

# The Model of Guided Care

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# Introduction

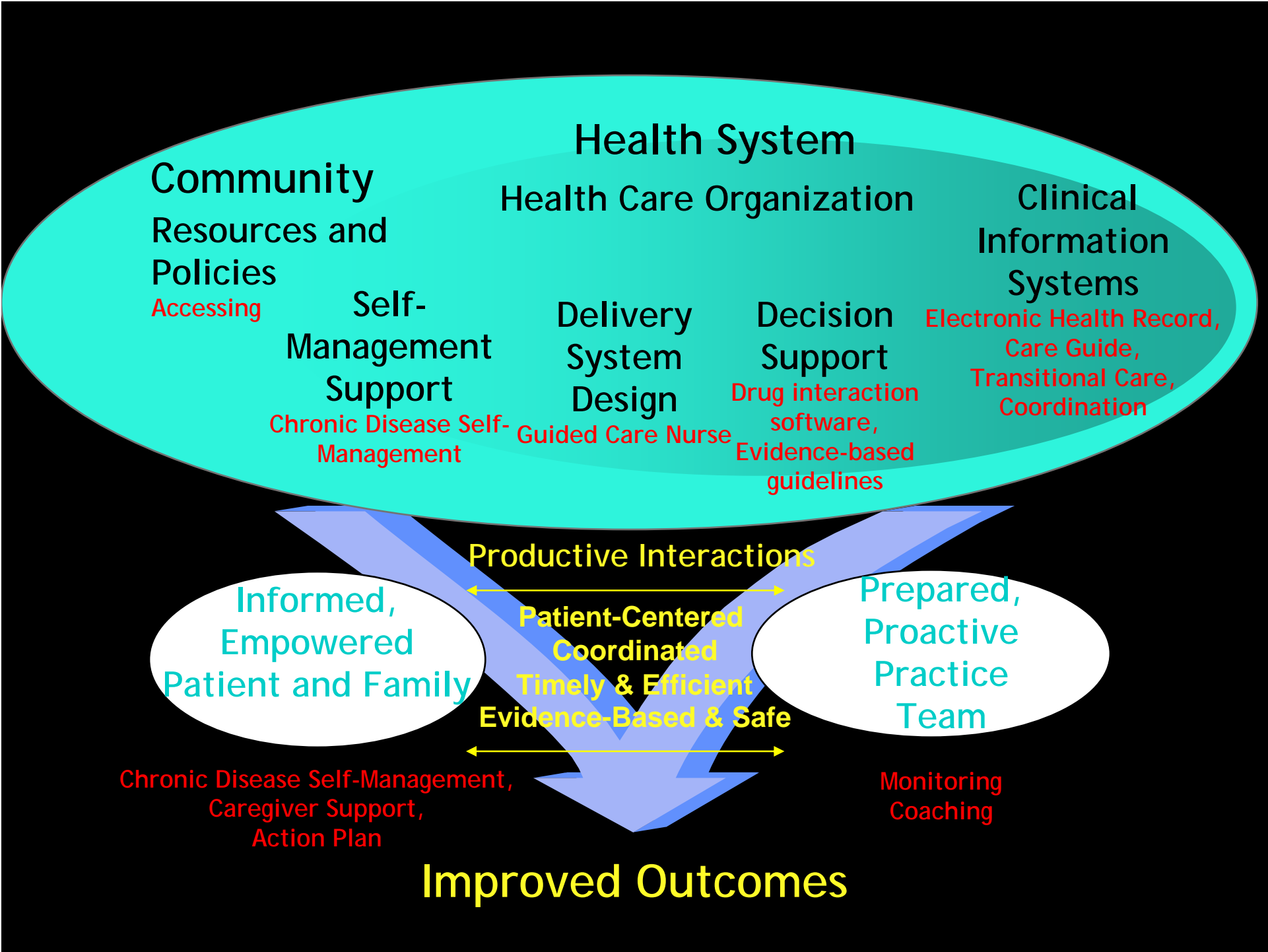
- The quality of primary care for older persons with several chronic conditions is often poor
- Guided Care
  - a specially trained RN, based in primary care practice, collaborates with primary care physicians
  - meet the complex needs of 50-60 high-risk older patients with chronic conditions

Boyd CM et al. *The Gerontologist*. In Press, 2007

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

| Model                                   | Provider(s)                     | Effects   |
|---|---------------------------------|---|
| Outpt geriatric evaluation & management | Nurse, SW, physician, PT        | ↑ function, \$ (Reuben, 1999)   |
|   | Nurse, SW, physician            | ↑ function, \$, satisfaction with care (Cohen, 2002)                            |
|   | Nurse, SW, physician            | ↓ depression, caregiver burden<br>↑ function (Boult, 2001)                      |
| Disease management                      | Nurse, physician                | ↑ quality of life, function, satisfaction with care (Ofman 2004; Unutzer, 2002) |
| Chronic disease self management         | Lay leaders                     | ↑ health, ↓ hospital days (Lorig, 2001)   |
| Health enhancement                      | Nurse practitioner              | ↓ hospital days, \$, disability (Phelan, 2002, 2004)                            |
| Case management                         | SW                              | ↓ \$ (Boult, 2000)  |
| Transitional care                       | Advance practice nurse          | ↓ hospital admissions, days, \$ (Naylor, 1999)                                  |
|   | Nurse, dietician, SW, physician | ↓ hospital re-admissions, \$ (Rich, 1995)                                       |
| Caregiver ed and support                | SW, psychologist                | ↓ NH admissions (Mittelman, 1996)   |





# 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

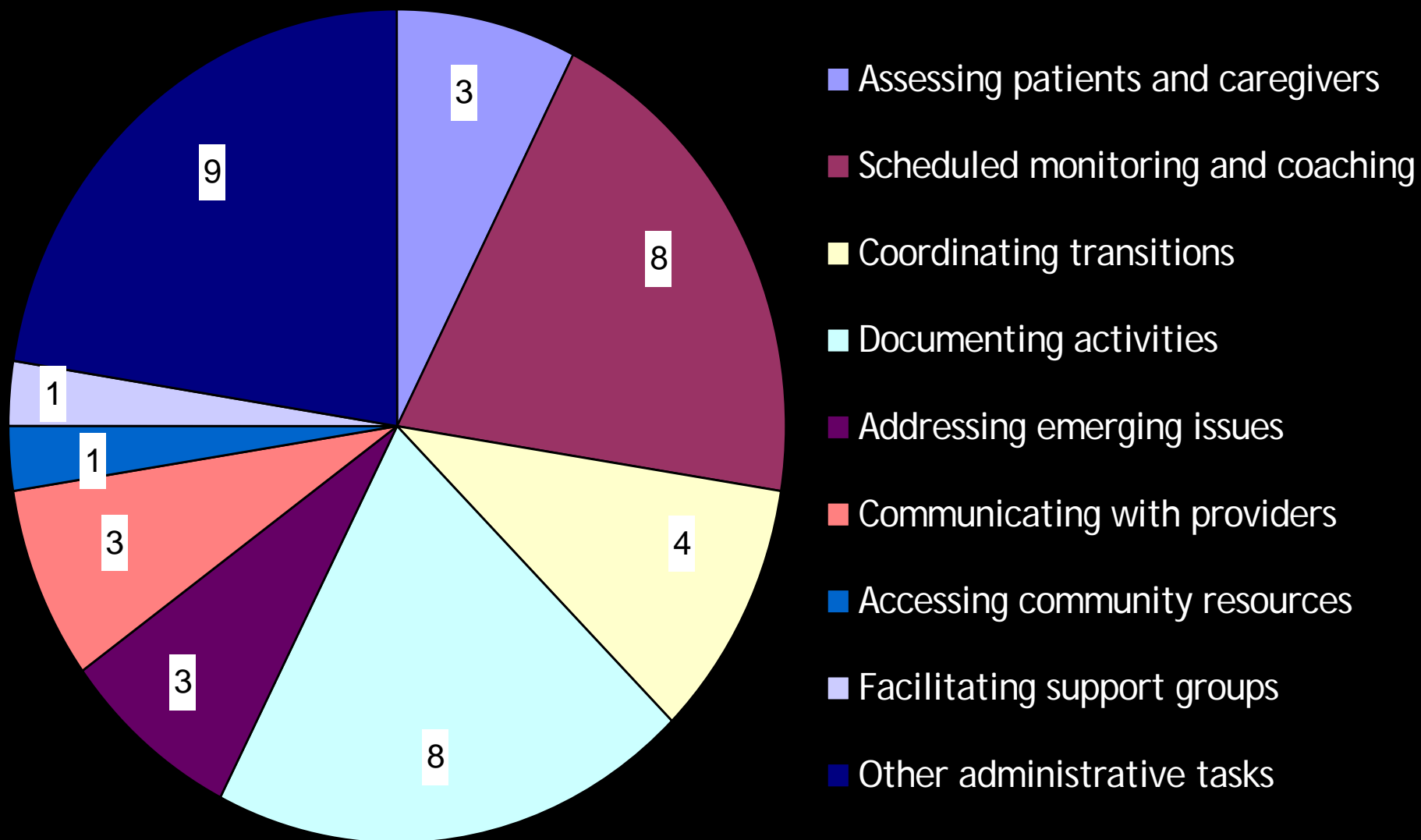
- *Educating and supporting caregivers*
  - for family or other unpaid caregivers of patients with functional impairment or difficulty with health care tasks
  - GCN offers individual and group assistance:
    - *initial assessment*
    - *free self-management course for caregivers (10 hours over six 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



# 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

Average  
hours/week

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