

Managed care as a concept – meeting the challenge

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Introduction

Contributing to the start of a brand new service is both an exciting opportunity and a daunting challenge. Adur, Arun and Worthing Teaching Primary Care Trust (PCT) has taken a view that the development of a managed care service such as this is worth investing in because it has the potential to bring about some fundamental changes in the way services are provided. It will also assist in empowering people with chronic conditions to determine their management with the support and intervention of professionals on a timely basis. This article discusses the steps taken by the PCT to develop a managed care service.

Adur, Arun and Worthing Teaching PCT has a population of 227 000. The PCT has three distinct localities encompassing 32 GP practices. Within these localities there are electoral wards with significant deprivation indices. The population comprises a higher than average number of over 65s – 24% compared to the UK average of 15.8%.

In addition, there are a higher number of over 85s – 4.9% compared to the UK average of 1.9%. The high proportion of older people has significant public health implications. We therefore need to improve health and health services for older people, re-balancing provision towards community-based models aimed at improving individual case management and preventing unnecessary interventions or hospital admissions that may inadvertently exacerbate deterioration.

The basic philosophy and principles behind the development of managed care locally arise from a number of national and local drivers. *The NHS Plan* (Department of Health [DoH], 2000) – which promotes developing flexible services that are patient focused, empowers individuals to influence their care and supports true partnership between service providers – offers a vehicle for development. This in turn is supported by the workforce development expectations encompassed in *Making a Difference* (DoH, 1999) and in addition the various NHS reforms, which have an inter-linking connection. So, the stage is set – it merely requires the right focus and willingness

for true collaborative development. There have been many initiatives over the years to improve health and health outcomes, but occasionally everything comes together. The ‘Evercare’ and ‘Kaiser Permanente’ models of chronic disease management (examples available on the NHS Modernisation Agency website, <http://www.natpact.nhs.uk/>, accessed 08.03.05) have provided food for thought as to how this type of approach could be implemented for the benefit of patients and the local health economy. PCTs vary enormously in terms of existing service provision, so one size is not likely to fit all. The key is in assessing local provision and need, linking the new service to these and positioning it to influence further development and cultural change.

The model used to develop the managed care service

The aims of managed care are given in *Table 1* and the structure of the model used to initiate the service is given in *Figure 1*. The Trust is currently at stage 5/6, in that we have recruited our initial cohort, having exceeded expectations and 14 nurses commenced in post on the 28 February 2005. The nurses come from a variety of backgrounds: acute, community, specialist community nurses and practice nursing. All are enthusiastic about being in at the start of a new service and all will have experience the others will benefit from.

The Trust has put together a comprehensive training programme that

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1 Managed care is worth investing in as it has the potential to fundamentally change the way services are provided.

2 Adur, Arun and Worthing Teaching PCT are developing their service using a model.

3 Nurses from a variety of backgrounds will attend a three-week training programme to become managed care nurses.

4 Networking with people in other services is important as services will have to work together to benefit patients. The diabetes service is a good example of this.

5 A high level of collaboration and commitment is required to improve future health outcomes for patients.

KEY WORDS

- Managed care
- Service development
- Training
- Collaboration
- Diabetes

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1 Three week's training will enhance nurses' clinical knowledge and skills.

2 The training programme consists of: policy context, leadership, teamworking, communication, chronic disease management, patient assessment, medicines management, emotional health and information technology.

3 Networking time with other community services facilitates joint thinking about how services will work together.

Table 1. The aims of managed care

- to reduce inappropriate hospital admissions
- to improve clinical outcomes
- to empower patients and improve their experience
- to act as a single point of contact
- to enable the gradual shifting of resources and focus towards more community provision
- to provide focused case management for people with long-term conditions.

will run over a three-week period. The reasoning behind this approach is to provide an opportunity for the nurses to 'leave behind' their previous role and adjust to the new one. The programme will enhance their clinical knowledge and skills by providing specific education. It will also enable local networks and working relationships to be established by utilising local expertise within the wider health economy, social and caring services, patient advice and liaison service and by drawing

on the experience of other redesigned services.

The training programme includes the following:

- The policy context relating to the *National Service Framework for Older People* (DoH, 2001) and its application to managed care approach.
- Leadership, team identity and development.
- Communication and how to engage individuals, their families and carers in future service design.
- Chronic disease management covering diabetes, chronic obstructive pulmonary disease and coronary heart disease.
- Patient assessment and history taking.
- Medicines management.
- Emotional health of older people and how to use assessment tools.
- Information technology to enable case finding and close communication with primary care.

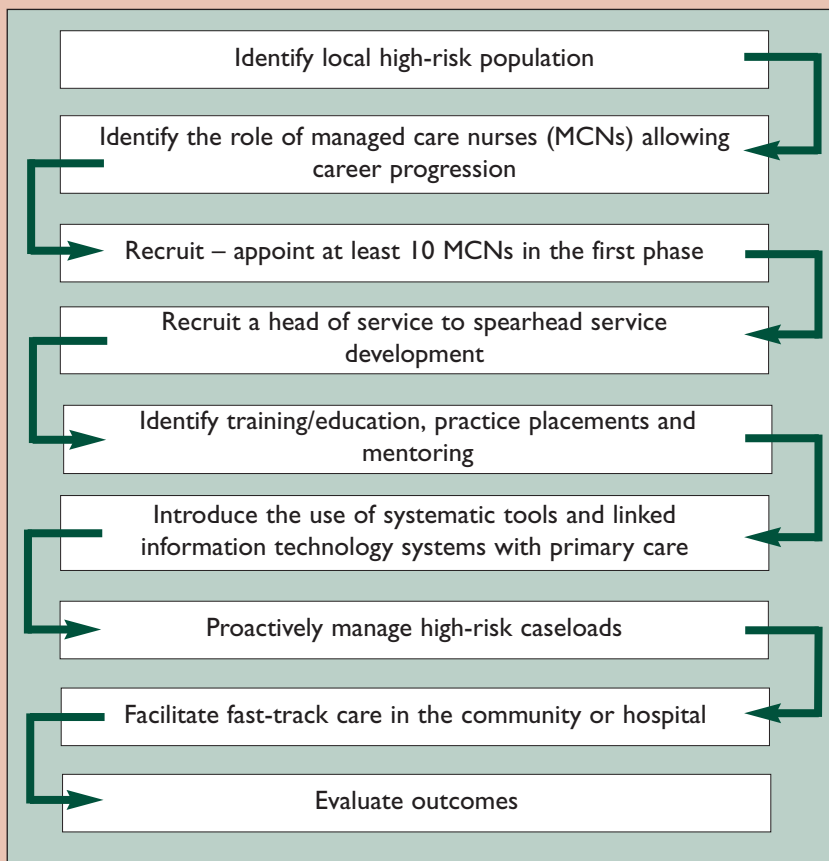
In addition, we have built in some networking time with other community services, such as intermediate care, specialist community teams and core district nursing services. This is in order to facilitate joint thinking about how services will work together for the benefit of existing and new patients. The Trust also has practice placements agreed with social and caring services to support informed decision making around the use of resources.

The Trust is currently exploring mentorship arrangements and the development of action learning sets to underpin learning with primary care and the prescribing team.

Example of managed care: diabetes service

One example of excellent local relationships is that which exists between ourselves and the local acute-based diabetes service. The diabetes nurse consultant is providing a two-and-a-half day workshop as part of our overall programme, which will specifically target the needs of this population and will also link into our medicines management component. People with diabetes are major consumers of healthcare services, so any additional nursing resources that can help prevent hospital admissions and improve patient

Figure 1. Flow diagram of the model used to plan and set up the managed care service.



outcomes must be welcomed. However, as an initiative directed from the DoH, there are challenges that our local health community must recognise and resolve in order to prevent duplication of effort and gaps in the diabetes service. The first step is to identify the differences between the managed care nurses and their specialist nurse colleagues, and the diabetes service will be used to demonstrate this.

Managed care nurses will focus specifically on people over 65 years with chronic diseases, such as diabetes. This will require them to work as informed generalists. This means that the diabetes specialist nurses (DSNs) will play a major role in advising and supporting managed care nurses, as they know the disease progression, influencing factors, treatment options and aims of management in the detail required.

As the DSN team have been established in our health community for the past 10 years, they have already developed networks among practice nurses and district nurses, have referral guidelines and protocols, and nurse-led initiatives such as clinics, group insulin transfers and education. They have, therefore, developed a structure and related supportive processes for diabetes care and services. This leadership is appropriate, as DSNs are the only group of clinicians whose sole focus is diabetes. Therefore, it is critical for patient care that the managed care nurses are firstly aware of these services, and secondly how to access them. During the workshops previously mentioned, referral criteria and liaison with the DSN team will be made explicit, which is as important for patient care as increasing the knowledge base of the managed care nurses about diabetes itself.

The DSNs already have the skills required of managed care nurses (see Table 2), so there will need to be discussion about gatekeeping, how patients are admitted and discharged from hospital, and where each nursing group's patient care begins and ends. The DSN team have authority and autonomy within the acute Trust, and are seen as clinical experts. The way in which this has been achieved over time will be valuable to share, because if the managed care nurses are to follow the patient

journey into hospital and contribute to their care, their expertise will need to be gained and recognised within this setting.

The potential contribution of the managed care nurses for patients with diabetes is huge. Patients in nursing homes do not access our advice in a timely or appropriate manner. Housebound patients have similar problems as we do not have the resources for home visits, and there are still patients referred to casualty who could have been treated in primary care. If these groups had their diabetes care improved, the benefits would be great. The diabetes team believe that through managed care collaboration and support, more people with diabetes will be able to access and benefit from specialist diabetes services in a more timely and appropriate way.

Conclusion

In conclusion, the above example of the diabetes service is aimed at providing the reader with an insight into the high level of collaboration required from various perspectives, both within the PCT and from external sources, if new and innovative approaches are to be given every opportunity to succeed. We have been very fortunate in the commitment to date across the board. That is not to say that there will not be difficulties to be overcome along the way. Such a view would be naïve in the extreme. If this momentum can be nurtured, however, these new nurses will have the chance to make a difference to the future health outcomes for their patients. ■

Department of Health (1999) *Making a Difference: strengthening the nursing, midwifery and health visiting contribution to health and healthcare*. DoH, London
 Department of Health (2001) *National Service Framework for Older People*. DoH, London
 Department of Health (2000) *The NHS Plan: a plan for investment, a plan for reform*. DoH, London

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1 Differences between managed care and specialist nurses need to be identified to recognise and resolve problems, prevent duplication of effort and identify service gaps.

2 DSNs will play a major role in advising and supporting managed care nurses as they know the disease progression, influencing factors, treatment options and aims of management in the detail required.

3 As the Trust DSN team have been established for 10 years, it is critical that managed care nurses are aware of the services and know how to access them.

4 Through managed care collaboration and support, more people with diabetes will be able to access and benefit from specialised services in a more timely and appropriate manner.

5 A high level of collaboration and commitment is required if new and innovative approaches to care are to be given every opportunity to succeed.

Table 2. Skills a managed care nurse will provide

- a clinician with enhanced skills
- a communicator – liaising with patients, their families, carers, professionals and other care providers
- a case manager and care coordinator
- a champion and advocate for the patient
- a coach – to teach and enable patients, their families and carers to better understand and manage the implications of their condition.