

# Lessons Learned from the UK's Chronic Care Program – A Case Study

By Kelly Birch

The need for greater intensity of care for individuals with chronic conditions is on the rise worldwide. Whether publicly or privately funded, health care systems today are looking for new ways to design care to meet the needs of the chronically ill — a population that represents the largest percentage of both health care spending and resource utilization. Ingenix Consulting, under the brand UnitedHealth UK (UHUK), is providing consulting services for the management of patients with chronic conditions within the National Health Service of the United Kingdom (NHS). Understanding the NHS programs and outcomes should be considered as the U.S. health system looks for new ways to improve the health outcomes for its citizens.

*Note:* Service delivery to chronic-care individuals is carried out differently in England, Scotland, Wales and Northern Ireland. Examples referred to in this article as “U.K.” are from experiences encountered in England.

## Background

The NHS continues to look for best practices in the management of individuals with chronic medical conditions. As in the U.S., the U.K. understands the need to intensely manage these individuals to ensure they achieve the highest state of wellness. However, the NHS is also acutely aware of the resource costs and historic difficulties in effectively managing this population.

In 2004, the U.K.'s Department of Health mandated that by 2008 each Primary Care Trust (PCT) establish a dedicated number of case managers per chronically ill patient. These case managers, known in the U.K. as community matrons, are specialist clinicians (often nurses) who work with patients and social care providers, offering their expertise in responding to their patients' complex problems. They assess patient needs and required levels of support and then work with general practitioners and primary care teams to develop

tailored care plans. They also act as a fixed point of contact for the patient, taking responsibility for coordinating the contribution of the many professionals involved in the delivery of integrated care. Their goal is to anticipate and address problems before they lead to worsening health or hospitalization (Department of Health 36-38).

The mandate requires a patient-per-case manager ratio of 83:1. In practice, however, models have been developed with average caseloads of 50 patients. While this mandate was designed to be in place by 2008, implementation across the U.K. has been slow.

## Challenges

UHUK is currently working with several PCTs to develop new case management programs. As part of this work, UHUK conducted comprehensive assessments of several existing PCT programs in order to examine case management structure and performance. Findings showed limited development of program frameworks, leading to multiple problems such as inconsistent program requirements, ill-defined case manager roles and responsibilities, and a wide variety of case management models being implemented. Consequently, limited positive results have been reported and many programs have not been able to meet even minimal key-performance indicators.

Findings from the UHUK assessments identified many key challenges, including:

- Achieving system buy-in
- Identifying patients and establishing program criteria
- Developing appropriate skill sets
- Providing timely care
- Aligning payment/incentive schemes
- Measuring performance
- Establishing IT support in the field

Examining these findings will lead to a better understanding of how to approach similar U.S. programs, such as the medical home model, chronic-care management and Medicare's special needs plan model of care.

### **Achieving System Buy-In**

Development of an effective case management program requires the cooperation and investment of all health care disciplines in order to establish an integrated-care approach. PCTs have experienced the greatest difficulty in gaining buy-in from the social care, behavioral health and rehabilitation services disciplines. These services, which are important in the delivery of care to the chronically ill, are usually not under the control of the PCT and require outside contracting. This leads to difficulty in gaining buy-in since payment incentives are misaligned due to a lack of proper funding. Even when support does exist, challenges remain due to competing priorities and lack of service integration

### **Identifying Patients and Establishing Program Criteria**

The majority of PCT case management programs utilize nationally reported data to identify their high-risk populations. This data, which is usually 9–12 months old, provides only minimal information on overall service utilization by the patient and is not predictive in modeling future utilization. A few PCT plans have put risk stratification and predictive modeling tools in place, which allows them to more intelligently identify and prioritize their high-risk patients. In addition, these tools help to stratify members based upon the Right Service Risk Pyramid, which is used by several U.K. case management programs.

The pyramid stratifies members into one of three risk levels, which are defined in different ways depending on the case management model adopted by the PCT. Two of the models currently used are the *Castlefield Model* and the *Evercare Model*:

- *Castlefield Model*: This model operates under the philosophy that case management can address the patient's current needs, improve the patient's disease state, and enable the patient to be discharged from case management. In this model, Level 2 patients are intensively managed.
- *Evercare Model*: In this model, the most intensive case management and skilled staff are provided to Level 3 patients, who utilize a majority of health care expenditures and tend to be at the end of their lifespan. Case management also occurs for Level 2 patients, but management is more focused on the disease state and tends to be intermittent in nature with specific admission and discharge criteria.

Case management of Level 2 patients is an area where many PCT programs focus their efforts, but impact on health care expenditures is minimal because these patients are not frequent users of high-cost resources. Level 3 patients, often classified by PCTs as "end-of-life", utilize the greatest number of high-cost resources. Case management staff, however, is frequently discouraged by their inability to improve the health of Level 3 patients, and their efforts are often discontinued. Under a well-defined program, the appropriate type of case management can be provided to Level 3 patients and financial benefits can be achieved. This exemplifies the importance of establishing a program that clearly defines patient populations and treatment models, along with a new culture that outlines realistic case management expectations.

### **Developing Appropriate Skill Sets**

Our assessments found that skill sets of the case management staff vary from program to program. Insufficient training contributes to the inability to provide

patient care at the community level, resulting in trips to the general practitioner's office or emergency department that might have otherwise been avoided. It is therefore critical to invest in aligning case manager skills with the patients' clinical needs. Skills training should also include proven techniques such as motivational interviewing and patient activation assessments. When UHUK assisted with case management staff training and development, outcomes included improved patient and family/caretaker satisfaction, decreased utilization of acute care services, improved case management skills and staff satisfaction, and increased autonomy.

### ***Providing Timely Care***

Only a few PCTs have been successful in establishing integrated case management programs that have sound frameworks and highly qualified staff. One roadblock has been that many of the disciplines necessary to provide successful case management do not have the capacity to provide timely care and service. For example, a case manager assessed a patient at risk for falls and established a plan of care that included an assessment of the patient's mobility and home safety. When the community physical therapy service was contacted to carry out this assessment, their first available appointment was 18 weeks out. This delayed the plan of care and required the case manager to make frequent contact with the patient due to the potential for patient falls and hospitalization. In a well-integrated model, the assessment would occur quickly, providing the case manager an opportunity to be successful and the patient a positive outcome. Case management programs can only succeed if the *entire* integrated team is available to support the development and implementation of the care plan in a timely manner.

### ***Aligning Payment/Incentive Schemes***

General practitioners in the U.K. have standard contracts to deliver care to their patients. Case

management is considered to be part of their contractual responsibilities; however, there is limited care coordination since specialty care, community care, and after-hours care are not included in these contracts. This creates difficulty in mobilizing a case management program and often requires the need to reevaluate the provision of community services.

### ***Measuring Performance***

A case management program needs to "begin with the end in mind" (Covey 95); therefore, **Specific Measurable Achievable Realistic Timely Key Performance Indicators** (SMART KPIs) need to be developed and implemented. In addition, a mechanism should be in place for acquiring and reporting data in order to evaluate ongoing program performance. Programs should also be evaluated using satisfaction surveys and value indicators. These measurement tools help to demonstrate the improvement a case management program brings to a patient's state of wellness and quality of life. Financial indicators need to be part of the performance indicators as well. Our assessments found that most programs do not develop SMART KPIs, and data and performance monitoring tends to focus on activity levels rather than outcomes.

### ***Establishing IT Support in the Field***

Although electronic medical records are available in many PCT locations, these systems often do not have interoperability with the various disciplines in the field. The case management team is therefore unable to electronically document while in the field, resulting in the need to maintain duplicative paper documentation in order to effectively coordinate integrated care delivery. In fact, the current standard is to maintain an unsecured paper copy of the case management record in the patient's home. Further IT field support is needed to automate the development of care plans, provide communication between the various care team disciplines, evaluate outcomes, and document reporting requirements.

## Solutions

The UHUK assessments of the PCT case management programs included: comprehensive evaluations; strengths, weaknesses, opportunities, and threats (SWOT) analyses of all program components (including clear, actionable recommendations for further development); a business case demonstrating the cost and impact potential of the case management program; and investment recommendations. Ingenix Consulting can provide similar assessments for U.S. organizations interested in developing a medical home model, chronic-care management services, or a Medicare special needs plan model.

## Outcomes

A comprehensive case management program requires a well-defined framework that provides direction, selection and management criteria, and outcomes measurements. A strong framework provides the integrated care staff with clearly defined roles, allowing them to work collaboratively to address client issues and provide expeditious care delivery.

UHUK assessments have shown that case managers are most effective when aligned with general practitioner or primary care practices. In addition, case managers must possess the skills necessary to adequately assess each patient's physical, social and mental state, and the ability to prescribe and act as advanced practitioners in planning and coordinating care. It is also imperative to assess all of the various disciplines that make up the integrated care team and evaluate their capabilities and capacities, for a single discipline cannot carry out such a plan in isolation.

A successful case management program requires a system that supports the identification, stratification and predictive modeling of high-risk members. IT support is needed for the development and management of a care plan, as well as the ability to document services provided across the system from the various disciplines involved in care delivery.

PCT case management programs that continue to follow the Evercare Model are showing successful outcomes and reporting average savings of 900 admissions annually (a net savings of 2 million pounds). UHUK is currently partnered with a PCT in the development of the next generation of the Evercare Model, now known as the UHUK Model. Although in the early stages of full deployment, key-performance indicators are being followed closely, as this PCT is already showing a decrease in the utilization of acute care services.

## What Needs to Happen in the U.S.

It is time for health plans in the U.S. to find a new way to approach the chronically ill and provide support to their families and caregivers.

For many years, case management in the U.S. has been the responsibility of payers, and outcomes have been questionable. A majority of this management has historically been carried out telephonically; however, numerous studies have shown that this is not an effective management method for the frail elderly. Further, this type of case management has not produced a positive return on investment, leading organizations to question their commitment to continued investment. This shows the need for U.S. payers to develop models that include community-based case managers who can provide effective, face-to-face assessments and treatment interventions in the patient's home, assisted living facility, or long-term care facility. Community-based programs provide the case manager an opportunity to develop a trusting relationship with the patient and family/caretaker — a relationship that is invaluable in times of declining health.

Considering that the chronically ill account for a majority of U.S. health care costs, we should look to new models to decrease expenditures for this population, including the Medical Home Model and Accountable Care

Organizations. This will require us to examine the provision of case management and the delivery of care from a different perspective. Providers will need access to tools and data to identify high-cost individuals, along with a change in the case management culture from telephonic support to that of an adjunct role that supports and coordinates with community and field services.

### Conclusion

“If we always do what we’ve always done, we’ll always get what we always got.” It’s time for change, and our experience working on the U.K.’s case management programs has provided us with a new perspective in delivering care to the chronically ill in the U.S. An interchange of best practices and the opportunity to learn from one nation to another is vitally important if we are to continue to improve the delivery of case management.

### Contact

Kelly Birch is Vice President, Government Program Management and Strategic Consulting with Ingenix Consulting.

### References

Department of Health. “The NHS Improvement Plan — Putting People at the Heart of Public Services.” 2004. (pp 36-38).

Crump, H. “Can integrated care usher in a new age of risk taking?” *Health Service Journal*. April 9, 2009. Retrieved on October 1, 2009 from <http://www.hsj.co.uk/news/policy/can-integrated-care-usher-in-a-new-age-of-risk-taking>

Rowland, M. “Admissible Evidence.” *Health Service Journal*. 2007. Retrieved on October 1, 2009 from <http://www.hsj.co.uk/admissible-evidence/54097article>

Torjesen, I. “NHS60: If the care fits.” *Health Services Journal*. 2008. Retrieved on October 1, 2009 from [Http://www.hsj.co.uk/nhs60-if-the-care-fits/1324305](http://www.hsj.co.uk/nhs60-if-the-care-fits/1324305)

