Evercare/ United Health Group Briefing Paper

by

Jane Lethbridge
j.lethbridge@gre.ac.uk
November 2005

Postscript
December 2006

Funded by: UNISON

1. Executive Summary

This is a briefing paper that examines some of the issues raised by the recent involvement of Evercare, part of the US company, United Health Group, in a Department of Health pilot initiative on the use of a case management approach to keep frail, older people out of hospital. The search for more effective ways of addressing the needs of people with long term conditions is helping to focus health and social care services on how to more effective in supporting people to maintain high levels of well-being. It raises wider questions about long term treatment, prevention and ways of promoting healthy ageing. Focusing resources on frail, older people may appear to be cost-effective if it keeps people out of hospital in the short term, but more long term preventive strategies are needed. Several policies that target NHS and local authorities reflect a growing awareness of the need for prevention.

United Health Group is a US for-profit healthcare services company. The care of older people has been one of its main business areas since 1979. It is also diversifying into services that reflect many of global trends in commercialised healthcare, for example, using information technology to check patient eligibility, payments and billing systems, and data management systems for practitioners. The company has a recent history of complaints and legal suits, in the United States, which are still unresolved.

In 2004, United Health Group set up a European wholly-owned subsidiary. The first stage in the United Health Group expansion into the UK has been through the involvement of Evercare in a pilot scheme with the Department of Health, which aims to keep frail, older people out of hospital. There are three key elements of the Evercare programme in England:
- Analysis of data to identify high risk patients
- Redesigning staff roles through a new role of Advanced Primary Nurse (APN) with extended generalist skills
- Organising care around the patient's needs rather than organisational boundaries (Boarden et al, 2005)

Nine Primary Care Trusts (PCTs) have been involved in this scheme, which uses an approach known as case management, which has been defined as the process of "*planning, coordinating, managing and reviewing the care of an individual*" (Department of Health 2000). The aim is to develop cost effective and efficient ways of coordinating services in order to improve the quality of life (Hutt et al, 2004).

The Department of Health provided £73,000 for each Primary Care Trust (PCT) supporting the Evercare model. The cost of UnitedHealth inputs per PCT feasibility study (phase 1) is about £383,000. In addition each PCT has had to find the costs of one full time project manager, a 0.5 information worker and fees for GPs and geriatricians (for mentoring). In total, an extra £455,000 was spent by each PCT involved in the Evercare pilot programme (Boarden et al, 2005).

One of the main issues raised in the project has been whether the Advanced Primary Nurses (APNs) can refer patients to hospital without the authority of a GP. This is one of several issues raised by increasing the scope of nurses in the delivery of healthcare in the community.

The relationship between Evercare projects and community nurses seems to have been more problematic. Boundary issues emerged between practice nurses and district nurses, between district and hospital nursing and between district nurses and Advanced Primary Nurses (APNs). Some nurses perceived the Evercare pilot programme as a criticism of their work. Some considered that although the Evercare project was aiming to improve coordination between different parts of the NHS, "*the appointment of APNs may have complicated relationships in some PCTs*" (Boarden et al, 2005: 110).

Assessment tools are one of the most important parts of US case management approaches. The

assessment tools in the Evercare pilot sites are the property of the UnitedHealth (UHG) business model, and so the company holds the copyright.   Everything that has been done within the Evercare project has United Health Group's copyright on it. The Evercare projects have often been approached by other PCTs interested in the programme but because of the copyright issues, they have been unable to share the tools and experiences. Some PCTs have approached the Department of Health to get clarification on the level of copyright that exists in the agreement for the project (Boarden et al, 2005).

In their conclusion, Boarden et al argue that what Evercare appears to be providing is not new to the NHS. The Evercare model may be carrying out these tasks in a more efficient and targeted way. In this sense, it is valuable in raising interest in case management. The NPCRDC concludes that the value of paying for the expensive replication of the Evercare model is not clear. Adoption of one model could lead to standardisation in a field where new approaches are still needed. There are other international experiences of case management, for example, Germany and Scandinavia, which could usefully be studied (Boarden et al, 2005).

Case management approaches are also being developed within the NHS. There is evidence that practitioners and PCTs, in different parts of England and Scotland, are already involved in developing their own models of care management and sharing practice locally (www.networks.nhs.uk).

The Department of Health is also promoting the concept of the Community Matron as the key to the implementation of case management throughout the NHS. Described by the Department of Health as "*one person, the community matron, acts as both the provider and purchaser of care*" (Department of Health, 2005a). This is an interesting admission that there are times when the purchasing and providing of care benefit from being integrated, reflecting an older model of care provision.

Effective case management depends on good coordination of information and services at local level as well flexibility of practitioners in both health and social care services. All these elements depend on adaptation to local needs and circumstances. There are dangers in allowing commercial companies to provide what looks like a solution in the short term, but hinders the development of flexible approaches in the future.

The issue of copyright of tools and other materials that companies will want to keep provides disincentives for experience to be shared across the NHS. The problems that this will create for the NHS, in the future, must be recognised now.   Already the prospect of competition causes barriers to sharing information at any level. One of the strengths of the NHS has been the ability to draw on the experience of practitioners in different areas, essential for the development of new services. Privatisation of information will threaten this strength.

Postscript
A further study (Gravelle, 2006), commissioned after the interim assessment, which compared 62 Evercare practices, with between 6960 and 7695 control practices across England, also found that there had not been any effect on emergency admissions, emergency bed days or mortality. The study concludes that the Evercare pilots introduced additional services, which may have identified unmet needs, but did not reduce hospital admissions (Gravelle et al, 2006).

2. Introduction

This is a briefing paper that examines some of the issues raised by the recent involvement of Evercare, part of the US company, United Health Group, in a Department of Health pilot initiative on the use of a case management approach to keep frail, older

people out of hospital. This development of case management has to be seen in the context of a range of policy initiatives to shape the delivery of primary care services and strategies to promote health and well-being, among older people.

Focusing resources on frail, older people may appear to be cost-effective if it keeps people out of hospital in the short term, but wider preventive strategies are needed. There are several national health reports that highlight the need for more preventive strategies. The Wanless Report argues for public health action, to keep control of health spending (HM Treasury, 2004). The White Paper "Choosing Health", published in November 2004, attempts to increase the participation of the population in public health strategies. The National Service Framework for Older People (2001) stressed the importance of health promotion and recommended three main types of health promotion initiatives for older people:

- Improving access to mainstream health promotion and disease prevention programmes;
- Specific health promotion activities reflecting different cultural needs;
- Multi-sectoral initiatives that promote the wider well being and independence of older people to address e.g. housing, public transport, lifelong learning (Standard 8, National Service Framework for Older People, 2001)

An (2004) Audit Commission report 'Promoting Well-being and Independence with Older People' recommended strategies to increase well-being in older people.

The government recognises the key role that local authorities and Social Service Departments can make in promoting health and well-being for older people, which are strengthened when working in partnership with local agencies. The Green Paper on Adult care 'Independence, Well-being and Choice' published in March 2005 outlines a vision for social care which includes "*an emphasis on preventing problems and ensure that social care and the NHS work on a shared agenda to help maintain the independence of individuals*" (DH, 2005b:9). As a way of stimulating good practice, the 'Partnerships for Older People Projects (POPP)', due to start in 2006, will focus specifically on prevention at local level and reducing emergency admissions for older people (DH, 2005c). £60 million is being made available for this scheme which aims to improve the health, well-being and independence of older people through promoting better coordination of care and encouraging investment in preventative approaches (Kaur, 2005). The White Paper on Health and Social Care Services, due to be published at the end of 2005, will deal with the provision of care outside hospitals.

As this list shows, there are a wide range of government policies and initiatives that aim to improve the health of older people, as well as improving systems of assessment so that needs of older people can be met more effectively in the community.   Any initiative that addresses a specific dimension of care for older people will have to be evaluated in relation to other initiatives so that there is no duplication or overlap of services.

The World Health Organization (WHO) is also promoting the concept of 'active ageing' which increases the opportunities for health, participation and security to improve the quality of life as people age. This requires action by all sectors – health, social services, education, planning and recreation (WHO, 2002).

This paper has the following objectives:
- To profile the United Health Group and its ways of operating including Evercare work with older people;
- To highlight key points of the King's Fund review of evidence of case management;
- To provide key points from the independent evaluation of the Evercare pilots programme;
- To highlight examples of good practice being developed from within the NHS e.g. Castlefields, Runcorn;
- To compare NHS good practice examples with the results of the Evercare pilot evaluation;
- To outline some of the problems of focusing solely on vulnerable older people;
- To outline arguments supporting the need to coordinate services and balance other prevention strategies to promote the health of older people.

3. United Health Group and Evercare

United Health Group is a US for-profit healthcare services company. Its development, since it was founded in 1977 as the United HealthCare Corporation, shows that the care of older people has been one of its main business areas. In 1979, it introduced the first network based health plan for older people, one of the first private alternatives to Medicare. In 1998, United Health Group entered into a 10 year contract to provide health insurance products and services to members of AARP (the American Association of Retired People). These products and services supplement benefits provided under Medicare (www.unitedhealthgroup.com).

In 1984, United HealthCare Corporation became a publicly traded company. The current President/ Chief Executive Officer, William McGuire, was appointed in 1989 and has led the recent expansion of the company.   He received $54 million from cashed-in stock, bonuses and salary in 2001 (The Bulletin's Frontrunner June 21, 2001).

The current business areas are:

Business area	Activities
United Health Care	• Health benefit plans for small and medium sized companies – fully insured or self-funded basis
Ovations	• Medicare supplements and hospital indemnity programmes for AARP * • Health and well-being programme e.g. pharmacy discount care, pharmacy mail services • Care for frail, older people with chronic disease through Evercare
Ameri-choice	• Network based services for beneficiaries of state sponsored healthcare programmes • Health plan management services for government agencies and health care organisations
Uniprise	• Health benefits giving access to United Healthcare networks of physicians, clinics and hospitals
Specialised Care Services	• Services including mental health services, occupational health, access to transplant services, oncology, health diseases, and neonatal services, physical therapy and alternative services
Ingenix	• Healthcare data analysis – including data tools, publications, research and education

* American Association of Retired People (AARP)
Source: United Health Group 10K, 2004

Perhaps one of the most significant changes, in the last decade, was when the company changed its name from the United HealthCare Corporation to the United Health Group. It reorganised the company into separate but strategically linked business areas. The company has expanded into business areas that complement the provision of health insurance and healthcare services. These services and products reflect many of global trends in commercialised healthcare (Pollock, 2004; Lethbridge, 2005). They can be considered as different stages of a vertically integrated industry. The key stages include insurance schemes to provide financing to cover the costs of healthcare, and information technology used to check patient eligibility, payments and billing systems, data management systems for practitioners, as well as access to healthcare services through doctors and other healthcare professionals.   The company employs 40,000 people in the United States (United Health Group 10K, 2004). Annual revenues showed an increase in 2004 which was due to the acquisition of two health insurance companies, Oxford Health Plans and Mid Atlantic Medical Services.

Table 1: United Health Group revenues 2000-2005 ($million)

	2004	2003	2002	2001	2000
Revenues	$37,218	$28,823	$25,020	$23,454	$21,122

Source: United Health Group 10K 2004

Ovations is the second largest division, in terms of revenue. It provides services for people aged 50+, including supplementary benefits for members of the American Association of Retired People (AARP), access to pharmacy discount schemes, and care for frail older people, through the Evercare programme. Evercare aims to help stop frail older people being admitted to hospital. It was set up originally in 1987 by two nurse practitioners, as part of a Medicare Pilot project in Minnesota. The initiative grew into Lifecare Inc. and was eventually taken over by United Health Group in 1999. The programme works almost solely with people in nursing homes rather that people living in the community.

United Health Group is gradually providing a much wider range of products than health insurance and healthcare. It is positioning itself as a healthcare company that aims to improve the healthcare system. It describes its mission as "*dedicated to making the health care system work better*" which makes it appealing to other national healthcare systems that are involved in health sector reform. The company also stresses its role in "*designing products, providing services and applying technologies*". The significance of applying technologies lies not just in the use of high technology treatments for patients but in using technology to maintain control over payments, billing and eligibility of patients to healthcare.

The company has a recent history of complaints and legal suits made under two US laws: the Employees Retirement Income Security Act (ERISA), a US federal law that sets minimum standards for retirement and health benefit plans in private industry; and the Racketeer Influenced and Corrupt Organizations Act (RICO), which is used for civil claims by individuals injured in business or property by companies involved in corruption or illegal activities.

In January 2005, the U.S. Supreme Court reaffirmed the class action status of a lawsuit brought by thousands of doctors claiming HMOs wrongly denied them fees for services rendered. The case, filed under the RICO legislation, alleges that a number of managed care companies, including United Health Group, WellPoint and Humana, use a reimbursement coding system that routinely denies doctors payment for patient services. The court rejected "*without comment an appeal brought by UnitedHealth Group, which alleged that the 11th U.S. Circuit Court of Appeals was too lenient in allowing the action to be certified last fall as a class action suit*" (CBS Marketwatch 10 January 2005).

In 2004, United Health Group set up a European wholly owned subsidiary, whose mission is "*to help European health services improve patient care*". The Chief Executive Office is Richard Smith, until recently editor of the BMJ. The European President is Simon Stevens, previously an adviser to the Policy Unit, 10 Downing Street. The Chief Operating Officer is Gail Marcus who had 20 years of working in healthcare and pharmacy management companies, including CIGNA, a large US health insurance company (www.unitedhealthgroup.com).

The first stage in the United Health Group expansion into the UK has been the involvement of Evercare in a pilot scheme with the Department of Health, which aims to keep frail, older people out of hospital. There are three key elements of the Evercare programme in England:

- Analysis of data to identify high risk patients
- Redesigning staff roles through a new role of Advanced Primary Nurse (APN) with extended generalist skills
- Organising care around the patient's needs rather than organisational boundaries (Boarden et al, 2005).

Nine Primary Care Trusts (PCTs) – Airedale, Bexley, Bristol North, Bristol South and West, Halton, South Gloucestershire, Walsall and Wandsworth – have been involved in this scheme, which uses an approach known as case management. The term case management has been defined as the process of "*planning, coordinating, managing and reviewing the care of an individual*" (Department of Health 2000). The aim is to develop cost effective and efficient ways of coordinating services in order to improve the quality of life (Hutt et al, 2004). The concept originates from social care where the aim is to avoid long term institutional care.

There are two other case management pilot schemes in England that draw on US experience. The Department of Health is also working with Kaiser Permanente, a US non-profit healthcare company, to try and reduce the length of time that patients spend in hospital by providing more services in the community. PCTs in Blackpool, Eastern Birmingham, East Sussex, Lincolnshire South West, Northampton, St Albans, Taunton Deane and Torbay are involved in this pilot scheme (Boarden et al, 2005).

On a smaller scale, Haringey PCT is working with Pfizer Health Solutions, a subsidiary of the pharmaceutical company, Pfizer, to set up a new call centre. This is staffed by nurses. They phone patients with long term chronic conditions, for example, heart disease or diabetes, and try and encourage them to live healthier lives and take their medication. All these schemes are trying out different ways of addressing the needs of people, mainly older people, with chronic conditions (Boarden et al, 2005).

It is useful at this point to consider the meaning of the term "*frail, elderly people*" because it covers several groups within the older population. The British Geriatrics Society defines (2005) frailty as a "*state when there are multiple conditions, particularly in*

advanced old age where physiological reserves are limited and where social and economic adversity is common". Some may have long term illnesses and multiple conditions. People may "*move in and out of frailty*". Frail people may live in their own homes or in a care home. Recent policy has attempted to limit the use of acute care by older frail people but they also need other services, such as rehabilitation and end-of-life care. The focus has to be on the whole person rather than on one aspect of care, supported by well coordinated services (British Geriatric Society, 2005).

This holistic approach needs to be remembered when using the Department of Health's analysis of the care needs of people with long term conditions (Department of Health, 2004). The majority of patients (70-80%) with long term conditions need a mix of self-care support and management. A small percentage are high risk patients who require more active management of their conditions by specialist nurses and nurses in general practice.   A further small percentage of patients with highly complex conditions will need case management so that their needs are identified and met by an integrated team of practitioners (DH, 2004). These groups are not mutually exclusive. A frail older person may still continue with self-care when requiring management of multiple conditions.

4. Key points from King's Fund review of evidence

Although the concept of case management has been used in social care for some time, it is being considered with new enthusiasm within the NHS. The King's Fund reviewed available research on the effectiveness of case management and published the report "*Case Managing Long term conditions What impact does it have in the treatment of older people*? (Hutt, Rosen and McCauley, 2004). The study found that case management requires:
- Individual practitioners;
- Systems to support case management – IT training, supervision;
- Processes to support patient centred care;
- Services available in the system to meet needs identified through assessments.

The studies considered in this review, had many different goals but most included home visits and some on-going re-assessment or evaluation. The intensity and type of case management varied. Most of the case managers were registered nurses. In one case a social worker was a case manager and in several cases a combination of the two. They generally had extensive experience in either chronic disease management or the care of older people. In US reviews of case management, assessment is a key element, whether managing access to services, coordinating care from different providers or in chronic disease management (Hutt el al, 2004).

The review found that there were several criteria used for choosing patients, which suggests that the aims of case management are varied and also making it difficult to draw definitive conclusions about case management models. There were three main

criteria for entry into a case management programme. Level of dependence was used to predict patients who would benefit from case management to prevent them from needing residential care or hospital admission. Recent hospital admission was also used to identify people suitable for case management. Membership of a population group or specific service use group was also used to identify people for case management. Sometimes, a combination of these three approaches was used (Hutt et al, 2004).

The authors emphasise the diversity of case management approaches and recommend that the NHS should build up an evidence base of case management experience because it is unlikely that one model will fit all Primary Care Trusts (PCTs). There a need to clarify which population case management programmes will target. This will then inform decisions about development and the services needs to support needs assessment. Local discussions are needed about whether existing systems can be used or whether new systems need to be put into place (Hutt et al, 2004).

The King's Fund review also recommended that case management should be developed in close collaboration with social care providers so that a wide range of health and social care services are available. People with less severe illness, but who have health and social care needs, also require access to services. The changing use of health services (including primary care) and patient satisfaction that result from case management programmes need to be key criteria in any evaluation (Hutt et al, 2004).

The King's Fund review shows that there are many different models of case management using different criteria for entry and often having different objectives. This is significant in considering the evaluation of the Evercare pilot sites because it suggests that flexibility in developing case management is important if the NHS wants to maximise the potential of this approach.

5. Evercare pilot evaluation

The National Primary Care Research and Development Centre (NPCRDC) [1] are carrying out an independent evaluation of the Evercare pilot scheme. It will be referred to in this report as Boarden et al, 2005. An interim evaluation report was published in February 2005. The final evaluation will be completed in 2006. An outline of the methodologies used in this evaluation can be found in Appendix A.

The interim evaluation report found overall that the Evercare approach provides a way of finding vulnerable older people in some cases those who had not been identified by other agencies already. It also provides some preventive health care, responds quickly to

---

[1] (Universities of Manchester and York, Manchester Business School, Sheffield Institute for Studies into Ageing (SISA), University of Sheffield.).

deteriorations in health and provides scope for organising care around patients' needs (Boarden et al, 2005). The quantity of care delivered to patients had increased, which includes the new assessment process done by the Advanced Primary Nurses (APN). One of the respondents thought that there was less face-to-face contact between the patient and the GP although the Advanced Primary Nurse (APN) does many tasks in cooperation with the GP.

5.1.   Patient satisfaction

Interviews with project Advanced Primary Nurses (APNs) suggest that patients are receiving more and better-coordinated primary care with greater interpersonal elements. Evercare nurses report positive outcomes for their patients, especially improvements in "quality of life" (Boarden et al, 2005).

In 2004, the United Health Group commissioned Picker Institute (Europe) to survey patient and career satisfaction in the Evercare sites in England. A majority of patients and carers showed favourable responses to the Evercare project. However, health survey results in the UK usually show high rates of satisfaction, more generally (Boarden et al, 2005). The interim evaluation looked at the 2004 National Patient Survey data for seeing a nurse and a GP and found that, for similar questions, the Evercare results were not necessarily much higher than the National Patient Survey results. However, it is not possible to say whether these differences were statistically significant without having access to the specific dataset from the National Patient Survey.

5.2.   Hospital Episode Statistics (HES)

The evaluation of Evercare in the US, by Kane et al (2003), was conducted for patients living in care homes, not living in the community. This is a different population to the one involved in the Evercare projects in England, where almost all patients live in the community. The NPCRDC interim evaluation does not have enough data to assess how well the Evercare criteria identified people at high risk of emergency admission or the impact of the Evercare intervention on the specific cohort of patients. However, the interim evaluation did use Hospital Episode Statistics (HES) to try and estimate the likely impact of Evercare on overall hospital admission numbers and bed occupancy (Boarden et al, 2005).

(Boarden et al, 2005) identified patients who had had two or more emergency admissions in 1997/8 and then tracked subsequent emergency admissions over the following 5 years for patients aged 65+. They identified a cohort of 227,206 Evercare eligible patients and also looked at the pattern of hospital admissions for age groups 75+, 85+ and 65-74 and 75-84 (Boarden et al, 2005).

The results shows that, rather than increasing with age, the admissions of older people with a history of two or more unscheduled hospital admissions declined with time. The results are similar, whether the Evercare eligible cohort is for 1997/8 or for 2001/2. This shows that the predictive value of two or more admissions as a risk factor for future hospital admissions is poor (Boarden et al, 2005:100). If the Evercare and other case management programmes are assessed/ monitored by the falling numbers of admissions, this cannot be completely attributed to the interventions, because the numbers would have dropped anyway.   These results apply to all the case management programmes, and do not given any indication of the health effects of these interventions.

The US evaluation of Evercare reported a reduction of admissions to hospital. However, intensive home nursing was available to enrolled patients when they became ill (called Intensive Service Days). In the US evaluation, the sum of Intensive Service Days and hospital admission days were the same in the Evercare group and the two comparator groups, suggesting that the Intensive Service Days acted as a substitute for hospital admission days (Boarden et al, 2005:103).

5.3.   Costs

The Department of Health provided £73,000 for each Primary Care Trust (PCT) supporting the Evercare model. The costs of UnitedHealth inputs, per PCT feasibility study (phase 1), are about £383,000. In addition each PCT has had to find the costs of one full time project manager, a 0.5 information worker and fees for GPs and geriatricians (for mentoring). In total, an extra £455,000 was spent by each PCT involved in the Evercare pilot programme. This represented between 1.81% (Wandsworth PCT) and 4.56% (Airedale PCT) of expenditure on primary medical services. If this is measured as a percentage of NHS funded nursing care in nursing homes, it was between 14.4% (Bristol North PCT) and 38.5% (Bexley PCT) (Boarden et al, 2005:105).

Cambridgeshire PCT and PCTs in Cornwall felt that the UnitedHealth management costs were too high. These projects have developed in a different way without United Health Group management input. The Cornish PCTs has grouped together to set up the **Eldercare project in Cornwall (EPIC),** which has developed it own assessment tools (Boarden et al, 2005).

5.4.   Involvement of other practitioners

General practice participation in the Evercare projects has been on a voluntary basis. Some practices with high levels of hospital admissions have been willing to take part but responses by GPs to the project varied. There were fears about loss of control of decision-making, increased workloads and whether it would lead to rationing of secondary care (Boarden et al, 2005).

One of the main issues raised in the project has been whether the Advanced Primary Nurses (APNs) can refer patients to hospital without the authority of a GP. This is one of several issues raised by increasing the scope of nurses in the delivery of healthcare in the community. Geriatricians in several NHS Trusts have been more positive and supportive of APNs (Boarden et al, 2005).

The relationship between Evercare projects and community nurses seems to have been more problematic. Boundary issues emerged between practice nurses and district nurses, between district and hospital nursing and between district nurses and Advanced Primary Nurses (APNs). Some nurses perceived the Evercare pilot programme as a criticism of their work. Some considered that although the Evercare project was aiming to improve coordination between different parts of the NHS, "*the appointment of APNs may have complicated relationships in some PCTs*" (Boarden et al, 2005:110).   Respondents felt that active involvement of other part of the NHS and other sectors was important for the success of case management.

5.5.   Intellectual property

There have been variants of the Evercare approach adopted by other PCTs and Boarden et al (2005) suggest that this indicates that the case management approach is meeting needs identified within the NHS. Case management uses resources for primary and community care, which PCTs are in a position to manage directly (as opposed to those of Trusts and Foundation trusts). This raises questions about how the learning is being shared between the Evercare pilot sites and the rest of the NHS as well as other case management programmes.

Assessment tools are one of the most important parts of US case management approaches. Appendix B compares three assessment tools used by Evercare, the Eldercare Project in Cornwall and one incorporated in NHS guidelines. The assessment tools in the Evercare pilot sites are the property of the UnitedHealth (UHG) business model, and so the company holds the copyright.   Everything that has been done within the Evercare project has UHG's copyright on it. The Evercare projects have often been approached by other PCTs interested in the programme but because of the copyright issues, they have been unable to share the tools and experiences. Some PCTs have approached the Department of Health to get clarification on the level of copyright that exists in the agreement for the project (Boarden et al, 2005).

The case of Bristol shows some of the longer-term problems of one company having copyright over practical tools designed to improve services. Although there has already been some adaptation of the tools in the Bristol sites, one of the Bristol sites wanted to make the tools available to the University of the West of England, which is developing a Masters course for nurses. UHG has refused to make the tools available because nurses from external organisations would be present on the course. A "*mild dispute*" has

developed with UHG. The overall agreement on copyright was made between UHG and the Department of Health but few people at PCT level were aware of the details of the agreement or the implications. The NPCRDC interim evaluation interviewed a project manager who felt the problem with copyright was "*essentially ….. holding us back*" (Boarden et al, 2005:114). UHG has ensured that it will still be able to sell the tools even after the pilot projects are completed. This is an example of how the commercial interests of a company are affecting the ability of practitioners within the NHS to share experiences and learn from each other.

NHS staff involved in the Evercare pilot sites have made study visits to the United States. Although the learning from the exchange visits to the US has been valued, there have also been accounts of UHG playing-off different project sites against each other (Boarden et al, 2005). Once again, this shows how commercial management styles are undermining the solidarity of the NHS by setting groups against each other.

In their conclusion, Boarden et al argue that what Evercare appears to be providing is not new to the NHS. GPs used to visit older people at home but have stopped because of pressure of time and because GPs did not always feel that home visits were useful. Community nurses then took over some of the visits but are now focused more on specific tasks   The Evercare model may be carrying out these tasks in a more efficient and targeted way. In this sense, it is valuable in raising interest in case management. Boarden et al conclude that the value of paying for the expensive replication of the Evercare model is not clear. The management and information management support can be provided in different ways. Other models of case management should also be shared in order to increase innovation. Adoption of one model could lead to standardisation in a field where new approaches are still needed. There are other international experiences of case management, for example, Germany and Scandinavia, which could be usefully studied (Boarden et al, 2005).

6. Good practice within the NHS

Case management approaches are also being developed within the NHS. This is partly the result of national policy initiatives which are encouraging practitioners to develop different ways of managing people with long term conditions. Over 60% of adults have a chronic long term condition.

The NHS Improvement Plan has a section on helping people with long term conditions to live healthy lives. In June 2005, the Department of Health published '*Supporting People with long term conditions, an NHS and social care model to support local innovation and integration*". Self care is being encouraged as part of the National Service Framework for Long Term Conditions.

The Department of Health is also promoting the concept of the Community Matron as the key to the implementation of case management throughout the NHS. A Community Matron is described by the Department of Health as "*one person who acts as both provider and procurer of care*" (Department of Health, 2005a). This is an interesting admission that there are times when the purchasing and providing care benefit from being integrated, reflecting an older model of care provision.

The actual role of community matrons was outlined in the 'Supporting People with long term conditions' (2005a) after being mentioned in the NHS Improvement Plan (2004). The Department of Health expects the community matron to cover roles ranging from needs assessment to agency coordination. They will:

- Identify needs of patients – assessing physical, mental and social care needs;
- Review medication and prescribe;
- Provide clinical care and health promoting interventions;
- Coordinate input from other agencies;
- Teach and educate patients and their carers about signs of crisis;
- Provide information to patients and families so they can make choices about future care;
- Be seen by colleagues across agencies as playing a key role for patients with "high intensity needs" and also by patients and their families/ carers. (Department of Health, 2005a)

Community Matrons are similar to the Advanced Primary Nurse that plays such a key role in the delivery of the Evercare model of case management. Nurses are considered to have a key role to play in delivering different models of care for people with long term conditions. The Department of Health suggests that "*Trusts may consider utilising case management more widely and may recruit community matrons with skills appropriate for different groups*" (DH, 2005a). The focus on one practitioner, where effective care depends on the coordination of a range of services and agencies, can be beneficial if the practitioner coordinates effectively and develops positive relationships with local agencies. However, existing practitioners should also be improving their own coordination and perhaps the presence of a Community Matron may take this responsibility away from them.

Practitioners and PCTs in different parts of England are already involved in developing their own models of care management and sharing practice locally. North East London, Essex Strategic Health Authority (SHA), Surrey and Sussex SHA, the Eldercare Project in Cornwall (EPIC), Bristol and South Gloucester PCTs, and Castlefields Health Centre, Runcorn have all made information available on the www.networks.nhs.uk website. Some use newsletters or regular meetings to share experiences.

In Scotland, the 'Joint Future' Group of the Scottish Executive recommended that the care manager role "*could be fulfilled by social workers, community nurses, occupational*

therapists or other similar professionals, supported by appropriate training". In 1994, the Social Services Inspectorate (SSI) recommended that occupational therapists should be able to move into care management. Stalker and Campbell (2002), in a review of care management in Scotland, found that 9% (164) of the care managers were occupational therapists, about the same percentage as nurses.   Occupational therapists usually lead the community health and social care needs assessment, when someone is in hospital. The needs being assessed will often cover leisure and recreation, social isolation and loneliness, and home and community safety issues, which are all areas in which occupational therapists are centrally involved.

One of the most developed models of NHS case management approach is called 'Unique Care', and operates at Castlefields Health Centre, Runcorn. The initiative is proactive in trying to find people who might need more intensive care and brings both medical and social interventions together. 'Unique Care' also aims to develop the skills of people already involved in a person's care rather than recruiting new practitioners. It emphasises self-management strategies for both the patient and carers.

The table below compares aspects of Unique Care with Evercare. Unique Care has been in existence for longer than the Evercare pilots but the comparison shows that there are significant differences in approach. Some of the most significant differences are in the assessment process, the way in which local practitioners are involved and trained, and the level of coordination between health and social care services.

Table 2: Comparison Unique Care and Evercare

	Castlefields	Evercare
Case finding or screening	All referrals are made to a practice-based 'Unique Care' team. Practices identify high need patients before they are referred for assessment or have to enter hospital. When a patient enters hospital for an acute medical problem, the hospital informs the practice and the Unique Care team of the admission. The nurse and social worker from the Unique Care team visit the hospital to support discharge planning. If the patient leaves hospital after only an overnight stay then the Unique Care team contacts the patient to see if there are any follow up needs.	Analysis of data to identify high risk patients e.g • Unplanned hospital admissions • A&E visits • Outpatient consultations Use of screening tools to identify patients – Evercare tools are based around specific competencies for clinical assessment, clinical risk stratification (a list of danger signs) and guidance on advanced care planning
Criteria	Criteria are agreed locally and may include: • number of chronic diseases; • previous hospital admissions; • social circumstances and; • number of medications	Main criterion – number of admissions to hospital in the previous year GPs referrals on pre-established criteria which were: • Exacerbation of chronic condition in previous 90 days; • More than 2 falls in the previous two months; • Recently bereaved or at risk of medical decline; • Cognitively impaired, living alone, medically unstable and high intensity social care needs.

Assessment	Assessments are made within one working day of the referral and are made jointly between health care and social services.	Assessments made with Advanced Primary Nurse – often working with GPs.
Patient and carer involvement	Wide range of support services and systems proposed to the patient/ family and carers Support for self management strategies	Advanced Primary Nurses have more frequent contact with patients and discuss with patients/ carers treatment options. Initial evaluation found that quantity of care had increased
Care planning	The social worker can put packages of care in place up to a defined level. This means that the 'Unique Care' team can put joint packages of care in place immediately following the assessment.	The Advanced Primary Nurse (APN) is the focus of care. Some issues have arisen about the scope of Advanced Primary Nurse to refer to hospital
Staff development	Existing practitioners were trained and introduced to new skills	Advanced Primary Nurses were recruited, trained and assigned to patients. Some were nurse practitioners already but others were nurses working in community roles. Other staff roles have had to be re-engineered to accommodate the Advanced Primary Nurse role.
Outcomes	The neighbourhood around Castlefields Health Centre, Runcorn, has high levels of deprivation and consequently high levels of hospital admissions for older people. In the second year of the project, the rates of admission of older people to hospital were reduced. The rest of Runcorn, which uses the same services but does not have a Unique Service Team, experienced continued increases in hospital admissions for older people, in line with national trends. However, the length of stay in Castlefields was already lower than surrounding districts and following	More patients identified in need of care but not current known to any agency Increased quantity of care delivered Whether hospital admissions have decreased significantly has still not been properly evaluated.

	the implementation of Unique Care, the rate fell further.	
Costs	The number of beds days saved was considerable and the savings have been estimated at £300,000 (£300 per day). The social services expenditure remained in budget in contrast with to the rest of Runcorn. There was no increased pressure on primary care either through increased home visits or attendance at the health centre. There were no excess residential and nursing home costs.	The Department of Health provided £73,000 for each Primary Care Trust (PCT) supporting the Evercare model. The costs of UnitedHealth inputs per PCT feasibility study (phase 1) is about £383,000. In addition each PCT has had to find the costs of one full time project manager, a 0.5 information worker and fees for GPs and geriatricians (for mentoring). In total, an extra £455,000 was spent by each PCT involved in the Evercare pilot programme

Sources

National Primary Care Development Team **Chronic Disease Management Briefing 'Unique Care'** www.npdt.org

UnitedHealth Europe **Assessment of the Evercare Programme in England 2003-2004**

Boarden R., Dusheiko M., Gravelle H., Parker S., Pickard S., Roland M., Sheaff R., Sargent P. (2005) **Evercare evaluation interim report: Implications for supporting people with long term conditions** 19 January 2005 National Centre for Primary Care Research and Development

7. Conclusion

The Evercare pilot scheme has several implications for nurses, especially community nurses. How community nurses relate to the Advanced Primary Nurse (APN) role and to what extent their jobs will be changed as a result, are two key questions. The increased amount of contact that the APN has with patients will affect the workload of community nurses. How will it affect the relationship between community nurses and their patients? It is not clear how the APN will relate to some of the service coordination between health and social care that is already taking place in many districts.

Nurses involved in the Evercare project will have access to specific tools and resources that may not be shared with other colleagues in different parts of the NHS. How this will affect professional development activities and relationships in the short and long term will have to be monitored. The issue of copyright, which has emerged in the evaluation of the Evercare pilots, shows how knowledge is being privatised within the NHS. More practitioners need to be aware of the longterm implications of private companies being involved in development work in the NHS.

Effective case management depends on good coordination of information and services at local level as well flexibility of practitioners in both health and social care services. All these elements depend on adaptation to local needs and circumstances. There are dangers in allowing commercial companies to provide what looks like a solution in the short term, but hinders the development of flexible approaches in the future. The National Primary Care Research and Development Centre interim evaluation recommends that other models of case management should be examined before any specific models are recommended for the NHS. PCTs need to be able shape their own programmes that address the needs of their local population and draw on several national policy initiatives that promote the well being of an ageing population.

There is also evidence that the NHS can deliver models of case management more effectively and cheaply. The example of 'Unique Care' (Castlefields, Runcorn) shows how models developed in the NHS can work more sensitively with local providers and stakeholders. The criteria for entry into the Unique Care programme were established through consultation with local stakeholders.   The work that had already taken place to

bring health and social care services together has become the foundation for this programme. Capacity building is used to build up the skills of existing practitioners rather than introducing a new type of practitioner. The many variations of case management, which were highlighted by the King's Fund review of evidence, suggest that the NHS can benefit from this approach but needs to remain open to innovation from all parts of the UK. This is being encouraged by the Department of Health.

The issue of copyright of tools and other materials that private companies will want to keep, creates disincentives for experience to be shared across the NHS. The problems that this will create for the NHS, in the future, must be recognised now.   Already the prospect of competition causes barriers to sharing information at any level. One of the strengths of the NHS has been the ability to draw on the experience of practitioners in different areas, essential for the development of new services. Privatisation of information created in developmental work will threaten this.

8. Questions to ask at local level

When new initiatives are being promoted by the private sector at local level there are several questions that practitioners need to ask:

1. In what conditions or circumstances have the initiatives been used before?
2. Are the circumstances directly comparable?
3. What are the differences?
4. What independent evaluation has been conducted on the model/ initiative?
5. What are the costs of the initiative?
6. Where will funding come from – existing NHS budgets and/or external sources?
7. Will additional staff be required?
8. What are the implications for existing staff roles and jobs?
9. What ownership does the PCT /Trust have on any resources/ tools/ materials developed in the project?
10. Is there a copyright agreement?
11. What scope will there be to share experiences and learning from the initiative?
12. How will the initiative be evaluated?

9. Postscript December 2006

9.1.   Evaluation

The interim assessment of the Evercare programme in 2003–4, found that although patients and carers felt that there had been improvements in quality of care, there had not been any impact on hospital admissions. A study, commissioned after the interim assessment, which compared 62 Evercare practices, with between 6960 and 7695 control practices across England, also found that there had not been any effect on emergency admissions, emergency bed days or mortality. The study concludes that the Evercare pilots introduced additional services, which may have identified unmet needs, but did not reduce hospital admissions (Gravelle et al, 2006).

9.2.   Court challenge

In March 2006, a Parish Councillor, Pam Smith, from Cresswell and Langwith in Derbyshire, challenged NE Derbyshire PCT in its decision to award a contract to run the local GP services to United Healthcare Europe. She argued that the PCT had failed to involve and consult local people who would use the service, under S.11(1) of the 2001 Health and Social Care Act. Although Pam Smith lost the first stage in the case, on a technicality, the court ruled that the public should be consulted on outsourcing of NHS services (KONP, 2006). On appeal in August 2006, Pam Smith was successful in her challenge and the judges ordered NE Derbyshire PCT to start the tendering process for the services, from the beginning (KONP, 2006). This is a very significant case and supports the right of local people to be consulted.

9.3.   New contract

Although the loss of the case for United Health Group could be considered a setback, in October 2006, United Healthcare Europe was awarded a five year contract to run a GP practice in Normanton in Derby (Unison, 2006). It is one of the first Alternative Provider Medical Services (APMS) contracts, which allow PCTs to contract out the running of primary care services to a wide range of provider organisations.

10.   References

Audit Commission (2004) <u>Older people – independent and well-being: the challenge for public services</u> London: Audit Commission

Boarden R., Dusheiko M., Gravelle H., Parker S., Pickard S., Roland M., Sheaff R., Sargent P. (2005) <u>Evercare evaluation interim report: Implications for supporting people with long term conditions</u> 19 January 2005 Manchester: National Centre for Primary Care Research and Development (NPCRDC)

British Geriatric Society (2005) <u>Geriatricians and the management of Long term conditions</u> Report of the Primary and Continuing Care Special Interest Group of the British Geriatrics Society, February 2005

BMJ Online (2006) Case Management for elderly people in the community BMJ,doi:10.1136/bmj.39027.550324.47 published 15 November 2006 www.bmj.com

Department of Health (2001) <u>National Service Framework for Older People</u> London: London: Department of Health www.dh.gov.uk

Department of Health (2004) <u>Choosing Health</u> London: Department of Health www.dh.gov.uk

Department of Health (2005a) <u>Supporting People with Long term conditions</u> London: Department of Health

Department of Health (2005b) <u>Independence, Well-being and Choice</u> Green Paper March 2005 London: Department of Health

Department of Health (2005c) <u>Older people to receive personalised care</u> Press release 8 November 2005

Gravelle H., Dusheiko M., Sheaff R., Sargent P., Boaden R., Pickford S., Parker S., Roland M. (2006) Impact of case management (Evercare) on frail elderly patients: controlled before and after analysis of quantitative outcome data <u>BMJ Online</u> BMJ,doi:10.1136/bmj.39020.413310.55 published 15 November 2006 www.bmj.com

HM Treasury (2004) <u>Wanless Report Securing Good Health for the Whole Population</u> Final Report London: H.M. Treasury

Hutt R., Rosen R., McCauley J. (2004) Case Managing Long-term Condition What impact does it have in the treatment of older people? London: King's Fund

Kane R.,Keckhafer G., Flood S., Bershadsky B., Siadaty M., (2003) The effect of Evercare on hospital use Journal of the American Geriatric Society 51:1427-34 – quoted in Hutt et al, 2004

Kaur R. (2005) Partnerships for Older People Projects A Policy Perspective Presentation given on 18 March 2005 Older People and Disability Division, Department of Health http://www.dh.gov.uk/assetRoot/04/10/82/16/04108216.ppt

Keep Our NHS Public (2006) Pensioner Boasts Patient Power in High Court Press release www.keepournhspublic.com

Keep Our NHS Public (2006) Pensioner Wins GP Privatisation Battle at Court of Appeal Press release www.keepournhspublic.com

Lethbridge J. (2005) The Promotion of Investment Alliances by the World Bank Global Social Policy 5(2):203-225

National Primary Care Development Team (2004) Unique Care Chronic Disease Management National Primary Care Development Team www.npdt.org

Pollock A. (2004) NHS plc London: Verso

Social Services Inspectorate (1994) Occupational therapy: the community contribution. London: HMSO

Stalker K, Campbell I, 2002, Review of Care Management in Scotland Edinburgh: Central Research Unit, Scottish Executive

UNISON (2006) Company Briefing October 2006, November 2006 www.unison.co.uk

United Health Group (2004) 10K Annual Report Securities and Exchange Commission (SEC): Washington DC

World Health Organization (2002) Active Ageing: a policy framework A contribution to the Second United Nations Assembly on Ageing, Madrid, Spain, April 2002 Geneva: World Health Organization

Newspapers

CBS Marketwatch 10 January 2005
The Bulletin's Frontrunner June 21, 2001

10.1.   Appendix A: Methodologies used in the NPCRDC evaluation

The National Primary Care Research and Development Centre (NPCRDC) evaluation has used several methodologies (Boarden et al, 2005).

- Field work in the US to understand the Evercare model – to understand how it is influenced by origins and how it has changed in its move to England
- Interviews with DH and other policy makers an NATPAT road show
- Exploratory case studies of 10 Evercare sites – involving interviewing key informants, analysis of grey documents and analysis of DH and NPCRDC data
- Published materials
- Collection of instruments and tools used by English Evercare sites

10.2.   Appendix B: Review of Assessment Tools

An important part of the case management approach is the use of assessment tools that enable nurses and other healthcare practitioners to identify older people at risk.   The interim evaluation compared three sets of assessment tools, Evercare, Eldercare Project in Cornwall (EPIC) and Brent (NHS guidelines), which all guide a practitioner through an assessment of clinical needs and risks. The Evercare tools are based around specific competencies for clinical assessment, clinical risk stratification (a list of danger signs) and guidance on advanced care planning. There are limited guidelines for medication but does not include commonly used drugs for hypertension and angina.

The tool used by EPIC (Eldercare Project in Cornwall), involving three PCTs in Cornwall and working with people aged 75+, include a standardised patient interview supported by a set of standard clinical instruments and scales covering mental and physical health. These are supported by aids for care planning in several contexts with some guidance on medication reviews.

The Brent tool is a standard implementation of a Department of Health approved overview assessment tool, called the Functional Assessment of the Care Environmental for older people FACE instrument. It fulfils national requirements, as set out in the National Service Framework for Older People, and can be used to trigger a more detailed assessment.

Each of the three tools aims for competent clinical assessment but uses different processes. The Evercare tool defines clinical competencies, the EPIC tool helps clinical assessment and care planning and the Brent tool provides overview assessment using national guidelines. The NPCRDC found that the Evercare tool was the "*least clearly defined of all three assessment processes and appear to rely mostly on the clinical judgement of the trained assessors*" (p.87). At the moment there is little evidence to show which tool would be more effective in reducing the number of unplanned hospital

admissions of older people. However how the tools are used and shared with practitioners is significant.

Source: Boarden et al, 2005