approach should be supported by Patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs) in order to shape the type of integrated approach that each patient may need. Without losing sight of the importance human interaction, an integrated digital technology approach could help improve not only the communication between patients and their health care providers but also improve diabetes care. The need to educate people with diabetes and their care providers on developments and opportunities of digital technology could become a challenge if people with diabetes start to increase demand for these services.

2. HOW TO ALIGN AND IMPROVE CARE COORDINATION EFFORTS AMONG PROVIDERS, AND ENHANCE COMMUNICATION BETWEEN PROVIDERS AND PATIENTS?

2.1 The significance of health data

Health data-driven decisions based on clinical outcomes can help improve the quality of life of patients, reducing co-morbidities associated with diabetes and improving individual adherence to medication, as well as driving systems change.

2.2 Education and patient empowerment

Patient education is essential and should be conceived as a lifelong learning process. Patients should be educated to better understand their condition, especially using health outcomes data (PROMS and PREMS) to support and empower them to manage their condition in an informed and sustainable way. Patient education should not just take place at diagnosis, but should be a continuous journey that is supported both in primary and secondary care. Better understanding of their condition would also empower patients to take a more active role in taking decisions on the management of their condition alongside healthcare professionals. Empowering patients to be involved in decision making can assist care providers to target resources and care more effectively and efficiently, driving better outcomes.

2.3 Flexibility

The delivery of diabetes care is often organised around rigid protocols that fail to assist the ones who need it the most. Diabetes care should be organised in a more flexible way that enables clinicians to differentiate the standard of care and tailor it to the needs of individual patients, thus allowing health systems to concentrate time and resources on the most problematic cases. Evidence indicates that targeting an integrated care approach to those patients that would most benefit improves outcomes.

2.4 Increase the focus on integrated care

Diabetes has multiple causes and effects, and the roles played by the different specialists involved in diabetes care can often lead to a fragmentation that impacts on the overall quality of care received by a given patient. A model of integrated care would instead bring together the different components of health services responsible for the clinical care of people with diabetes, facilitating communications between specialists and favouring a holistic approach to treatment.

2.5 Ensure the right balance of health care resources

Diabetes care requires the support of qualified staff not only among clinicians but also among other professionals, such as nurses. It is essential that tailored training is provided to ensure that diabetes nurses are able to support patients in an integrated care system. Demographic changes, an increase in chronic disease prevalence, co-morbidities and financial pressure on health systems means health systems often lack the resource to support an integrated approach to diabetes management. Addressing this challenge will be an essential element of ensuring a person centric approach to integrated care is achievable.

Capacity to absorb changes in the health system needs to be built-in to allow for beneficial disruptive changes to occur. This should include allowing resources for healthcare professionals to learn, adapt and share good practices. This will require capacity in the system to allow for evidence-based changes to be trialled, evaluated and implemented. A bottom-up approach to defining and implementing care services can be beneficial, allowing care providers to tailor disease management and integrated care services to for the needs of their patents. Having indicators that allowing for evaluation are essential and should reflect local conditions.

2.6 Shared ownership

Better cross communication is essential to establish a model of shared leadership where all the actors involved in diabetes care can share their viewpoints and align on common objectives, in order to offer patients a coordinated and comprehensive model of care.

2.7 A role for Europe

The European Union can play a role in supporting Member States to shape the provision of their diabetes care. This could include the establishment of a Strategy for Non-Communicable Diseases, using diabetes as a specific case to demonstrate

the effectiveness of approaches such as integrated care. The European Union could also assist in building consensus on a minimum basic checklist of indicators of how diabetes care should be implemented. This could be complimented by the development of a hub for data on diabetes, possibly in the form of a European-wide registry.

The European Semester process the European Union should evaluate whether Member States have the resource and appropriate structures in place to ensure adequate provision of services to manage the growing burden of chronic diseases. The recommendations in the Semester process can help ensure that governments are held accountable for the measures proposed if, for example, financial aid (such as through structural funds) is conditional on countries' compliance with the recommendations received. This approach could help in targeting support to the countries' most at need with the aim of reducing health inequalities between countries in Europe.

3. HOW IS DAILY PRACTICE SUPPORTED AND EMPOWERED BY HEALTH AUTHORITIES TO IDENTIFY THE RIGHT INCENTIVES TO IMPROVE PRIMARY CARE?

3.1 Bottom-up approach

The traditional top-down approach to design and managing health systems should be rebalance towards a more dynamic bottom-up approach, able to adapt to disruptive changes in the system of care. Good practices put in place in a given hospital or local community can provide evidence of improved outcomes that can lead to uptake and support across the whole system. These should be evidence based and demonstrate short-term efficiency gains that can convince policy makers, payers and care providers of their benefit.

However, there can also be value in a top-down approach, where standards and indicators can help to identify where inequalities exist and where support can be targeted. A top-down approach can also assist in setting an ambition for some countries to shoot for.

3.2 Having the right incentives

Choosing the right incentives to drive the changes needed is key. Guidelines updates are not always implemented as thoroughly and swiftly as expected, but financial incentives can drive change more effectively. However, incentives that drive care providers towards approaches that do not allow them to target their resources towards high-risk patients ultimately risk jeopardising the provision of care to those who could benefit most from an integrated approach to diabetes management.

4. SHARING INSIGHTS AND EXPERIENCES

4.1 The Steno Centre, Copenhagen, Demark

The Steno Diabetes Centre has demonstrated significant improvements in patient outcomes from the effective use of an integrated, multi-disciplinary approach to diabetes care. Incidence of all lower-extremity amputations decreased by 87.5% among men and 47.4% among women with type 1 diabetes and by 83.3% among men and 79.1% among women with type 2 diabetes between 2000 and 2011. These results were achieved by careful and targeted monitoring and follow-up on patient data by a multi-disciplinary team of health care professionals. Daily coordination meetings involving a cross-spectrum of care providers allow for close monitoring of patient outcomes, but also ensured effective communication and an integrated approach to care provision.

4.2 Centre for Diabetes, Copenhagen, Denmark

The centre is a central element in the Copenhagen municipality's diabetes action plan. The centre is the first of its kind in Denmark and aims to bring together various components of diabetes management into one place to make it easier for people with type 2 diabetes to navigate the healthcare system. The centre is an attempt to replace prevention centres, gather municipal services in one place and raise the level of diabetes efforts in Copenhagen. An essential element is the focus on a continuous collaboration between patients, hospitals, GPs and civil society. This is based on strong communications, leadership and data driven decision making to target care effectively. To achieve this a collaboration amongst different

actors – the so-called healthcare triangle – namely clinicians (GPs), municipalities and hospitals, is essential to improve cross-sector communication and understanding of the needs and hurdles faced by the different stakeholders involved in the continuum of care.

4.3 Diabetes Project Aalst, Belgium

The Diabetes Project Aalst focuses on providing chronic disease management in a primary care setting. It focuses on establishing an integrated care team, including diabetes educators, that support patients with education to enhance self-management of their condition. This could include blood-glucose self-monitoring and insulin initiation. Coaching is also provided by secondary care specialists. Care is organised around a Regional Diabetes Coordination Cell which coordinates interdisciplinary working. The success of this approach meant 69% of general practitioners within the Aalst region signed-up to participate. The project has led to a significant improvement in patient outcomes within a short period. The rapid success of the project led to adoption and promotion of this approach by the national authorities across Belgium.

4.4 Association for people living with diabetes (APDP), Lisbon, Portugal

APDP Diabetes Portugal was founded in 1926 originally to supply insulin to poor people with diabetes from all over Portugal. It has evolved into a nationwide institution which provides healthcare and a wide range of other services to people with diabetes. Due to its multidisciplinary facilities, it is also recognised, since 2011, at European level, as a Centre of Reference for Paediatric Diabetes. APDP believes that education is a vital part of the provided care. With its staff of highly trained specialists, APDP is well prepared to handle this aspect of care, thus providing therapeutic education to people with diabetes. APDP also provides training courses for healthcare professionals, for people with diabetes, their families and caregivers in order to promote a better disease management and quality of life of people with diabetes. APDP develops a number of projects focused on the community, providing screenings and educational programs to encourage behavioural lifestyles' changes in those at risk of developing type 2 diabetes.

Annex 1: Programme

11.00-11.10	Welcome and introduction	Dr. Nick Fahy, Senior Researcher, University of Oxford Milena Richter, Co-chair, EFPIA Diabetes Platform Dr. Xavier Cos, Chairman, Primary Care Diabetes Europe
11.10-11.20	Understanding and defining the meaning of integrated care in diabetes management	Prof. John Nolan, Executive Director, European Diabetes Forum
11.20-11.35	Rethinking health systems: integrated care and empowerment of primary care	Dr. Xavier Cos, Chairman, Primary Care Diabetes Europe
11.35-12.05	Experience of integrated and primary care: sharing insights and experiences Sharing experiences from across the EU in order to stimulate discussion and debate during the roundtable and workshop	Prof. Guy Rutten, UMC Utrecht, the Netherlands Prof. Dr. Frank Nobels, Endocrinologist, Olvz, Aals; Guest Professor, Catholic University Leuven, Belgium Sari Koski, Development Manager, Finnish Diabetes Association, Helsinki, Finland
12.05-13.00	Roundtable discussion	
13.00 – 13.30	Lunch break	
13.30 -14.30	Workshop session – Diabetes Circles	All participants led by a moderator for each session
14.30 -14.50	Plenary – provide feedback and outcomes from workshops	Moderators from each of the workshops
14.50-15.00	Concluding remarks	Dr. Xavier Cos on behalf of PCDE Milena Richter, Co-chair, EFPIA Diabetes Platform

Annex 2: Participant list

Name	Job Title	Organisation
Arantxa Mugica	European Communications and Digital Public Affairs Manager	Lilly
Dr. Charlotte Glümer	Center Manager	Center for Diabetes
Cristina Maria Petrut	Board Member	IDF Europe
Dr. Desimira Mironova	Specialist Endocrinologist	European Academy of Dermatology and Venerology / Bulgarian Dermatological Society
Elvera Laanen	Government Affairs Manager External Affairs, Region Europe	Novo Nordisk
Enrica Obizzi	Consultant	FIPRA
Dr. João-Filipe Raposo	Scientific Director	Association for Protection of People with Diabetes in Portugal
Farida Lamkanfi	Medical Advisor	Lilly
Prof. John Nolan	Executive Director	European Diabetes Forum
Nadia van Der Plaetsen	Market Access Director	Novo Nordisk
Neil Causey	Account Director	FIPRA
Dr. Nick Fahy	Senior Researcher	University of Oxford
Prof. Dr. Paul De Raeve	Secretary General	European Federation of Nurses
Prof. Dr. Frank Nobels	Endocrinologist Guest Professor	OLV Ziekenhuis Aalst Catholic University Leuven
Prof. Guy Rutten	Professor of Diabetology	Julius Center for Health Sciences and Primary Care
Marian Meeusen	Medical Director Human Pharma	Boehringer Ingelheim
Milena Richter	Co-chair	EFPIA Diabetes Platform
Roberta Savli	Senior Manager Healthcare Systems	EFPIA
Sari Koski	Development Manager	Finnish Diabetes Association
Sorina Chivu	Senior Account Executive	FIPRA
Sophie Joubert	Associate Director, Market Access	MSD
Dr. Xavier Cos	Chairman	Primary Care Diabetes Europe
Kris Doggen	Head of Unit, Initiative for quality promotion and epidemiology in diabetes care	Scienscano

The **EFPIA Diabetes Platform** brings together six companies whose aim is improving the lives of everyone affected by diabetes. Together with various stakeholders across the research and health community, we look at how to improve diabetes management and to reduce complications.

Primary Care Diabetes Europe exists to provide a focal point for primary care clinicians and their patients. Its purpose is to promote high standards of care throughout Europe. Emphasis is placed on incorporating evidence based medicine into daily practice as well as promoting diabetes education and research in primary care.

We remain ambitious about the future for people living with diabetes. Through research, better management and collaboration, #WeWontRest until diabetes is defeated.