The Model of Guided Care

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Introduction

• The quality of primary care for older persons with several chronic conditions is often poor

• Guided Care
  ▪ a specially trained RN, based in primary care practice, collaborates with primary care physicians
  ▪ meet the complex needs of 50-60 high-risk older patients with chronic conditions

## Successful Innovations in Health Care for Older People with Chronic Conditions

<table>
<thead>
<tr>
<th>Model</th>
<th>Provider(s)</th>
<th>Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpt geriatric evaluation &amp; management</td>
<td>Nurse, SW, physician, PT, Nurse, SW, physician</td>
<td>↑ function, $ (Reuben, 1999)</td>
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<tr>
<td></td>
<td>Nurse, SW, physician</td>
<td>↑ function, $, satisfaction with care (Cohen, 2002)</td>
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<td></td>
<td>Nurse, SW, physician</td>
<td>↓ depression, caregiver burden</td>
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<td></td>
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<td>↑ function (Boult, 2001)</td>
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<td>Disease management</td>
<td>Nurse, physician</td>
<td>↑ quality of life, function, satisfaction with care (Ofman 2004; Unutzer, 2002)</td>
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<td>Chronic disease self management</td>
<td>Lay leaders</td>
<td>↑ health, ↓ hospital days (Lorig, 2001)</td>
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<tr>
<td>Health enhancement</td>
<td>Nurse practitioner</td>
<td>↓ hospital days, $, disability (Phelan, 2002, 2004)</td>
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<tr>
<td>Case management</td>
<td>SW</td>
<td>↓ $ (Boult, 2000)</td>
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<tr>
<td>Transitional care</td>
<td>Advance practice nurse</td>
<td>↓ hospital admissions, days, $ (Naylor, 1999)</td>
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<tr>
<td></td>
<td>Nurse, dietician, SW, physician</td>
<td>↓ hospital re-admissions, $ (Rich, 1995)</td>
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<tr>
<td>Caregiver ed and support</td>
<td>SW, psychologist</td>
<td>↓ NH admissions (Mittleman, 1996)</td>
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<td>Comp. patient eval.</td>
<td>Ind. care planning</td>
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<td>HEP</td>
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<td>CM</td>
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<td>TC</td>
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<td>CS</td>
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<tr>
<td>GC</td>
<td>XX</td>
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</tbody>
</table>
Informed, Empowered Patient and Family

Prepared, Proactive Practice Team

Improved Outcomes

Community Resources and Policies
Accessing

Self-Management Support
Chronic Disease Self-Management

Health System
Health Care Organization

Clinical Information Systems
Electronic Health Record, Care Guide, Transitional Care, Coordination

Delivery System Design
Guided Care Nurse

Decision Support
Drug interaction software, Evidence-based guidelines

Evidence-Based & Safe

Prepared, Proactive Practice Team

Productive Interactions
Patient-Centered Coordinated Timely & Efficient Evidence-Based & Safe

Monitoring Coaching

Chronic Disease Self-Management, Caregiver Support, Action Plan

Improved Outcomes
Components of Guided Care

• **Assessment**
  - home visit
  - Standardized instruments:
    - *Instrumental Activities of Daily Living (IADL)*,
    - *Activities of Daily Living (ADL)*,
    - *Nutritional Screening Initiative checklist*,
    - *Mini-Mental State Exam*,
    - “*Get Up & Go*” test,
    - *Geriatric Depression Scale (GDS)*
    - *CAGE alcoholism scale*
    - *hearing impairment, falls, and urinary incontinence*
    - *highest priorities for optimizing health and quality of life*
Components of Guided Care

• **Planning**
  - EHR merges individual data with “best practices”
  - preliminary “Care Guide”
    • *medical and behavioral plans*
  - GCN and primary care physician personalize preliminary Care Guide
  - GCN modifies preliminary Care Guide with patient and caregiver
  - final Care Guide: concise summary
    • *updated regularly by GCN*
  - patient-friendly version “My Action Plan”
Components of Guided Care

- *Chronic disease self-management (CDSM)*
  - GCN promotes patients’ self-efficacy
    - referral to a free, local, 6-session CDSM course
      - Led by trained lay persons and supported by GCN
      - Patients learn to refine / implement Action Plans
  - Action Plans
    - Reinforced by easy-to-read schedules / reminders
      - healthy eating, sleeping, exercising
      - use of medication
      - self-monitoring
      - using the health care system
      - avoiding tobacco and alcohol abuse
Components of Guided Care

• **Monitoring**
  - reminders from the EHR
  - GCN monitors at least monthly by phone
    - *detect and address emerging problems promptly*
  - when problems appear, GCN
    - *discusses them with MD*
    - *takes appropriate action*
  - GCN directly accessible by phone weekdays
Components of Guided Care

• **Coaching**
  - motivational interviewing
  - *monthly monitoring calls*
  - *facilitate patient’s participation in care*
  - *reinforce adherence to Action Plan*
  - based on Transtheoretical Model of Change
  - motivational interviewing principles and strategies
Components of Guided Care

- **Coordinating transitions between sites and providers of care**
  - efforts of all health care professionals
  - contact GCNs before or during admissions (EDs/hospitals)
  - GCN does not usurp duties of other professionals
    - provides each with current information (Care Guide)
    - explains GCN role
    - visits patients during stays in institutions
    - helps plan and execute follow-up
  - GCN smoothes path between all sites and providers
    - transitions through hospitals
    - keeping the primary care physician informed of the patient’s current status
Components of Guided Care

- **Educating and supporting caregivers**
  - for family or other unpaid caregivers of patients with functional impairment or difficulty with health care tasks
  - GCN offers individual and group assistance:
    - initial assessment
    - free self-management course for caregivers (10 hours over six weeks)
    - monthly support group meetings
    - ad-hoc telephone consultation
Components of Guided Care

- **Accessing community resources**
  - facilitates access to community resources
  - suggests patient or caregiver contact a transportation service, Meals-on-Wheels, the Area Agency on Aging, or the local Alzheimer’s Association
Allocation of Time by GCN's
Average Hours/Week

- Assessing patients and caregivers: 9 hours
- Scheduled monitoring and coaching: 3 hours
- Coordinating transitions: 8 hours
- Documenting activities: 4 hours
- Addressing emerging issues: 8 hours
- Communicating with providers: 3 hours
- Accessing community resources: 3 hours
- Facilitating support groups: 3 hours
- Other administrative tasks: 1 hour
Information Technology

- laptop computer
- a secure, custom-designed, web-based EHR:
  - conduct initial assessments
  - check for potential drug interactions
  - create Care Guides
  - monitor and coach patients
  - document clinical encounters
- used only by the GCN
- printed reports that supplement the Guided Care patients’ other medical records
Identification of Patients

- **Target:***
  - Multimorbidity, complex health care needs
  - High expenditures for health care (cost-effectiveness)
- Predictive modeling (uses administrative data and diagnoses to estimate a patient’s future health care needs)
- Insurers or provider organizations
  - Analyze previous year’s insurance claims
  - Using the hierarchical condition category (HCC) model
  - 25% of older patients in primary care panels
- No high-risk patients are excluded because of a condition (e.g., dementia) or place of residence (e.g., nursing home)
  - Some are unable to participate in CDSM
Guided Care Nurse Qualities

• proficiency in communication
• flexibility in complex problem-solving
• cultural competence
• comfort with interdisciplinary team care
• experience in geriatric and community nursing
• enthusiasm for coaching patients and caregivers in self-management
Curriculum

- 3 week full-time educational program
  - skill development through interactive role-playing
  - supplemented by readings and brief lectures

- Topics:
  - EHR
  - comprehensive assessment and planning
  - monitoring
  - coaching to enhance self-management
  - transitional care
  - cultural competence
  - communication with health care professionals
  - elder abuse
  - health insurance
  - community resources
Practice Sites

• Groups of primary care physicians (general internists and family physicians)
  ▪ care for at least 400 older (age 65+) patients
  ▪ likely to have at least 50-60 multi-morbid older patients

• Practice:
  ▪ provides an on-site office
  ▪ integrates the GCN into the work flow of physicians and office staff
    • over 3 - 4 months
Integration

• GCN:
  ▪ physicians’ practice styles and patient interactions
  ▪ cases
  ▪ medical records
  ▪ office staff members’ roles and interactions
  ▪ office operating procedures
  ▪ identity as a member of the office staff
  ▪ familiar with local community resources:

Physicians introduce the GCN to their patients
GCN-physician dyads develop patterns for communicating about their patients
## Allocation of Time by GCNs

<table>
<thead>
<tr>
<th>Activity</th>
<th>Hours/Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessing new patients and caregivers</td>
<td>3</td>
</tr>
<tr>
<td>Scheduled monitoring and coaching</td>
<td>8</td>
</tr>
<tr>
<td>Coordinating transitions between sites/providers of care</td>
<td>4</td>
</tr>
<tr>
<td>Documenting activities, updating Care Guides and Action Plans related to transitional care and monitoring/coaching</td>
<td>8</td>
</tr>
<tr>
<td>Addressing emerging issues with patients and caregivers</td>
<td>3</td>
</tr>
<tr>
<td>Communicating with PCPs and other providers</td>
<td>3</td>
</tr>
<tr>
<td>Accessing community resources</td>
<td>1</td>
</tr>
<tr>
<td>Facilitating caregiver support groups</td>
<td>1</td>
</tr>
<tr>
<td>Other administrative tasks: attending meetings, traveling to/from patients' homes/hospitals, responding to email, interacting with office staff, and organizing patient charts</td>
<td>9</td>
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