The Guided Care Medical Home: Primary Elder Care in a New Age

Alicia I. Arbaje, MD, MPH

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Alternative Aging
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Mrs. Marian Jones

- 79 year old widow
- Retired, lives alone
- Income: SS, pension and Medicare
- Daughter, lives 10 miles away with three teenagers
- Five chronic conditions
- Three physicians
- Eight medications

In 2010, Mrs. Jones had

22 prescriptions, 8 meds
19 outpatient visits
3 hospital admits
6 weeks sub acute care
2 nursing homes
5 months home care
2 home care agencies
6 community referrals

Administered by: 8 Physicians, 6 Social Workers, 5 Physical Therapists, 4 Occupational Therapists, 37 Nurses

Mrs. Jones
- Confused by care, meds, bills
- Gets discouraged
- Adheres poorly

Mrs. Jones' daughter
- Stressed out
- Reduced work to half-time
- Considering nursing homes

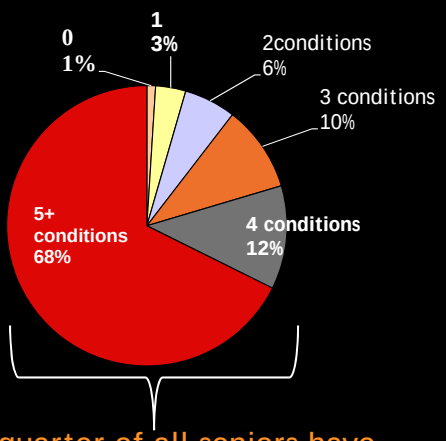
Medicare paid $45,000 to providers for her care

Mrs. Jones' Health Care

- No proactive monitoring of her conditions.
- Limited access to PCP for urgent visits.
- Hurried, one-problem office visits.
- Poor follow-up on lab tests.
- Poor coordination with specialists.
- Discontinuity through transitions.
- Limited guidance for self-management.
- No support for family caregivers.

Today's Chronic Care is:

- Fragmented
- Hard to access
- Inefficient
- Unsafe
- Expensive

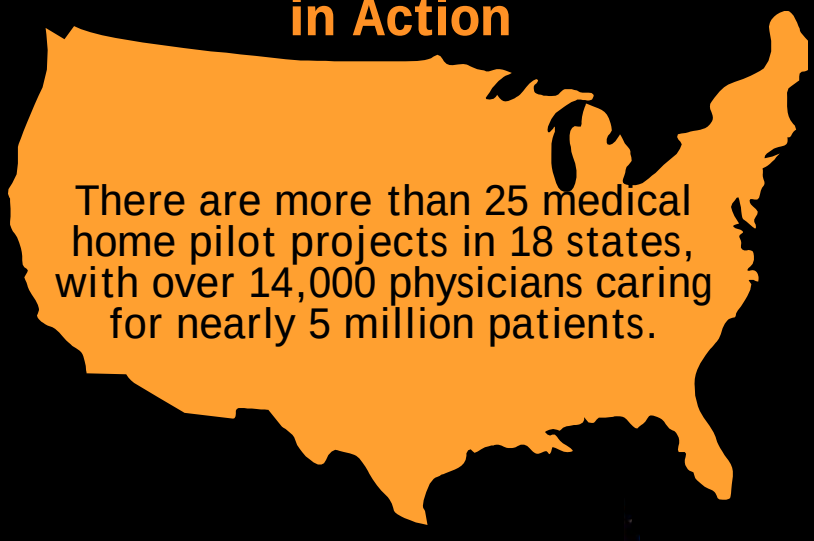


One quarter of all seniors have 4+ chronic conditions and account for 80% of health care spending

Patient-Centered Medical Home

- Patient-Centered Medical Homes (PCMH) seek to improve quality and outcomes of health care.
- An interdisciplinary team takes responsibility to improve care access, continuity and coordination.
  - Managing care in the office, home, hospital, nursing home.
- Patients and family members are educated and engaged in self-care and disease management.

Patient-Centered Medical Home in Action



GUIDED CARE

A Path to Patient-Centered Medical Home

Comprehensive, team-based primary care for people with multiple chronic conditions

1. Evidence-based and proven to improve care.
2. May reduce cost in well-managed systems.
3. Can help shift culture to a collaborative model.
4. Easy to implement and ready for adoption.

About the Guided Care Model

- Specially-trained RNs are based in physicians' offices.
- The nurse collaborates with 3-4 physicians in caring for 50-60 high-risk older patients with chronic conditions and complex health needs.
- The nurse partners with the patient for the rest of their life; it is NOT a "one episode" solution.

Guided Care Nurses

- Assess patient needs & preferences
- Create an evidence-based Care Guide and Action Plan
- Monitor patient proactively
- Support patient self-management
- Smooth transitions between sites of care
- Coordinate with all providers:
  - ✓ Hospitals, EDs, specialty clinics, rehab facilities, home care agencies, hospice programs, and social service agencies
- Educate and support family caregivers
- Facilitate access to community services

Boyd et al. *Gerontologist* 2007

Evidence-Based and Proven to Improve Care

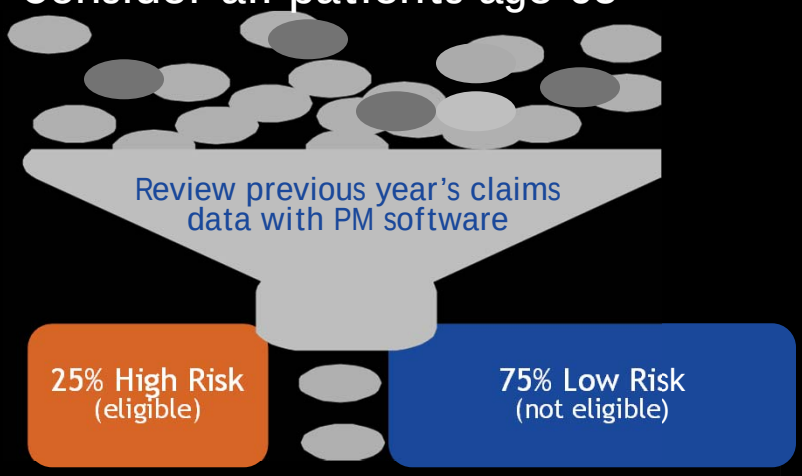
A three-year randomized trial: 904 high-risk older patients of 49 community-based primary care physicians practicing in 14 teams.

- Early results show improved utilization, higher physician and nurse satisfaction, and improved care quality.
- Physician/patient teams randomly assigned to receive Guided Care or "usual" care.
- Outcomes measured at eight, 20 and 32 months.

Boult et al. *J Gerontology* 2008

Who is Eligible?

Consider all patients age 65+



Baseline Characteristics

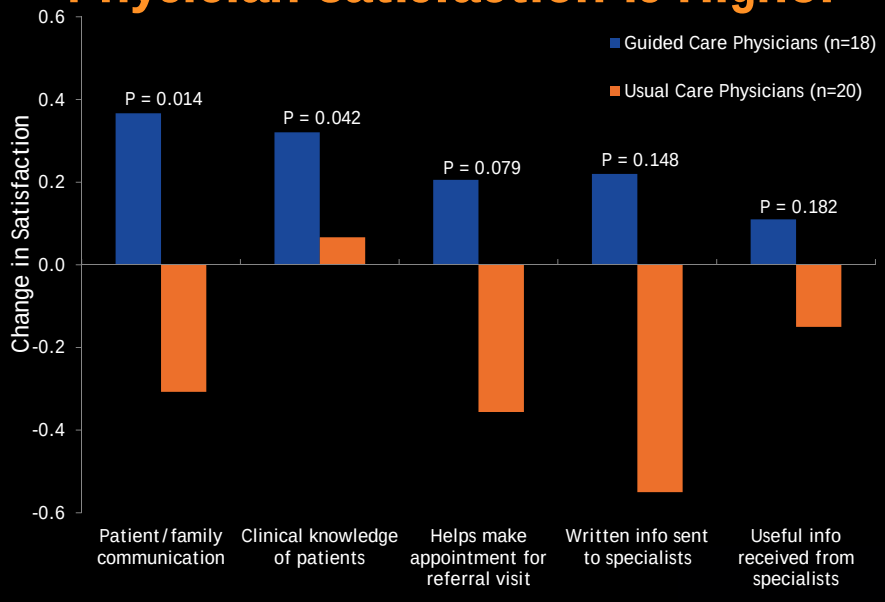
	Guided Care	Usual Care
Age	77.2	78.1
Race (% white)	51.1	48.9
Sex (% female)	54.2	55.4
Education (12+)	46.4	43.4
Living alone	32.0	30.6
Conditions	4.3	4.3
HCC score	2.1	2.0*
ADL difficulty (%)	30.9	29.3
Cognition (SPMS)	9.1	9.0

Patient Perceptions on Quality of Care

- At 18 months, patients were surveyed using the Patient Assessment of Chronic Illness Care (PACIC).
- Guided Care recipients were twice as likely to rate their chronic care highly than were those in control group.

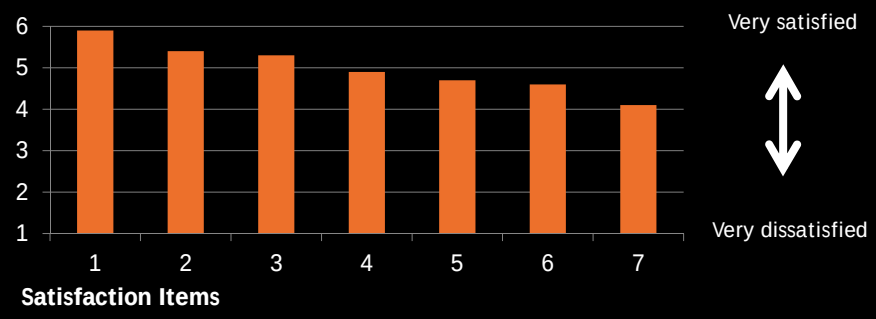
Boyd et al. *J Gen Intern Med* 2010

Physician Satisfaction is Higher



Marsteller JA et al. *Ann Fam Med* 2010

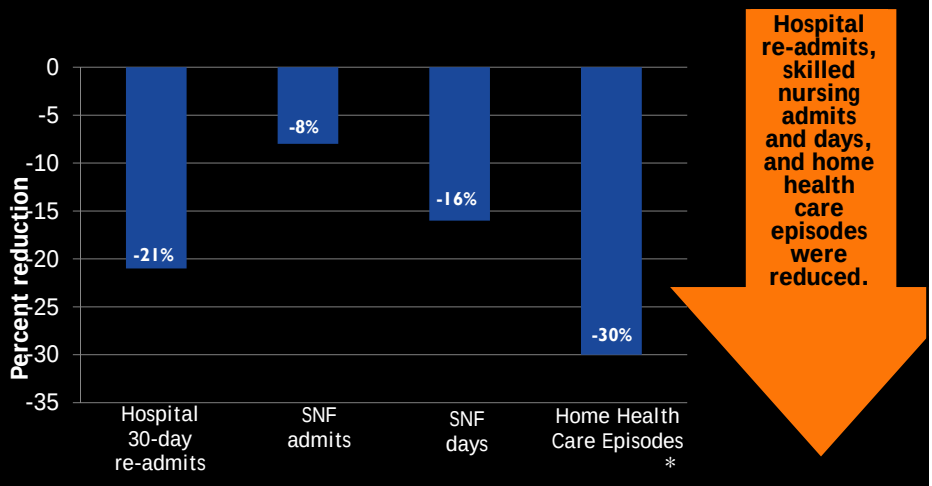
Nurses Are Highly Satisfied



1 Familiarity with patients
2 Stability of patient relationships
3 Comm. w/ patients; availability of clinical info; continuity of care for patients
4 Efficiency of office visits; access to evidence based guidelines
5 Monitoring patients; communicating w/ caregivers; efficiency of primary care team
6 Coordinating care; referring to community resources; educating caregivers
7 Motivating patients for self management

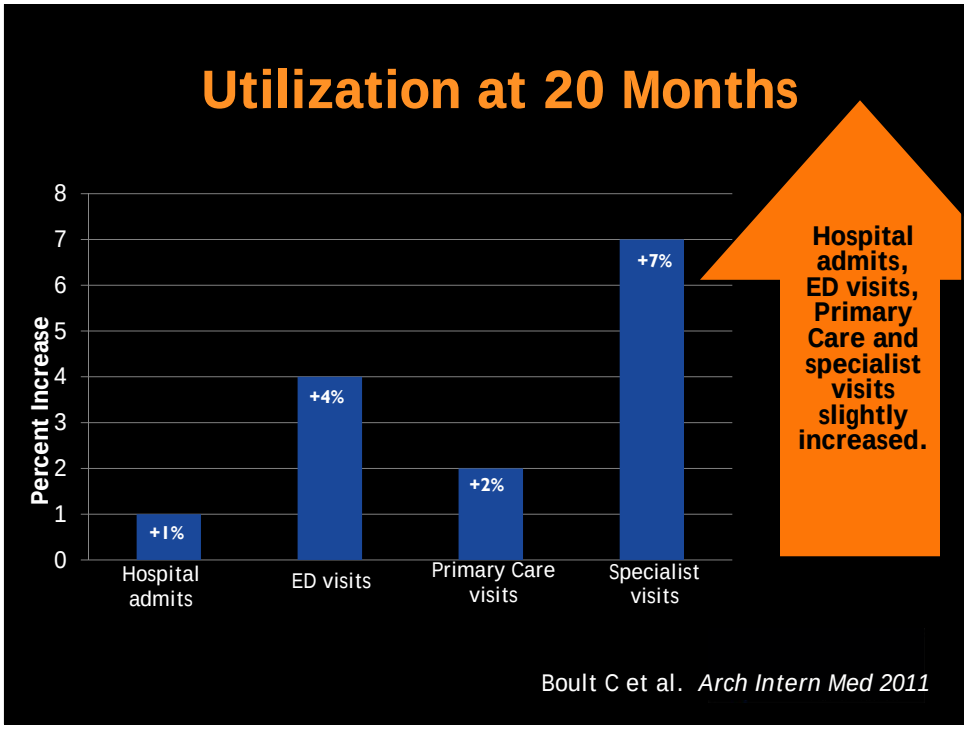
Boult et al. *J Gerontology* 2008

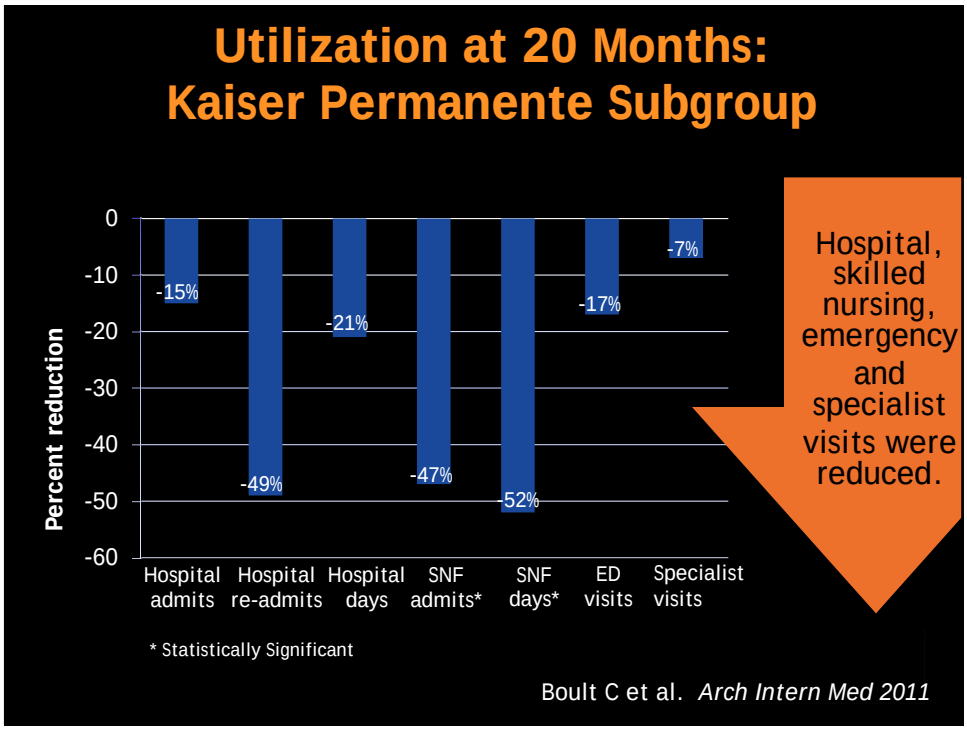
Utilization at 20 Months



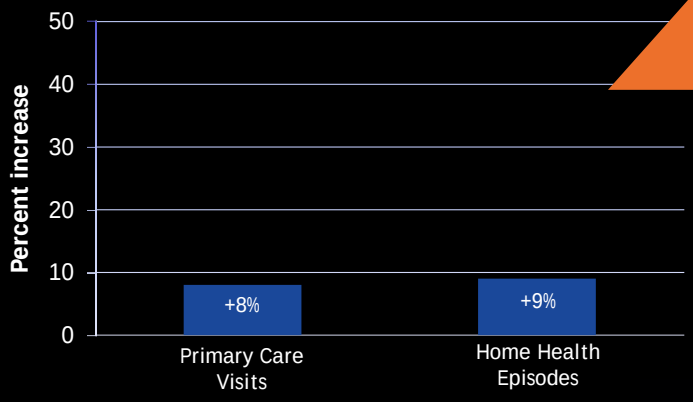
* Statistically significant

Boult C et al. *Arch Intern Med 2011*


Utilization at 20 Months
Percent Increase
8
7
6
5
4
3
2
1
0
+1%
+4%
+2%
+7%
Hospital admits
ED visits
Primary Care visits
Specialist visits
Hospital admits, ED visits, Primary Care and specialist visits slightly increased.
Boult C et al. Arch Intern Med 2011


Utilization at 20 Months: Kaiser Permanente Subgroup
Percent reduction
0
-10
-20
-30
-40
-50
-60
-15%
-49%
-21%
-47%
-52%
-17%
-7%
Hospital admits
Hospital re-admits
Hospital days
SNF admits*
SNF days*
ED visits
Specialist visits
* Statistically Significant
Hospital, skilled nursing, emergency and specialist visits were reduced.
Boult C et al. Arch Intern Med 2011

Utilization at 20 Months: Kaiser Permanente Subgroup



Primary care visits and home health episodes increased slightly.

Boult C et al. *Arch Intern Med 2011*

Can Help Shift Culture to a Collaborative Model

The Guided Care Nurse works in the physician's office, which improves communications, teamwork, and efficiency.

"My favorite thing about Guided Care is I am in the middle, filling the gaps in the health care system and making sure the patient really gets the care they need."

Guided Care Nurse

"The Guided Care Nurse saved me time, and made my practice more efficient."

Participating Physician

Time Builds Trust

The nurse, physicians, patient and family build a long-term, trust-based relationship.

"I developed a closer relationship with my patients through the Guided Care nurse. Because of her coordination, I was better able to care for my patients."

Participating Physician

Easy to implement, ready for adoption, free support

Practices planning to use Guided Care to become a medical home can get free technical assistance.

- **FREE** Implementation Manual
  - *Guided Care: A New Nurse-Physician Partnership in Chronic Care* (Springer Publishing 2009)
- **FREE** book for patients and families
- Online course for RNs **(SCHOLARSHIPS AVAILABLE)**
- Online course for physicians and practice leaders

For details, go to
www.GuidedCare.org/adoption.asp

"Guided Care: a New Nurse-Physician Partnership in Chronic Care"

Implementation manual for practices:

- Describes how Guided Care operates.
- Helps practice leaders determine if Guided Care is right for them.
- Prepares the practice for Guided Care.
- Provides tools for implementing Guided Care plus hiring and managing Guided Care nurses.
- Includes checklist for integrating nurses into practice.

"Transformation: A Family's Guide to Chronic Care, Guided Care, and Hope"

Book for patients and families:

- Describes Guided Care in a narrative format.
- Explains how Guided Care can help patients and families.
- Hard copy and electronic versions available in English and Spanish; audio version is coming soon.

Online Course for Nurses in Guided Care Nursing

- Offered by the Institute for Johns Hopkins Nursing.
- 40-hours, asynchronous-synchronous course with an online examination.
- Contains Transitional Care module.
- Confers eligibility for the American Nurses Credentialing Center's Certificate in Guided Care Nursing.

Online Course for Practice Leaders

- Provides an awareness of competencies that facilitate effective practice in advanced primary care.
- 9-module, 9-hour asynchronous course.
- Topics include: leading change, patient communication, interdisciplinary teams, care management, continuity of care, HIT.
- Accredited CME.

Summary: Guided Care is:

- A proven, evidence-based team approach that can improve care, quality and satisfaction, and may reduce costs for older patients with multiple chronic conditions.
- A team approach to building the accountability needed for a successful Medical Home.
- Ready to adopt with FREE TA and tools.
  - Free for practices that use Guided Care to transform to a PCMH

"It's like having a nurse in the family."

www.guidedcare.org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