The Chronic Care Model - A new approach in DK

Country: Denmark
Partner Institute: University of Southern Denmark, Odense
Survey no: (11)2008
Author(s): Frølich, Anne, Strandberg-Larsen, Martin and Michaela L. Schiøtz

Health Policy Issues: HR Training/Capacities, System Organisation/Integration, Public Health, Long term care, Quality Improvement, New Technology, Prevention, Benefit Basket, Funding / Pooling, Pharmaceutical Policy, Political Context, Access, Remuneration / Payment, Responsiveness

Current Process Stages

1. Abstract

The purpose of this health policy idea is to improve care for people living with chronic conditions. The policy is based on the Chronic Care Model (CCM) which summarizes the basic elements for improving care in health systems at the community, organization, practice and patient levels. The National Board of Health has developed a policy strategy, and the Health Act has been revised. The implementation of the policy is in its early stage, but is expected to have major impact over time.

2. Purpose of health policy or idea

New national strategy for improving chronic care
The health policy described in this report is inspired by the Chronic Care Model (CCM). The CCM summarizes the basic elements for improving chronic care in health systems at the community, organization, practice and patient levels.

The National Board of Health recommends in a strategy paper inspired by the CCM that emphasis should be given to self-management support programs, appropriate organization of the delivery system and the core services delivered, use of decision support tools such as guidelines and disease management programs, community participation, and expanded use of health information technology. The purpose of such initiatives is to improve the quality of care for people living with chronic conditions at a cost efficient level. It is recommended by the National Board of Health that these assumptions and specific initiatives are monitored and evaluated. (National Board of Health 2005)

It is recommended that the health care system supports patient self-management by systematic patient education and rehabilitation initiatives. The health care system should be adjusted to support provision of a continuum of services delivered to people living with chronic conditions, with emphasis given to a strong primary care sector. Key elements are regional coordinators, use of non-financial and financial incentives, interdisciplinary health care teams, and general practitioners in a coordinating role. Furthermore it is recommended that case managers are assigned to patients with a poorly controlled condition or for whom special support is needed. Patients should be stratified according to needs, and the diagnosis and state of disease should be reported to clinical databases or registries. Individual disease management programs based on available evidence should be assigned according to
the stratification level of the patient. **Community participation** should involve local authorities, patient associations and voluntary organization to support chronic care and self management. (National Board of Health 2005)

**Incentives to promote implementation of policy ideas**

To support the implementation of the policy ideas financial and non-financial incentives have been introduced (Schiøtz ML et al. In Press):

1) **Financial incentives for the municipalities at the local level of health care delivery**

   The new healthcare act has introduced municipal co-financing (per capita and activity based; see HPM report "Municipal co-payment for health services") for health services provided by the regions. The idea behind the municipal co-financing is to create incentives for municipalities to increase preventative services in order to reduce hospitalisation.

2) **Fee for chronic disease management programs in primary care**

   A financial incentive for general practitioners for delivery of care to type 2 diabetes patients has been introduced. With the fee, the GP is paid an annual rate that covers the single parts of the disease management program. This entails that the annual rate can cover different performances in relation to different patients, because it is the needs of the patient that determine how many control visits the patient should be offered within a year. In relation to the settlement of the annual rates there must be documentation of the patients' visits of the specific disease management program during the past year.

3) **Quality improvement incentives through benchmarking of providers**

   Through clinical databases benchmarking between providers is to an increasing extent possible and is meant to serve as a non-financial incentive to improve quality of care.

**Main objectives**

The main objective of the initiatives is to improve the quality of care for people living with chronic conditions at a cost effective level.

**Type of incentives**

To support the implementation of the policy ideas financial and non-financial incentives have been introduced: 1) Financial incentives for the municipalities at the local level of health care delivery, 2) a fee for chronic disease management programs in primary care, and 3) quality improvement incentives through benchmarking of providers.

**Groups affected**

General practitioners in primary care, health professionals at the local level of care delivery, health professionals working at public hospitals, patients and citizens

---

**3. Characteristics of this policy**

<table>
<thead>
<tr>
<th><strong>Degree of Innovation</strong></th>
<th>traditional</th>
<th>innovative</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Degree of Controversy</strong></td>
<td>consensual</td>
<td>highly controversial</td>
</tr>
<tr>
<td><strong>Structural or Systemic Impact</strong></td>
<td>marginal</td>
<td>fundamental</td>
</tr>
<tr>
<td><strong>Public Visibility</strong></td>
<td>very low</td>
<td>very high</td>
</tr>
</tbody>
</table>
The policy might be able to improve the general quality of delivered health care in Denmark. But it is unclear if the different stakeholders are willing to accept their new roles and tasks to the extent that is needed to meet the challenges of the increasing prevalence rates of chronic conditions and the economical burden on the healthcare system.

4. Political and economic background

Denmark is facing the challenge of macroeconomic restraints and a rise in patients living with chronic conditions, demanding a continuum of services. It has been estimated that about 1.5 million Danish people live with one or more chronic conditions (National Board of Health 2005) and the prevalence is increasing. People with chronic conditions currently account for about 70% of the total costs of health care (National Board of Health 2005). These challenges have lead to an understanding of a need for re-organizing delivery of health care services in Denmark.

Change based on an overall national health policy statement

Implementation of elements from the CCM are in accordance with the overall legislative framework as described in the health act of 2007, and they give particular emphasis to quality and coordination of care. (Strandberg-Larsen et al. 2007a)

5. Purpose and process analysis

Origins of health policy idea

The CCM was originally developed by a Seattle based research group lead by Ed Wagner (Wagner E et al 1998). The model migrated to Denmark since it was seen as a possible way to meet the challenges associated with the increasing number of people living with chronic conditions, the associated costs, and concern of the quality of care provided. The acceptance of the model might be linked both to the fact that it is evidence based and that some healthcare organizations have implemented elements from the model with success, e.g. Kaiser Permanente (KP), a US managed care organization in California (Feachem RG et al 2002; Ham C et al 2003). Kaiser Permanente has received much attention in Denmark. During the last three years about 130 people representing different levels of the Danish healthcare sector and various interest groups have visited Kaiser Permanente. This includes visitors such as the Minister of Health, members of the Parliament and local politicians, groups of health professionals, and administrators. This has started to influence mindsets and policy developments within the Danish healthcare sector (Strandberg-Larsen M et al. 2008).

Initiators of idea/main actors
- Government: The government's role for the policy has been positive and the Minister of Health has been at sight visits to Kaiser Permanente and has strongly encouraged the development and the new approach to chronic care delivery.
- Providers
- Patients, Consumers

Approach of idea

The approach of the idea is described as: new: There is increased focus on organisation of care for chronic conditions. The CCM gives important input on organization of the healthcare system and care management. The primary care sector is seen as an important resource to support high quality care.

Innovation or pilot project

Local level - A project between the Copenhagen Municipality and Bispebjerg hospital was initiated in 2003. The main goal of the project is to improve care in chronic conditions.

Stakeholder positions

The National Board of Health, supported by the Ministry of Health, has taken the leadership for bringing the policy ideas forward. The regional authorities have supported the policy and hold the main responsibility for implementation. The Organization of General Practitioners has to some extent supported the development. Main stakeholders and affected groups are health professionals working at hospitals, general practitioners (GPs) and health professionals employed in the municipalities. Health professionals in hospitals are to some extent reluctant to the idea of the CCM as they are not sure how much their position, influence and working conditions will be affected. Furthermore hospital funding might be affected due to prioritization of building a stronger primary care sector an essential part of the CCM. However, GPs working as private entrepreneurs in the primary care sector are also concerned with the implications of increased regulation and quality monitoring of the sector. Health professionals will to an increasing extend have to comply with clinical guidelines, which might be the biggest challenge for GPs who have been used to a higher level of self governance and professional authority.

Actors and positions

Description of actors and their positions

**Government**
- The Government very supportive strongly opposed
- Ministry of Health very supportive strongly opposed
- National Board of Health very supportive strongly opposed

**Providers**
- Regional Authorities very supportive strongly opposed
- Local Authorities very supportive strongly opposed
- The Organization of General Practitioners very supportive strongly opposed
Influences in policy making and legislation

The policy ideas of the CCM have already started to influence the mindsets of stakeholders in care delivery. Some key elements can be identified in the health act of 2007, including mandatory joint health planning to plan cooperation between regional and local authorities involved in health care provision (Strandberg-Larsen M et al. 2007b). The National Board of Health has been empowered in the new health care act, imposing stronger central control in a traditionally highly decentralized system (Strandberg-Larsen M et al. 2007b). The regions are powerful stakeholders as they administer most of the resources in the healthcare sector and hold the primary responsibility for provision of services. Also, the municipalities are to an increasing extent becoming important stakeholders as they have been put in charge of preventive services and out-patient rehabilitation.

Legislative outcome

pending

Actors and influence

Description of actors and their influence

Government

- The Government: very strong □ □ □ □ □ none
- Ministry of Health: very strong □ □ □ □ □ none
- National Board of Health: very strong □ □ □ □ □ none

Providers

- Regional Authorities: very strong □ □ □ □ □ none
- Local Authorities: very strong □ □ □ □ □ none
- The Organization of General Practitioners: very strong □ □ □ □ □ none

Patients, Consumers

- Patient Associations: very strong □ □ □ □ □ none

Positions and Influences at a glance

Adoption and implementation

The adoption process and the following implementation of policy ideas inspired by the CCM are very dependent on a mutual interest from the leadership of the regions, the municipalities and the general practitioners. Also agreement on common goals for the implementation and the following process are dependent to a high degree on collaboration between the leadership in the regions, municipalities as well as the general practitioners.

Monitoring and evaluation

The National Board of Health has developed a scheme that includes the design, development, implementation and follow-up on an ongoing basis for disease management programs for the most common chronic conditions that very
precisely describes how the regions are expected to set up the programs. The scheme from the National Board of Health demands ongoing quality development in and between organizations described as an element of the disease management program. Indicators for assessment of implementation of the disease management programs can either be derived from national clinical databases or from locally developed databases. The National Board of Health has recommended ongoing monitoring and evaluation of the specific initiatives described in the strategy paper on chronic care, however no formal evaluations have been initiated. (National Board of Health 2005).

6. Expected outcome

It is difficult to foresee whether the implementation process of CCM with inspiration and possible transfer of important learnings from Kaiser Permanente will become successful in the Danish Healthcare System. However optimistic hopes as well as sceptical expectations have been expressed (Schiøtz ML et al. In Press).

<table>
<thead>
<tr>
<th>Health Care Services</th>
<th>fundamental</th>
<th>marginal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Health Care Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of Equity</td>
<td>system more equitable</td>
<td>system less equitable</td>
</tr>
<tr>
<td>Cost Efficiency</td>
<td>very high</td>
<td>very low</td>
</tr>
</tbody>
</table>
7. References

Sources of Information


Author/s and/or contributors to this survey

Frølich, Anne, Strandberg-Larsen, Martin and Michaela L. Schiøtz

Suggested citation for this online article
