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Editorial

Case management of chronic diseases and long-term conditions: make haste slowly

The management of long-term conditions and chronic diseases is the main challenge for primary care, worldwide (Bodenheimer *et al*., 2002a). Individuals with long-term conditions consume a large proportion of health and social care resources, including 60% of hospital bed days in British hospitals (Department of Health, 2004), and 78% of all health care spending in the USA. It is estimated that 17.5 million adults in the UK are living with a chronic disease and that the incidence of chronic diseases and disabilities (long-term conditions) among those aged over 65 will double by 2030 (Department of Health, 2004; 2005).

Clinical practitioners in Britain may be wary of systematic approaches to a whole population group like those with chronic conditions, given the failure of population screening for untreated morbidity in older people. Not only did the '75 and over checks' introduced in 1990 have little discernable impact on the health of older people (Iliffe *et al*., 1999), but the recent Medical Research Council (MRC) trial of screening older people showed no benefits from such screening (Fletcher *et al*., 2004). Neither general practitioners nor specialists in care of older people performed well in the MRC trial, suggesting that medical management of problems revealed by screening is essentially ineffectual. Nevertheless, the belief that screening could prevent functional impairment in older people has had an enduring appeal to researchers, politicians, clinicians, and older people themselves, and the accumulating evidence against the value of whole population screening is not going to extinguish this enthusiasm for intervention. Nor should it, since there is some evidence from studies in the USA that *targeted* needs assessment of older people followed by active management may improve both survival and functional ability (Stuck *et al*., 2004).

In North America comprehensive geriatric assessment with subsequent systematic management reduces hospital admission rates (Stuck *et al*., 1993), and models of chronic disease management have evolved (Bodenheimer *et al*., 2002b) to exploit this impact and contain care costs for an ageing population. Whole systems approaches in the USA, using case management methods (Wagner, 1998; Dixon *et al*., 2004), have been championed as a means of ensuring continuity of care, improving patient outcomes and achieving efficient management of resources (RCP *et al*., 2004; Department of Health, 2004; 2005). The core elements of any case management activity are: identification of individuals likely to benefit from case management, assessment of the individuals' problems and need for services, care planning of activities and services to address the agreed needs, referral to and co-ordination of services and agencies to implement a care plan, and regular review, monitoring and consequent adaptation of the care plan.

The National Health Service (NHS) is being encouraged to embark on a chronic disease management programme built around fostering self-management, enhancing disease management in primary care, and introducing case management for individuals with complex problems who make high use of hospital services (Department of Health, 2004). The Royal Colleges of Physicians and of General Practitioners and the NHS Alliance have endorsed this programme and have made proposals for joint clinical directorates and clinical governance, across the specialist-generalist divide (RCP *et al*., 2004). Demonstration projects providing care across a spectrum of long-term conditions have developed (Matrix, 2004).

In the UK nurses are seen as the professional discipline with the abilities to carry out and co-ordinate chronic disease management, and chronic

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disease management is seen as one of the three core roles of primary care nurses (Department of Health, 2002). This is logical, since nurses have always been involved with people with chronic diseases through health promotion, patient teaching, direct nursing care and the application of medical treatments. The current expectation that nurses will take greater responsibility for the day to day care for people with chronic diseases, long-term disabilities, and complex needs is only an extension of a familiar role. This expectation is expressed in England by the drive to appoint 3000 'community matrons' to support people with complex long-term conditions using case management techniques, by 2007 (Department of Health, 2005). Their task will be to identify need, achieve continuity of care, promote coherence of services, and review the quality of the care provided (Drennan and Goodman, 2004).

Is this new approach to health care a decisive breakthrough in person-centred service provision, and are new case management roles for nurses in the community likely to be welcomed, effective, and worthwhile? Whilst there are good reasons for exploring the potential for nurse-led case management, we should be cautious about the political emphasis given to chronic disease management and expectations of nurse-led case management within it. Chronic disease management remains problematic as a model of care, with evidence from the USA of limited effectiveness, reliance on traditional forms of patient education, poor linkages to primary care, and dependence on referrals rather than active case-finding approaches (Wagner *et al.*, 2002). In the UK primary care organizations should be able to overcome some of the negative features of American experience, simply because we still have an integrated and resourced system of primary care, with a relatively influential discipline of public health. But we may not be able to overcome them all, for a number of reasons.

First, there is some doubt about whether chronic disease management is wanted by all patients. Patient priorities may differ from those of NHS managers and clinicians (LMCA, 2004), and older people may feel that their independence and autonomy is threatened by an intrusive care system (Drennan *et al.*, 2003). Nurses involved in public health drives like influenza immunization, or disease management tasks like diabetes and Chronic Obstructive Pulmonary Disease (COPD) care will have experienced the scale and persistence of resistance in people with long-term problems.

Second, there is the problem of how to identify those who are likely to need high levels of care, for there is no linear and unambiguous link between the presence of a condition that can be labelled chronic and the need for health or social care (De Lepeleire and Heyrman, 2003). Patients with multiple emergency admissions ('frequent fliers') are often identified as a high risk group for subsequent admission and substantial claims are made for interventions – like case management – designed to avoid such admissions. However, simply monitoring admission rates cannot assess the effectiveness of case management, since admission rates fall without any intervention (Roland *et al.*, 2005). Promotion of case management on the basis of before and after comparisons of admission rates is, therefore, reliant on potentially flawed evidence.

Third, case management as a technique is not a single or simple entity, there being several different types which require different types of work organization, demand different skills, and respond to different needs. For example, there are traditional forms of case management based on discipline or clinical speciality, like district nursing; social services led care management, involving nurses; specialist nurses supporting people with particular diseases or conditions, like heart failure or COPD nurses operating out of hospital departments or practice nurses focussing on care of patients with diabetes or asthma; and specialist nurses for the case management of people with multiple conditions. They are all carrying out different levels of case management work, but they are not necessarily interchangeable.

Finally, nurses may not be the best professionals to carry out chronic disease management as currently understood, despite the historic role of the discipline and the attractive logic of extending nursing roles. Studies that have compared nurse-led case management with case management led by other disciplines provide mixed evidence as to whether nurses achieve equivalent or better outcomes. Invariably, the studies lack detail about the nursing contribution, their exact roles, activities, and the expertise used (Bodenheimer and Macgregor, 2005; Cullum *et al.*, 2005). There is, therefore, an urgent need to study the actual content of case management activities, and to mount the comparative studies that will reveal the optimal

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configurations of competencies for chronic disease management in its different forms.

The current policy emphasis on chronic disease management will require extensive changes in service provision, significant retraining of staff, and widespread renegotiation of relationships between disciplines and agencies. The opportunities for innovation are huge, and the potential for rigorous evaluation of new approaches to care is great, so both primary care practitioners and researchers will be busy as the 'community matrons' get to work. The risks are equally great, for health service policy could be decided prematurely, so that particular models of chronic disease management are promoted on the basis of superficial assessment, political attractiveness, or organizational expediency. We are at risk of repeating the errors of the '75 and over checks' policy, which took 14 years to undo. Fortunately, both the practice and research communities in primary care seem better prepared for this policy change, and we are probably better positioned to intervene and redirect policy in the light of emerging knowledge than general practitioners were in 1990.

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