

Keeping Professional Executive Committee members and other clinicians in touch with key policy developments and their impact on PCTs

4. United Health Group

In November 2002 representatives from US Health Maintenance Organisation (HMO) United Health Group (UHG) scoped with PCTs the potential to adapt and implement their EverCare model of care management for a vulnerable elderly population.

Following this, 9 PCTs contracted with UHG for hands-on support in implementing the EverCare model in their local system.

What is United Health Group?

United Health Group, the parent company of EverCare, offers health and well being services to over 50m people in the US. The company develops, organises and manages health care and support services for many diverse private and public companies, non-profit organisations, and federal, state and local governments, including:

- Federal Medicare health programme services for older and disabled Americans
- State-administered Medicaid programmes for low-income individuals
- Employee health care coverage and related services for states, counties, cities, and many other local governmental bodies and jurisdictions

How case management approaches can help

We know that the elderly and chronically ill make the most use of NHS resources. This type of model offers a chance to build services that can meet these needs. It also helps bring about system benefits by providing more efficient and effective care to the chronically ill outside hospital, so hospitals can concentrate on treating those with acute conditions.

"The NHS Plan sets out our vision for a modern health service that responds to the needs of patients. PCTs are key to the delivery of the plan and this work gives PCTs an opportunity to provide radically different services modelled around the complex needs of the vulnerable elderly"

Stephen Ladyman, Health Minister





The EverCare model

Evaluation of the model in the US has shown that:

- EverCare has demonstrated a 50% reduction in the hospitalisation rate of its enrollees in care facilities while achieving the same mortality results as compared to a control group
- EverCare significantly reduces the number of prescription drugs a Medicare patient takes while maintaining health. This achieves cost savings for beneficiaries and lowers side effects
- EverCare has a 97% satisfaction rating among families, as well as an extremely high physician satisfaction rating

Key features of the model include:

- Primary care team model led by nurses working in partnership with GPs and rest of the primary care team and other care staff
- Helping the elderly to stay healthy and at home - preventing avoidable admissions
- Facilitating safe early discharge when the vulnerable elderly are admitted to hospital
- Catching illness early and preventing deterioration in condition

Implementing the model

Implementing the model involves

- Identifying and stratifying the high-risk elderly within a geographic population. In the pilot sites, high-risk elderly have been identified as those that have had two or more unplanned admissions to hospital in the last year
- Establishing an extended nurse role to proactively manage the high-risk caseload
- Introducing systematic tools and processes, such as retrospective analysis of avoidable admissions, pharmacy review and early alert processes

What has happened to date

Each PCT has identified the vulnerable elderly population.


Doing this work revealed that 2% of the high-risk group were driving 30% of the unplanned admissions within this group.

Many of the patients identified were not in touch with the relevant community services such as district nursing or social services. For many of the unplanned admissions, the cause was something that could have been prevented or treated in the community e.g. urinary tract infections and dehydration. This has highlighted a real opportunity to make a difference for these patients.

Each pilot has now established an extended nursing role. Nurses with enhanced clinical skills are currently working in collaboration with GPs and others to manage and co-ordinate the care for the vulnerable elderly on their caseload.

These nurses have built towards a caseload of 50 patients. To increase the impact, the intention is to move beyond this and extend caseloads where possible.

Stories are emerging now of a positive impact for patients with inappropriate admissions averted, reduced lengths of stay and improved function/quality of life, for example.



Roles of the primary nurse

Advancing the NHS Plan - Initial Findings and Recommendations



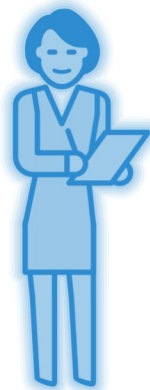
- Conduct individual assessments of high-risk elders including comprehensive history and focused physician examination.
- Collaborate with nurse practitioner or general practitioner (GP) to diagnose problems and develop care plan.
- Monitor elder to determine effectiveness of treatment.



- Identify and address health issues of elders across health care and social care systems.
- Integrate pathways of care to decrease duplication, fragmentation, and delay.
- Advocate high-quality, integrated, and consistent care for individual elders.



- Coordinate each instance of intervention across all health providers —GPs, consultants, nurses, rehabilitation specialists, social services, and family members.
- Orchestrate care in all settings, including at home, in hospitals, and in nursing care homes.



- Inform elders and their families about anticipated decline in health related to a disease.
- Formulate and update advanced care plans with elders and their families.
- Teach service providers and carers to recognize early signs of a change in elder's condition.



- Relay information about elder's health condition to all service providers, especially to A&E staff and consultants, upon admission to hospital.
- Communicate health condition, treatments, services, and expected outcomes to elders, their families, and non-medical carers.



A Learning Network

It is crucial that the lessons from implementing this model can be distilled for other NHS organisations wishing to work with these principles to develop their own case management approaches for patients with the highest burden of illness.

Each PCT is participating in Action Learning Sets and has participated in events to capture this learning for others.

More information on the experience identified at a recent learning event, and on the project more generally, is available on our website at www.natpact.nhs.uk/cms/2.php