

	Summary  Research paper	Contributors JENNIFER DIXON RICHARD LEWIS REBECCA ROSEN BELINDA FINLAYSON DIANE GRAY	Date JANUARY 2004
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MANAGING CHRONIC DISEASE

What can we learn from the US experience?

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This summary appears in the full report, Managing Chronic Disease: What can we learn from the US experience?, available from the King's Fund, priced £8.00.

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King's Fund Publications
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Edited by Eleanor Stanley
Typeset by Martin Jeeves

Summary

A growing challenge

Chronic medical conditions – such as asthma, diabetes, heart failure and hypertension – are lifelong and often progressive. As the population in England ages, growing numbers of patients will need help in managing complex, multiple conditions over sustained periods. Quite apart from the burden of ill health, treating these conditions is likely to cost the NHS in England far more than elective surgical procedures.

Yet government policies and targets for acute sector managers and health commissioners, such as reducing waiting lists and increasing productivity, are strongly focused on the elective care sector. Several recent government initiatives – for example, the national service frameworks for diabetes and coronary heart disease – aim to improve the care of people with chronic disease. But these are taking place against a background of wider changes in the NHS, in particular the introduction of market-style incentives for hospitals, which may inhibit the development of good chronic care management. There is a growing danger that less, rather than more, collaboration between health service providers may result. There is a need for a new, co-ordinated national approach that helps people with chronic disease – and their carers – manage their conditions more effectively and thus reduces the burden of chronic disease on the health service.

Better primary care and better integration between primary and secondary care can play a significant part in reducing the use of expensive and disruptive hospital stays for people with chronic conditions. But in England, there are large variations in hospitalisation rates associated with chronic diseases between different primary care trusts (PCTs) that serve similar populations. These suggest the need for a wider, more systematic approach – and accompanying incentives – to help primary care providers manage chronic disease in consistent and targeted ways.

What happens in other countries?

There is much to learn from other countries. Managed care organisations (MCOs) are organisations that offer comprehensive health care to defined populations in return for a fixed capitation payment (an annual premium per patient). MCOs in the United States have in-built incentives to manage the care of patients more proactively. Some have achieved striking results – for example, good-quality care, high levels of patient satisfaction and much lower hospitalisation rates than in the NHS. There are obvious parallels between the structure and function of MCOs in the United States and PCTs in England – in particular, the need to manage financial risk while meeting all the health needs of their associated patients.

A number of MCOs have been particularly active in improving the care of people with chronic conditions – for example, Kaiser Permanente in California and United Healthcare in Minnesota. At present, initiatives inspired by their activities are being piloted in 18 PCTs in England under the leadership of the NHS Modernisation Agency. In addition, a generic model of care – the Chronic Care Model – is gaining support in the United States

and underpins the approach to the prevention and management of chronic disease in many MCOs.

But we have, as yet, a limited understanding of the features responsible for the success of these MCOs, and we know still less about which of these features might appropriately be adapted to the very different context of the NHS in England. We also need to assess the trade-offs that might be involved in applying lessons from market-driven, local health care organisations in the United States to a national health service based on principles of social equity and public good in England.

As the King's Fund contribution to the increasingly pressing debate about chronic care management, we undertook further research that we felt could usefully inform future decision-making. *Managing Chronic Disease* offers a critical analysis based on a study of five MCOs, all among the top performers in the United States in the care of people with chronic conditions, and asks what lessons or transferable models might emerge for health care in England.

About the study

We selected five MCOs as the basis of our study, largely because of their high scores on performance indicators (such as the control of blood pressure and the prescribing of appropriate medications) related to chronic disease management. One was a 'group model' MCO (where services were provided exclusively by a medical group affiliated to the MCO), one was a 'networked model' (where the MCO contracted freely with most local providers) and three were 'mixed models' (where the MCO worked with an affiliated medical group and contracted with other providers). The organisations we studied were:

- Kaiser Permanente (North California) – group model
- Group Health Cooperative (Washington State) – mixed model
- Health Partners (Minnesota) – mixed model
- Touchpoint Health Plan (Wisconsin) – mixed model
- Anthem Blue Cross Blue Shield (Connecticut) – network model.

A team from the King's Fund visited each MCO in the period February–August 2003 to identify what might lie behind their strong performance. Information was collected from each site by means of:

- semi-structured interviews with senior staff
- a review of 'grey' literature
- visits to clinical facilities
- presentations from staff
- contact with practising clinicians.

In putting together our analysis, we scrutinised the factors that appeared to be associated with their success in relation to three broad areas:

- the wider environment in which they operated – for example, the use of market incentives
- their organisational domain – including the relationship between healthcare purchasers and providers
- clinical process – such as the disease management programmes in place.

The wider environment

Our main findings were:

The impact of competition and the market

- Competition between MCOs for enrolees appeared to encourage innovation in service design and quality.
- Competition for enrolees (particularly competition for contracts with the large employers that are major purchasers of health care) seemed to have a greater influence than competition between providers for contracts with MCOs.
- The need to survive in the marketplace helped to align the objectives of managers and physicians, particularly where MCOs contracted with affiliated medical groups. The ability of enrolees to switch to another MCO prompted close collaboration.
- Excessive competition between MCOs could lead them to focus on attracting young and healthy enrolees at the expense of improving chronic disease management.
- Market competition could have both a positive and a negative impact on chronic disease management, and the value MCOs placed on this type of care was critical to their success in improving quality.

Recommendations for the NHS

- An assessment by the Department of Health of how different current national policies might help or hinder the development of better care for people with chronic conditions is needed – in particular, how proposed new market incentives for hospitals and the introduction of foundation trusts will impact on chronic care.
- We suggest that there could be stronger financial incentives on PCTs, GPs and acute NHS trusts to manage patients with chronic conditions more effectively in the community and reduce the need for admission. There is scope here for creativity, pilots and evaluation. The incentives could arise from the encouragement of competition and a market – for example, between PCTs for patients, or through contestability of PCT management, although both have significant risks. Another route could be taken that does not rely on encouraging market pressures, but which assesses in a much more sophisticated way the mix of incentives already acting on GPs, practices, PCTs and acute trusts, and aligns them more strongly to the goal of better health and reduced avoidable hospitalisation.

The organisational domain

Our main findings were:

Relationships and incentives

- MCOs had local discretion to set organisational goals and priorities through negotiation between corporate and clinician managers. Such negotiation helped to determine how successfully goals and priorities were implemented.
- Long-term relationships between MCOs (as commissioners) and providers (hospitals and networks of physicians working in the community) were considered critical in providing incentives for investment in chronic disease management.
- Larger and more organised networks of physicians were more willing and able to engage in effective chronic disease management than loose networks of solo practitioners.
- Where MCOs worked exclusively with affiliated medical groups, both the purchaser and the provider of care had very similar incentives to improve disease management.
- Doctor–manager relations were strong, although there were fewer leadership opportunities for other clinical professionals.
- There were effective financial incentives for quality, targeted mainly at physicians, to encourage better care of people with chronic conditions.

Recommendations for the NHS

- PCTs should be helped to develop a business case for investing in chronic disease management – this might be a role for strategic health authorities.
- Better-developed financial incentives for providers (primary and secondary) are needed to provide integrated care and to keep people with chronic conditions well enough not to be hospitalised. Current financial incentives that apply to hospitals do not promote good chronic disease management and should be reviewed.
- The IT infrastructure in primary care should be further developed to enable the identification of high-risk patients and the ‘real time’ feedback of information to clinicians, thus encouraging continuing peer review.
- Much greater investment is needed in developing clinician–manager relations within PCTs and between PCTs and their providers.

Clinical process

Our main findings were:

- All of the MCOs used at least some of the six elements of the Chronic Care Model – a generic model designed in the United States to help MCOs organise better care for people with any chronic disease.

- Four of the five MCOs identified high-risk patients ('risk stratification') and targeted them for intensive case management – mainly nurse-led outreach care to work with patients to effectively manage their disease (the fifth MCO was developing this model).
- Lower-risk patients were offered disease management programmes that involved:
 - proactive management of care using guidelines with prompts to clinicians and patients
 - decision-support systems for patients and clinicians
 - patient education and self-care
 - electronic disease registries that identify affected patients and record details of their care management
 - the feedback to physicians of accurate, 'real time' clinical data on their own patients, with supportive peer review.
- There was limited choice for patients in whether or not to participate in case or disease management programmes (selection was determined by the MCO).
- There was a marked lack of focus on social care.

Recommendations for the NHS

- A generic model of chronic disease management should be developed.
- Risk stratification (and the identification of patients at high risk of ill health and hospitalisation) should be developed in every PCT.
- Case and disease management programmes in which support for self-management is a central feature should be developed in every PCT.

Taking things forward

The King's Fund is working with others in 2004 and 2005 to help take forward some items of the agenda outlined above.

- We are convening a national coalition of stakeholders interested in improving the care of people with chronic conditions. The coalition aims to raise the profile of chronic disease management, increase synergy between the work of participants to improve chronic care, and develop a chronic care model for England.
- We are discussing the agenda with the Department of Health, the Modernisation Agency and the Commission for Healthcare Audit and Inspection.
- We are embarking on development work with selected PCTs in London to help them improve the care they give to people with chronic conditions.

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