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CONFERENCE ABSTRACT

Value-based integrated care for people with multi-morbidity

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Introduction

Person-centered integrated care for people with complex needs due to multi-morbidity is subjected to evidence-based decision making, like many other interventions that require additional resources. Payers and policy makers ask for evidence of the added value to guide resource allocation. They commonly define value in terms of health outcomes or cost-effectiveness, where the latter often refers to the 'costs per quality adjusted life year'. However, the impact of person-centered integrated care for people with complex needs extends beyond health outcomes and includes the improvement of well-being and experience with care.

Methods

For this reason we have adopted a broader, more inclusive method of evaluation for the 17 different integrated care programs for people with multi-morbidity, that were studied in the four-year Horizon2020 project SELFIE. The method is called Multi-Criteria Decision Analysis (MCDA). In an MCDA, a broad set of outcomes is not only measured, but also valued on the same latent utility scale, which allows the results to be aggregated into an overall weighted value score. In the SELFIE project we measured a core set of 8 outcome measures and some additional program-specific outcome measures in quasi-experimental studies which compared integrated care to usual care. Besides the health outcomes 'physical functioning' and 'mental health', the core set included the well-being outcomes 'enjoyment of life', 'social relationship and participation', and 'resilience', the experience outcomes 'person-centeredness' and 'continuity of care', and 'total costs'. The relative value of these outcomes was obtained using Discrete Choice Experiments and Swing-Weighting in a total sample of more than 5100 patients with multi-morbidity and other stakeholders from the following eight European countries: AT, DE, ES, HR, HU, NL, NO, UK.

Results

Across the 17 programs, we generally found higher overall value scores for integrated care than for usual care, although the differences were small. These differences were often driven by improvements in the outcome 'enjoyment of life', which had the highest value.

Eight programs showed statistically significant improvements in ‘person-centeredness’ and/or ‘continuity of care’, but the value of especially that first outcome measure was relatively low compared to the other outcome measures. Some programs even generated net cost savings. In the presentation, the full MCDA results of one or more of the programs, including the ‘Better Together in Amsterdam North’ program, which is a program for people with problems in multiple life domains (e.g. health, financial, labor, housing), will be shown.

Conclusion

We have shown that it is possible to perform a broader health technology assessment (HTA) of integrated care for multi-morbidity using MCDA and provided evidence that improvements in well-being outcomes and experience with care outcomes contribute to higher overall value scores for integrated care than usual care.

Discussion

The duration of follow-up after the start of a program was relatively short (12 months max), and some control groups were more comparable to the intervention groups than others, despite the use of advanced statistical techniques to improve comparability. Nevertheless, it is this type of evidence that we need to provide to ensure value-based integrated care.