Supporting the delivery of enhanced health in care homes

Supporting enhanced integration within care homes and social care

The new models of care agenda is designed to bring greater alignment of and accountability to provider organisations responsible for delivering care. Internationally, there is increasing evidence that the transfer of accountability from commissioners to providers improves clinical quality, safety, financial and patient experience outcomes. It also carries additional risks and rewards for provider groups and requires new capabilities to manage accountability and deliver outcomes.

There are an estimated 400,000 older people resident in care homes across the UK with complex healthcare needs, reflecting multiple long-term conditions, significant disability and advanced frailty. Their requirements for care often include physical, social and mental health issues, most provided within the care home. There is significant variation in the care residents receive and a high level of unmet need with infrequent primary care and poorly coordinated secondary care. Care provided to this complex cohort of people is often fragmented. Day-to-day care is task based with variable use of proactive care planning to reduce the need for consultant services and hospitalisation. Care provided to this complex cohort of people is often fragmented with limited support from the wider health system.

There is a substantial body of evidence that considerable savings can be made when the NHS works more closely with care homes and nursing homes. The impact on quality and patient safety is also significant. Therefore, one of the biggest challenges facing the NHS is to try and reduce the total costs of care whilst increasing primary care and the availability of secondary care services at care homes to provide a better experience to residents and their families and prolong independent living.

For example, two key areas where costs could be saved are associated with the 25 percent of emergency admissions from care homes that are avoidable, 40 percent of which are exacerbations of long-term conditions, with a significant proportion of older people aged over 80 years.

What sets us apart

People
Unmatched healthcare expertise

Technology
Comprehensive solutions

Data
Insights that drive decisions

Action
Scale to mobilise and achieve results

In a single year, five percent of the population …

£££££££ … accounts for 50 percent of healthcare costs …

… and more than one in three (38 percent) of these ‘frequent flyers’ remains in the most costly five percent of people the following year.

Effective care for such a complex cohort of patients requires broad expertise from multiple disciplines delivered in a coordinated and managed way. Effective care delivery and engagement will drive down healthcare costs, support independence and enhance quality of life.

Transitioning to new ways of working takes time. Irrespective of structure (standalone or part of MCPs/PACS), all care home models will require new tools and capabilities to manage the health, mental health and social care needs of complex populations in a more holistic way whilst improving immediate effectiveness and efficiency to support **the transition from reactive, uncoordinated, fee-for-service models to proactive value-based models**.

Optum® managed care solutions for care homes enhance healthcare delivery and preventive care management for the most medically complex populations, creating a disproportionate expense.

Custom-built, co-designed and delivered in partnership with the NHS, local authorities, adult social care teams, and the local community and voluntary sector, Optum Integrated Care Home Solutions helps you reduce costs whilst improving patient health outcomes. What makes our model unique is that it creates a **personalised care plan** that elevates care quality and reduces cost at the same time, breaking the high-cost cycle.

Care model overview

Optum nurse practitioners act as care managers, helping medically complex patients residing in care homes receive the care they need before events escalate. Our key solution elements are:

- Optum clinical care management expertise in nursing home facilities. With a caseload of 80–100 patients, Optum nurse practitioners manage all patients in each care home. Optum NPs visit the patient **five to seven times more frequently than average GPs,** which allows for **early identification** of issues and modifications in the care plan.
- Use of predictive models and **risk stratification** identifies risks of deterioration and gaps in care patient by patient.
- Creating and supporting **shared models of in-reach support**, including medical reviews, medication reviews (using StoppStart criteria), and rehab services, utilising new technologies and telemedicine. Proactive, preventive treat-in-place models, combining effective use of health information technology and multidisciplinary clinical teams. Key specialists incentivised to travel to care homes to see patients rather than transporting whenever possible through value based contracts.
- Initial **comprehensive assessment** by Optum care managers at bedside, driving care planning and **preventative programmes** to avoid exacerbations.
- Proactive, preventive/maintenance, **joint care plans** developed collaboratively by Optum care managers, GPs and care home staff, patients and families to make sure everyone is aligned on goals and that the care plan meets those goals.
- **Shared care plans, information and issue identification** amongst Optum care managers, GPs, community, mental and acute providers, and care home staff. Shared local care protocols with out-of-hours providers and ambulance trusts.
- Clinical, environmental and psycho-social conditions managed to **reduce hospitalisations**. Our clinicians are experienced in caring for the geriatric population, working with facility staff and reducing the number of avoidable hospitalisations.
- Focus on reducing unnecessary hospitalisations and A&E visits through **preventative care**, redesigning and closely managing **discharge process** (A&E discharge and bed-based utilisation).
- Patient, family and care home staff **engagement and collaboration** on potential return to home, support of **shared decision-making**. Discussions on disease trajectory and care goals lead to advance care directives.
- Family, care home facility and GP **collaboration on end-of-life issues**, such as hospice or palliative care and helping people to die in place of choice.
- Focused on **continuous improvement**, our team of NPs care managers in each care home review every admission every week to identify and document what could have prevented that admission and what changes need to be made to the care plan going forward.

Advancing care delivery

Services aligned to holistic patient needs focused on prolonging independent living.

High patient and family satisfaction.

Enhances access to primary and preventive care.

Individually tailored, proactive and personalised approach.

By combining these approaches, Optum can help health and social care systems (MCPs, PACS or standalone care home models) measurably improve quality, whilst achieving up to:

40–50%
decrease in A&E visits and hospital admissions

30%
reduction in hospital costs

25%
reduction in overall costs

No two patients are the same. A good clinical team recognises that all patients have their own concerns, needs, fears, expectations and hopes — with any condition.

Our model makes a difference because of our quality care and experience. Our expertise managing the care of in-facility geriatric and medically complex populations, whilst substantially reducing costs, places our value-based model above any standard fee-for-service approach.

- **Creators of the treat-in-place model.** We are the founders of the Evercare model, designed to treat people in a care home setting whilst focusing on preventive care.
- **Clinical expertise.** Optum nurse practitioners and physician assistants provide bedside care and care management to more than 36,000 residents in 1,100 care home facilities.
- **Collaboration.** A key priority for our clinicians is collaborating with care home staff and the patient's GP.

Optum managed care model	Traditional fragmented approaches
NP care manager completes a comprehensive assessment of geriatric syndromes and comorbidities during all visits.	Generally focuses on one condition per visit, creating a fractured approach that doesn't consider the whole person or the comorbidities from the geriatric syndrome in total.
Documentation is consistently evaluated for appropriate notation of chronic conditions and shared between clinicians in different organisations and settings.	Chronic conditions and psychosocial needs are not noted and documented as part of the visit beyond the resident's initial needs assessment.
Model of care focuses on relationships with key stakeholders in the nursing facility, enhanced communication and buy-in to a treat-in-place model.	Focus is on multiple visits by multiple specialists rather than MDT collaboration. Poor focus on staff development, information sharing and attention to resident's care preferences.
Acts as a single touch point to track and account for chronic conditions. Supports navigation and guidance for the patient and their family. Allows for collaboration led by a single clinician.	Multiple visits with multiple specialists, not coordinated, and not collaborative.
A value-based approach, supported by strong innovative partnerships with aligned incentives (opportunity to participate in shared savings) between service providers and care services aligned around the patient.	Fragmented funding and reimbursement systems and care services provided according to organisational capability rather than need, fee-for-service arrangements focused on volume of interventions rather than value and patient goals of care.

About Optum

Clinically led and exclusively healthcare focused, Optum is built on the foundational pillars of clinical care insight, technology, data and information. **Our mission is to help make the healthcare system work better for everyone.**

We are both a commissioning and provider support organisation and have worked **in partnership with the NHS for over 10 years**. We have built one of the **largest population health businesses in the world**, partnering with and providing services to risk-bearing groups. We operate primary-care led accountable care organisations across 24 markets in the US, teaching and enabling clinicians and health systems to take on financial risk for the populations they serve.

For more information on how Optum can help, please email info@optum.co.uk.

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