

Addressing the Needs of Multi-morbidity through Digitally Enhanced Integrated Care: The C3-Cloud H2020 project

Theodoros N. Arvanitis, RT, DPhil, CEng, FRSM, FGBHI Chair in Digital Health Innovation & Director of the Institute of Digital Healthcare









SETTING THE SCENE



People living with multimorbidity:



are at greater risk of negative outcomes such as increased mortality, lower quality of life, and greater use of healthcare services, including unplanned admission to care settings.



face challenges in navigating the health and care system and managing their health and are generally less satisfied with the care they receive.



experience too much emphasis on their conditions, and not enough emphasis on how these conditions affect them.



see little attention on the wider determinants of health and how these impact on their lives and outcomes.



2015-2035: Three Domains of Health Challenges

Demographic change Impoverishing medical High rates of avertable and shift in GBD expenses, infectious, child, and towards NCDs and unproductive cost maternal deaths injuries increases Unfinished Emerging Cost agenda agenda agenda

Source: The Commission on Investing in Health





MULTIMORBIDITY IN THE CONTEXT OF C3-CLOUD

- > Accumulation of multiple chronic conditions, including a growing number of functional and cognitive impairments
- > Currently, around 50 million European citizens suffer from two or more chronic conditions
 - More than 50% of all older people have at least 3 chronic conditions, and a significant proportion has 5 or more.
- > Multimorbidity is also relating to newly observed trends of older people in the EU, as being identified as more likely than average to be obese
- ➤ Multimorbidity can also refer to:
 - disability
 - acute conditions
 - or more severe conditions that are more sudden in onset than chronic diseases, eg a cancer diagnosis
 - have increased vulnerability or decreasing resilience to seemingly cope with minor health events, e.g. infection or medication changes
- > Multidimensional view, taking into account social and environmental as well as physical and psychological factors



CHALLENGES OF MULTIMORBIDITY



Clinicians' knowledge is insufficient for assessment of multimorbidity – particularly in terms of care and support planning.



The current model of health and 'traditional way of doing things' acts as a barrier to client and family participation and involvement in **shared decision-making.**



Much of the health and care system and workforce is designed to respond to a **single disease** rather than multiple ones



Movement towards selfmanagement and social prescribing for achievement of medium to long term outcomes is inhibited by single disease focus.



DIGITALLY ENHANCED INTEGRATED CARE

At present, it is suggested that there is no 'single model' that can be applied universally to achieve care services for people with complex needs.

➤ Integrated Care

- The management and delivery of health services so that citizens receive a continuum of preventive and curative services,
 - according to their needs over time
 - and across different levels of the health system
- Can potentially provide such a co-ordinated approach.
- ➤ Digitally-enabled approaches can provide more adaptive and radical solutions to the provision of integrated care.
- >C3-Cloud: a software-intensive sociotechnical system for integrated care



PROJECT INFORMATION



- ➤ A Federated Collaborative Care and Cure Cloud Architecture for Addressing the Needs of Multi-morbidity and Managing Poly-pharmacy
 - H2020 RIA project
 - Dates: May 2016 April 2020
 - Total budget: €4.9 million
 - Coordinator: University of Warwick, UK
 - 12 partners from 7 European countries
- Pilot sites:
 - Region Jamtland Harjeladen, Sweden
 - South Warwickshire NHS Foundation Trust, UK
 - Servicio Vasco de Salud Osakidetza, Spain



Inserm

de la santé et de la recherche médicale

research centre on chronicity





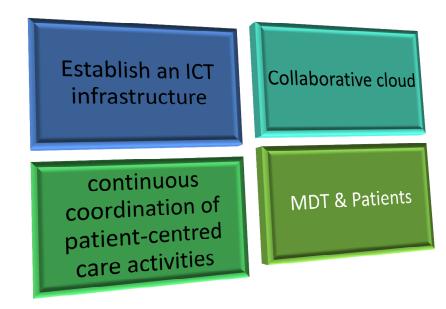


C3-CLOUD OBJECTIVES



- Collaborative creation and execution of personalised care plans for multi-morbid patients through systematic and semi-automatic reconciliation of clinical guidelines.
- **Decision Support** for risk prediction and stratification, recommendation reconciliation, poly-pharmacy management and goal setting.
- Fusion of multimodal patient and provider data.
- Integrated Terminology Server with advanced semantic functions will enable meaningful analysis of multimodal data and clinical rules.
- Active patient involvement and treatment adherence evaluation.

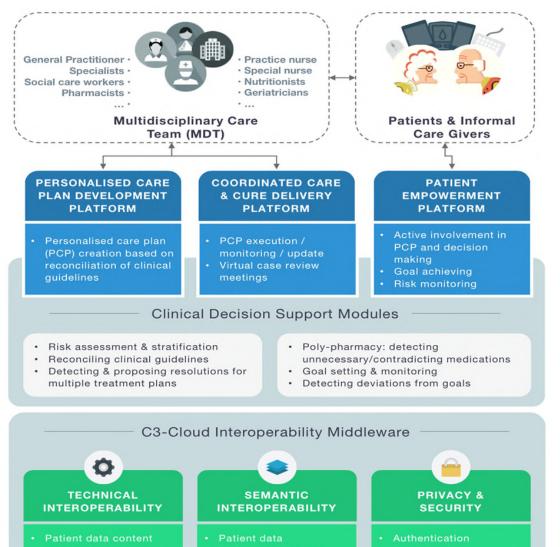
To demonstrate feasibility, pilot studies will focus on diabetes, heart failure, renal failure, depression in different **comorbidity combinations**. (3 European regions)



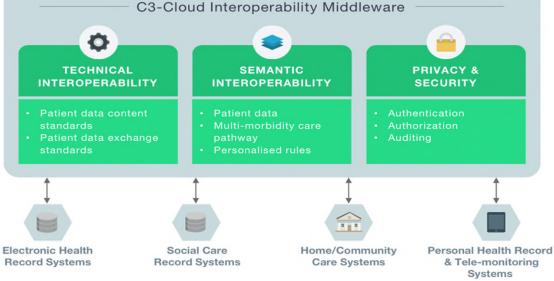








The C3 Cloud Architecture







PERSONALISED CARE **PLAN DEVELOPMENT** PLATFORM

Personalised care plan (PCP) creation based on reconciliation of clinical guidelines

COORDINATED CARE & CURE DELIVERY **PLATFORM**

- PCP execution / monitoring / update
- Virtual case review

PATIENT EMPOWERMENT PLATFORM

- Active involvement in PCP and decision making
- Goal achieving
- Risk monitoring

Clinical Decision Support Modules

- · Risk assessment & stratification
- · Reconciling clinical guidelines
- · Detecting & proposing resolutions for multiple treatment plans
- · Poly-pharmacy: detecting unnecessary/contradicting medications
- · Goal setting & monitoring
- Detecting deviations from goals



Record Systems

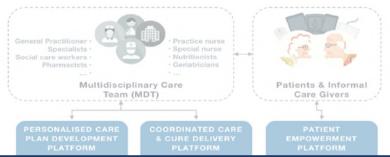


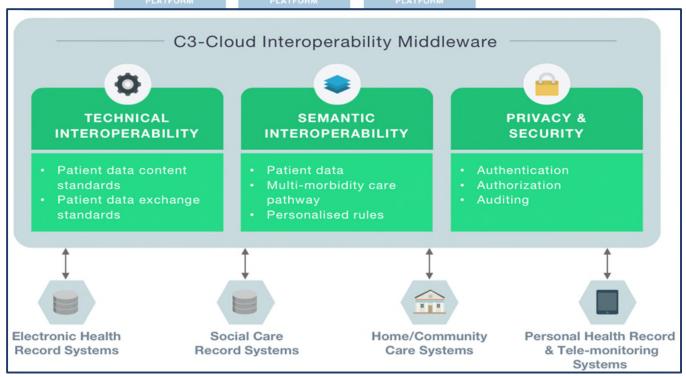




The C3 Cloud **Architecture**







The C3 Cloud Architecture



DIGITALLY-ENHANCED AND SOFTWARE INTENSIVE TOOLS IN C3-CLOUD





Specific Challenges

- Managing multimorbidity without **informed involvement** of all stakeholders, resulting in **specialty silos and fragmented care**
- Existing organisational models and care pathways are inadequate for integrated care delivery

C3-Cloud Objectives

- Enable MDT members to collaboratively manage integrated care plans, and support them to provide the best possible care
- **Seamlessly integrate** with the existing health and social care information systems

C3-Cloud Results

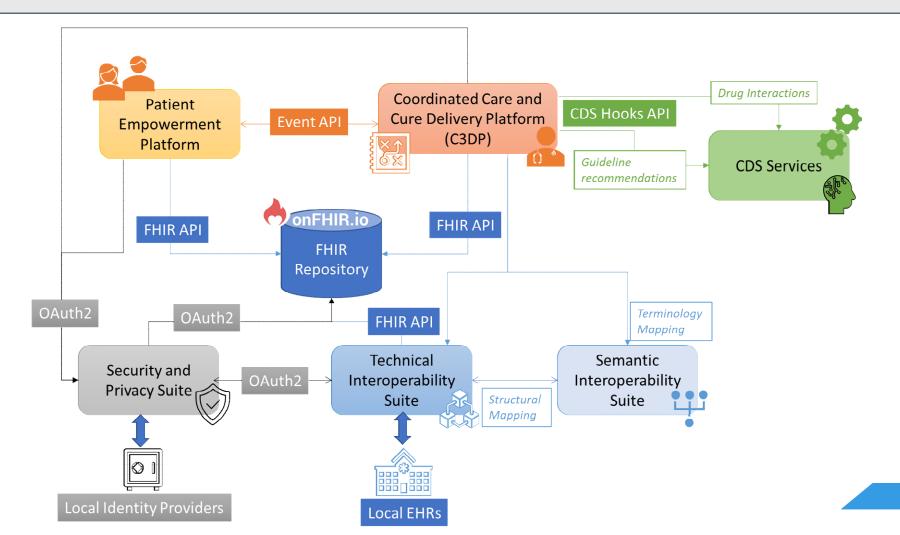
- C3-Cloud integrated care approach and ICT tools is **an end-to-end solution** for integrated care delivery
- **Optimisation** of multi-morbidity care pathways and organisational models based on the assessment of the pilot applications

Integrated Care Delivery End-to-end Solution



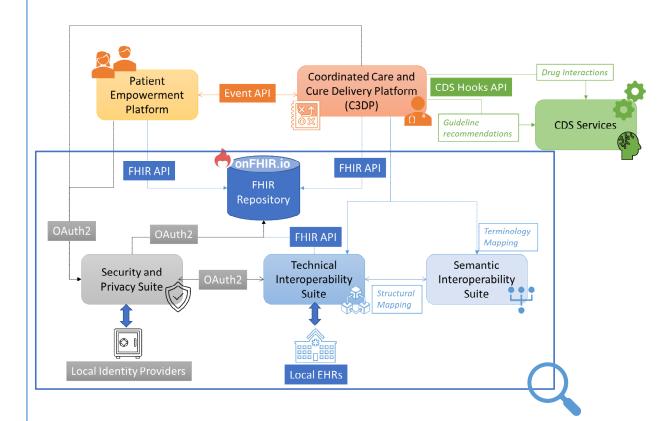
C3-Cloud Integrated Care Coordination Design

- Identification of stakeholder needs using scenarios for the 3 pilot sites
- 60 Pilot application requirements identified
- 348 technical requirements identified for 6 components of the system
- Survey of the latest technologies, standards, architectures



C3-Cloud Interoperability Layer

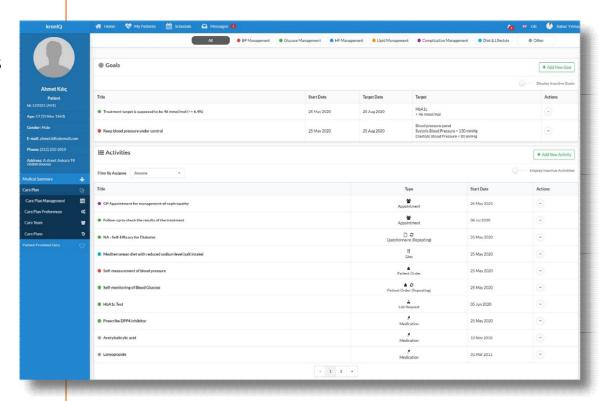
- HL7 FHIR has been chosen as the common model
- C3-Cloud's common shared repository is a secure, scalable FHIR Repository
- Technical Interoperability Suite (TIS)
 - Enables data exchange between the local EHR systems of the pilot sites and the C3-Cloud components via FHIR Repository
- Semantic Interoperability Suite (SIS)
 - Structural transformation from local EHR formats to HL7 FHIR & Teminology mapping
- Security and Privacy Suite (SPS)
 - Care Team Member authentication and authorization
 - Implements OAuth 2.0, OpenID Connect 1.0 and Smart App Authorization specifications
 - Integration with pilot site IdP systems (e.g. MS ADFS)
 - Audit Record Repository





Online Platform for the Management of Integrated Care Plans by MDT

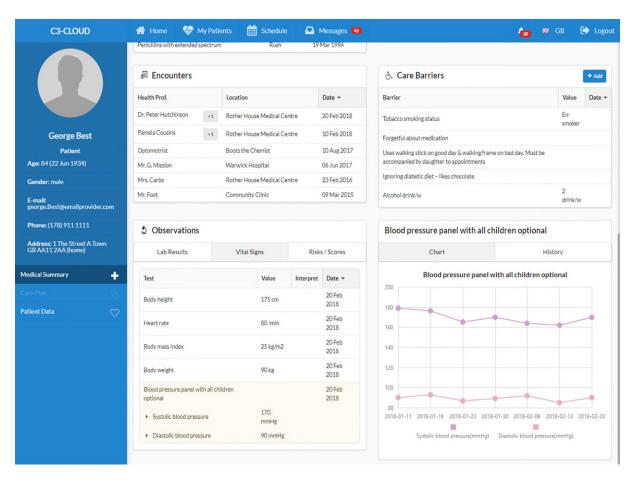
- Review of medical summary
- Cross-check of all patient data needed as input by the CDS services
- Management of the care plan building blocks; goals, activities and education materials
 - Manual entry from scratch
 - Recommendations from the CDS services
- "Execution" of a care plan
 - Updating the progress of goals and activities
 - Re-execution of CDS services during planned and unplanned encounters
 - Display of patient provided data
 - Commenting on the care plan items
- Management of the care team
- Communication among care team and patient/informal care giver
- Dashboard view
- Patient provided data screen
- Activity calendar
- Real-time system notifications

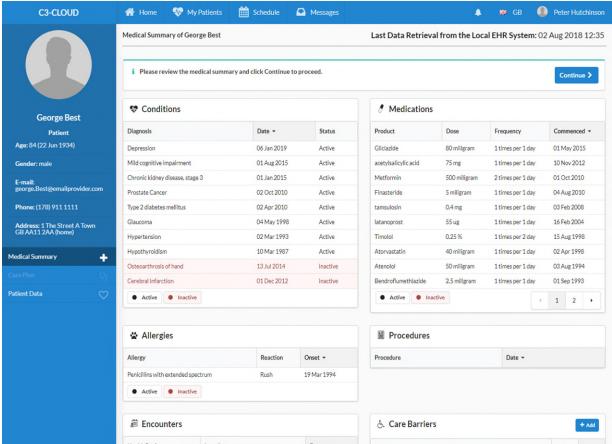




CARE PLAN AT THE HEART OF C3-CLOUD









Specific Challenges

- Clinical guidelines are single-disease centred; falling short for multimorbidity
- Polypharmacy in elderly leads to more comorbidities and medications

C3-Cloud Objectives

- Enable personalised care plan development by reconciling clinical guidelines
- Provide several clinical decision support services to support personalized care plan development and management

C3-Cloud Results

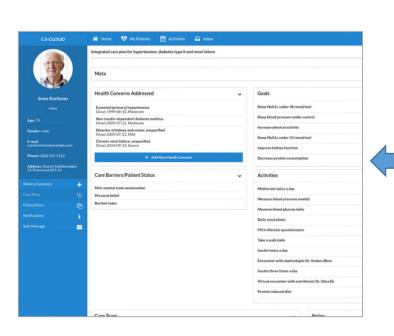
- CRG led identification and reconciliation of clinical guidelines
- 43 flowcharts implemented as 41 CDS services (283 rules and 52 reconciliation rules)
- Drug-drug Interaction Service developed based on NICE BNF database

Clinical Decision Support



Clinical Decision Support Services

- The GDL2 CDS services are available on GitHub: https://github.com/C3-Cloud-eu/gdl2-cds-services
- Used by the C3DP to support healthcare professionals to develop and manage care plans





No indication for lipid lowering primary

prevention

Offer atorvastatin 20 Set BP target Systolic:120-129 Indication for secondary mmHg, Diastolic < 80mmHg cardiovascular prevention No Yes Offer atorvastatin 80 mg. See also >40% reduction in non-HDL cholesterol ACR > 3 mg/mmol No y Yes No YYes Patient with a ≥10% 10 years risk of developing CVD eGFR >30 RASA 20 mg Indication No Yes non-HDL choles RF Care Plan DM2 Care Plan Interactions Disease-Disease Monitor Progress RASA Treatment.
Manage CVD Risk Diet & Exercise Disease-drugs Personalized Drugs-Disease Suggestions Drug-Drug goals and interventions Diet, exercise, training Follow-up Severity and Pharmacotherapy and self-care stage classification -Modification of -Significant modifications -Changes in the content and in the Reconciliation the severity and frequency of visits -Changes in "prescription module": of guidance -Necessity of new -Criteria of referral to nephrology Disease-drug and drug-drug DM2 & RF Care Plan

RF Clinical Guidelines

Patient CKM with

Diabetes Mellitus

Institute of Digital Healthcare

C3-CLOUD

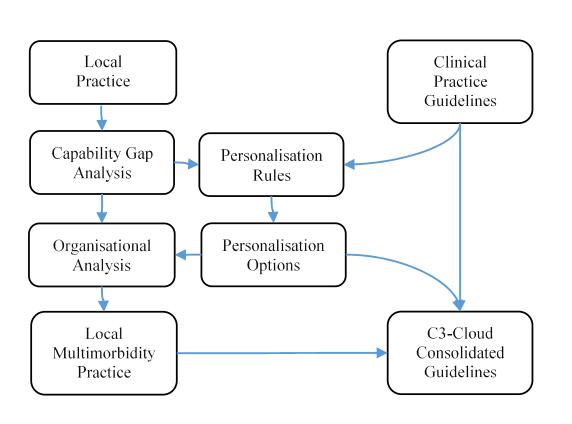
T2D Clinical Guidelines

No X Yes

with or without diabete:

COPRODUCTION FOR SOFTWARE DEVELOPMENT





- > Identification of best practice guidelines
- > Identification of local practice
- > Organisational transformation analysis
- > Development of personalisation rules
- > Identification of conflicts
- > Reconciliation of conflicts
- > Validation of consolidated guidelines



Specific Challenges

 Patients and their informal care givers often do not have a voice in their own care

C3-Cloud Objectives

• Ensure active participation of patients and their informal care givers

C3-Cloud Results

- C3-Cloud integrated care approach and supporting bundle of ICT tools, including the Patient Empowerment Platform
- Improved cooperation among formal and informal caregivers
- Increased participation of patients in care management

Patient Empowerment



Care Team - Patient Collaboration

- Care plan access
- Reminders to increase adherence
- Actively collect data related to the care plan activities
- Safe messaging

HL7° FHIR° REST API

Access to relevant self-management material





My Patients Activities

Health Concerns Addressed

Care Barriers/Patient Status



New/Updated Care Plan New Updated Care Team



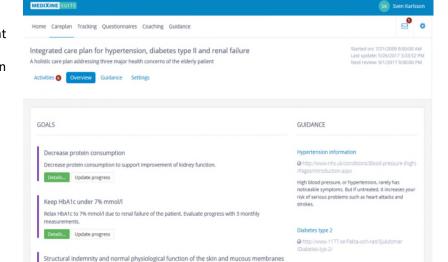












m maintenance of the feet in: temperature, sensitivity, hydration, pulses. Evaluate every 6 months

Personalised Care Plan Management

Care Plan Model

C3DP (for professionals)

Event Notification Integration

PEP (for patients / care givers)

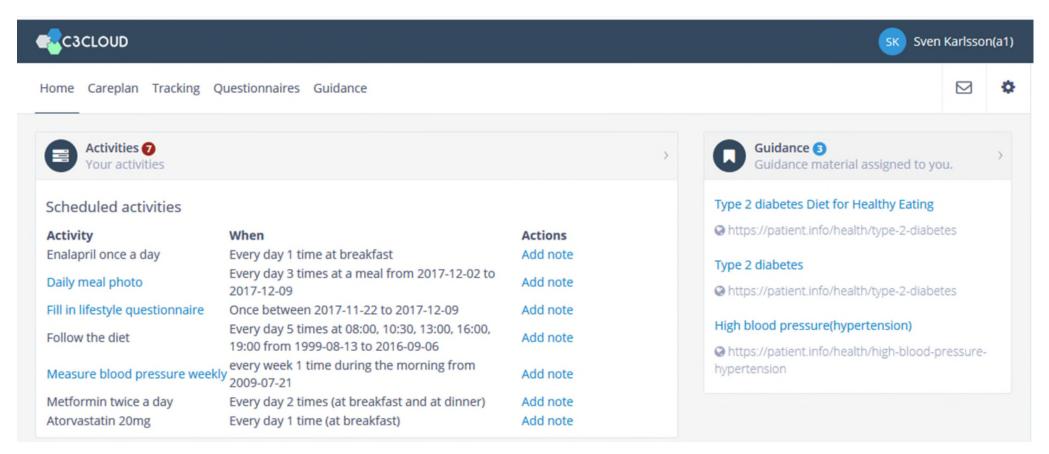
Food aspect in diabetes

http://www.1177.se/Fakta-och-rad/Sjukdomar



PATIENT EMPOWERMENT







Specific Challenges

- Managing multi-morbidity without informed involvement of all stakeholders, resulting in specialty silos and fragmented care
- Existing organisational models and care pathways are inadequate for integrated care delivery

C3-Cloud Objectives

- Enable MDT members to collaboratively manage integrated care plans, and support them to provide the best possible care
- Seamlessly integrate with the existing health and social care information systems
- Identify best practices in caring for multi-morbid patients across sites

C3-Cloud Results

- C3-Cloud approach validated in **3 European regions** with diverse health systems and underlying infrastructures
- An innovative large-scale impact modelling tool for industrial exploitation and large-scale roll out
- Addition to evidence for optimised multimorbidity care pathways and organisational models

Validation of C3-Cloud approach



TECHNOLOGY TRIAL



Is the use of a personalised ICT tool that facilitates coordinated care planning, treatment optimisation and patient self-management acceptable to patients with multiple long-term conditions and their team of health professionals?



phase 1

Months 1-18

- User centered design is tested with early mockups and discussion groups
- The system components are tested for specified technical software requirements



- UTAUT Acceptance evaluation
- Training material evaluation
- User interaction satisfaction



Acceptable C3-**Cloud system and** components ready for upscaling



- Application testing for component integration
- Heuristic evaluation
- Early usability and satisfaction testing
- General feedback



Months 48-52

- C3-Cloud system usage logfiles
- Large scale impact modelling with ASSIST toolkit and predictive modelling
- User impact survey
- Clinical optimisation
- Medical device usage



C3-CLOUD

STUDY RESULTS



Cautious acceptance: UTAUT patients: 4.76 UTAUT MDT: 4.00



Healthcare provider organizations save time



Payers save money



Satisfaction can be increased



Operational benefits are key



Consider benefit shifts



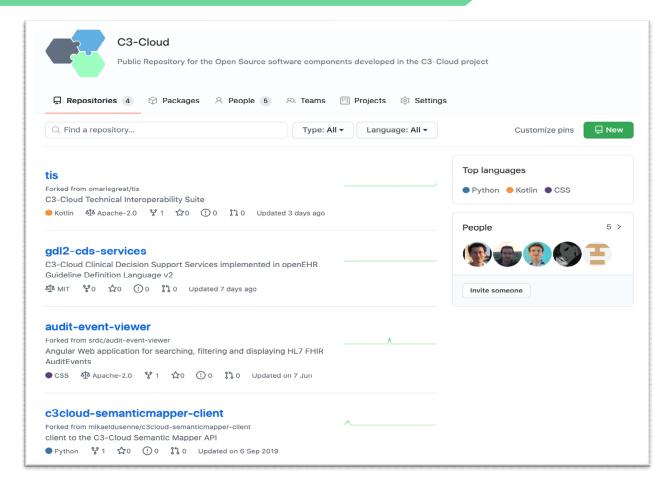
Upscaling suggested



OPEN SOURCE REPOSITORY

- The Audit Event Viewer developed by SRDC.
- The Semantic Mapper client developed by INSERM,
- ➤ GDL2 CDS services developed by CAMBIO,
- ➤ A Technology
 Interoperability Suite (TIS)
 developed by WARWICK,

27





FOREGROUND IP ASSETS AND INNOVATION RADAR



Application site integration Toolkit: provides means for organizations to assess their readiness to deploy (or connect to) a C3-Cloud healthcare service

Market maturity: Market Ready Project: C3-Cloud Innovation Topic: Health & Care SRDC YAZILIM ARASTIRMA VE GELISTIRME VE
DANISMANLIK TICARET ANONIM SIRKETI - TURKEY
THE UNIVERSITY OF WARWICK **?** - UNITED KINGDOM
INSTITUT NATIONAL DE LA SANTE ET DE LA RECHERCHE
MEDICALE - FRANCE



C3 Cloud Architecture: providing healthcare professionals with guideline-based recommendations for paitients based on automated interpretation of available data

Market maturity: Market Ready Project: C3-Cloud Innovation Topic: Health & Care



SRDC YAZILIM ARASTIRMA VE GELISTIRME VE DANISMANLIK TICARET ANONIM SIRKETI – TURKEY THE UNIVERSITY OF WARWICK \P – UNITED KINGDOM INSTITUT NATIONAL DE LA SANTE ET DE LA RECHERCHE MEDICALE – FRANCE

Clinical Guidelines: Interpretation, Specification, Implementation, and Execution

Market maturity: Market Ready

Project: C3-Cloud

Innovation Topic: Health & Care

SRDC YAZILIM ARASTIRMA VE GELISTIRME VE
DANISMANLIK TICARET ANONIM SIRKETI – TURKEY
THE UNIVERSITY OF WARWICK **?** – UNITED KINGDOM
CAMBIO HEALTHCARE SYSTEMS AB – SWEDEN



Functional implementation of C3-Cloud components

Market maturity: Market Ready Project: C3-Cloud

Innovation Topic: Health & Care



THE UNIVERSITY OF WARWICK **?** – UNITED KINGDOM
INSTITUT NATIONAL DE LA SANTE ET DE LA RECHERCHE
MEDICALE – FRANCE
MEDIXINE OY – FINLAND



KEY POINTS

- ➤ Integrated Care Delivery End-to-end Solution
- > Tackling Health Challenges on Chronic Diseases: Multimorbidity and Polypharmacy
- ➤ New patient pathways & corresponding care plans that can perform multi-morbid chronic disease management
- ➤ Care Team Patient/Informal Career Co-operation
- > Development of guidelines for smooth management of changes in models of care delivery
- ➤ Validation of Solution
- ➤ Digitally-enabled integrated care the way forward: The benefits to individuals and society are multiple. People's health journeys are better understood and appropriate lifestyle choices can be better tailored and promoted to the individual.
- In the case of chronic conditions, disease management can be more effectively supported and avoidable deaths can be prevented.





THANK YOU





Any questions?

t.arvanitis@warwick.ac.uk





















