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Active Ageing with Type 2 Diabetes as Model for the Development and Implementation of Innovative Chronic Care Management in Europe

Summary

Coordinator, Leader contact and partners

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Active Ageing with Type 2 Diabetes as Model for the Development and Implementation of Innovative Chronic Care Management in Europe

JA2015 - GPSD [705038]

| START DATE: | 23/05/2013 |
| END DATE:  | 23/05/2016 |
| DURATION:  | 36 month(s) |
| CURRENT STATUS:  | Finalised |
| PROGRAMME TITLE:  | Second Programme of Community action in the Field of Health 2008-2013 |
| PROGRAMME PRIORITY:  | - |
| CALL:  | Promote Health (Hp-2012) |
| TOPIC:  | IMPROVE CITIZEN'S HEALTH SECURITY (HS-2012) |
| EC CONTRIBUTION:  | 692441.4 EUR |
| KEYWORDS:  | Elderly, Health system, Innovation initiatives, Survey, type II |
| PORTFOLIO:  | Ageing |
General objectives

General Objective:
MANAGE-CARE aims to prevent costly complications and frailty in elderly with type 2 diabetes, enabling them to live independent, healthy and active lives as long as possible. This will be achieved by driving innovation and change in the current treatment approach, shifting from diabetes management (disease-specific care trajectory) to chronic care management (non-disease focused model). A roadmap for implementation of the model will be developed, providing also guidelines for development of chronic care models in a broader context.

Strategic relevance and contribution to the public health programme

MANAGE-CARE aims to create a shift from disease management to chronic care management, in line with the second objective of the annual work plan to promote health, through change in care delivery and through partnering for change, addressing in particular older patients with multiple chronic conditions and using innovative business modelling. Diabetes will be used as a test-case for developing this innovative model, which coincides with the Health Policy of the Danish Presidency focusing on chronic diseases with diabetes as a model disease. Prevention of costly complications, hospitalisation and frailty in elderly with chronic diseases is directly in line with the Implementation Plan of the EIP on active and healthy ageing, aiming at an increase in healthy life years and promoting healthy ageing. Patient empowerment and telemedicine, both mentioned in EIP which is supported by the 2012 public health work plan, constitute an important part in MANAGE-CARE as well.

Methods and means

Based on a state of the art assessment, providing knowledge and evidence on the existing disease management models and on the needs of older people with diabetes mellitus, a new chronic care model will be developed, driving change in the current treatment approach by shifting from disease management to chronic care management. Training programs for both health professionals and patients will be developed to work in accordance to this model and ensure a patient-centred approach. Finally a toolkit for implementation of the new model and transfer of the model to other chronic diseases will be constructed. Desk research (literature, web) and surveys will be conducted; consensus building and use of expertise of key partners will be applied throughout the project.
Expected outcomes period

By developing a new chronic care management model the project will contribute to improve the health of EU citizens. By working on wide implementation across the EU, MANAGE-CARE will help to reduce health inequalities between and within EU Member States, especially for older patients with chronic diseases. In addition, the project will build capacity for development and implementation of effective public health policies particularly in areas of high need for the improvement of quality of care for patients with chronic diseases. The MANAGE CARE project will lead to concrete outcomes for key stakeholder groups. More effective care and enhanced patient empowerment will lead to improved health and quality of life outcomes, enabling patients to stay independent, healthy and active. This in turn will reduce the burden on family members and other informal carers. Improved cooperation and communication between health professionals and stakeholders who play a key role in chronic care management, clarity on new and shifting roles within the care team will lead to a better way of working.
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D04 - MANAGE CARE MODEL technical handbook
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D05 - e-Health portal with MANAGE-CARE PRO training curriculum for healthcare professionals
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D06 - Patient empowerment booklet and e-Health portal on active ageing with T2DM
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