Managing High-Risk Patients in ACOs

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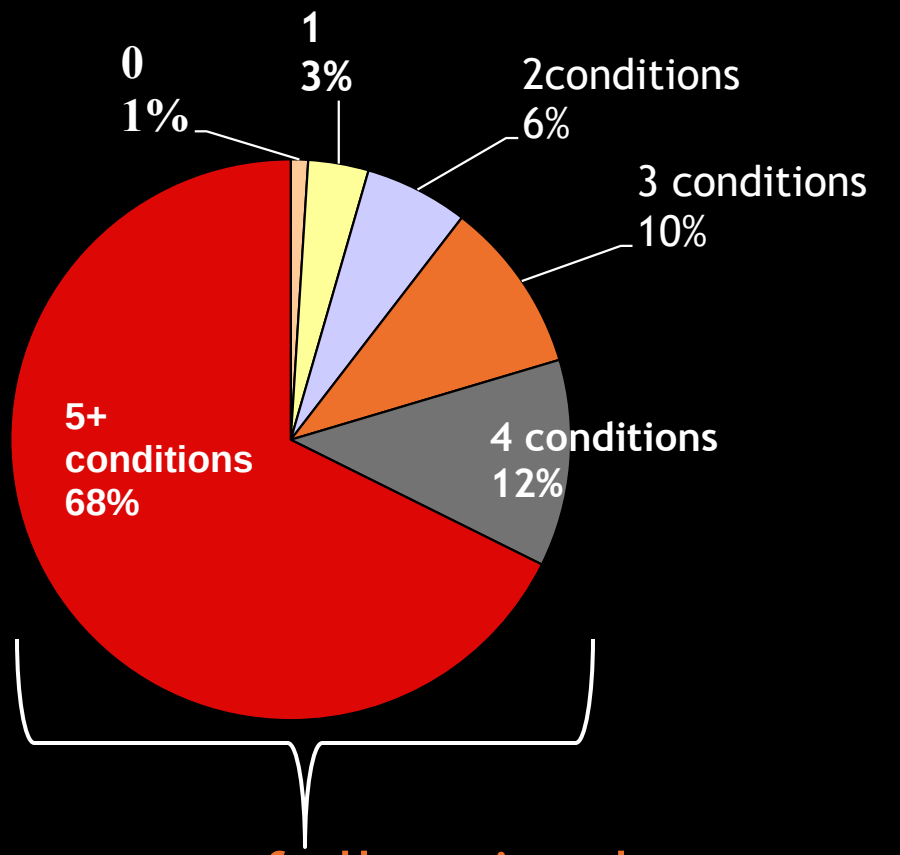
Chronic Care is:

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



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

Flaws in Chronic Care

- No proactive monitoring of conditions.
- Limited access to PCP for urgent visits.
- Hurried, one-problem office visits.
- Poor coordination among providers.
- Discontinuity through transitions.
- Limited guidance for self-management.
- Provision of unwanted care.
- No support for family caregivers.

Alternate Models of Care Coordination

Community-based care coordination teams

- Community Care of North Carolina
- Vermont Blueprint for Health

Clinics for complex patients

- Camden Coalition of Healthcare Providers ("hot spotters")
- Intensive outpatient care program (Boeing)
- Commonwealth Care Alliance

Primary care-based care coordination teams

- GRACE
- Guided Care

Boult and Murphy, *IOM Report* 2012

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 patients with chronic conditions and complex health needs.
- The nurse partners with the patient for the rest of life.

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

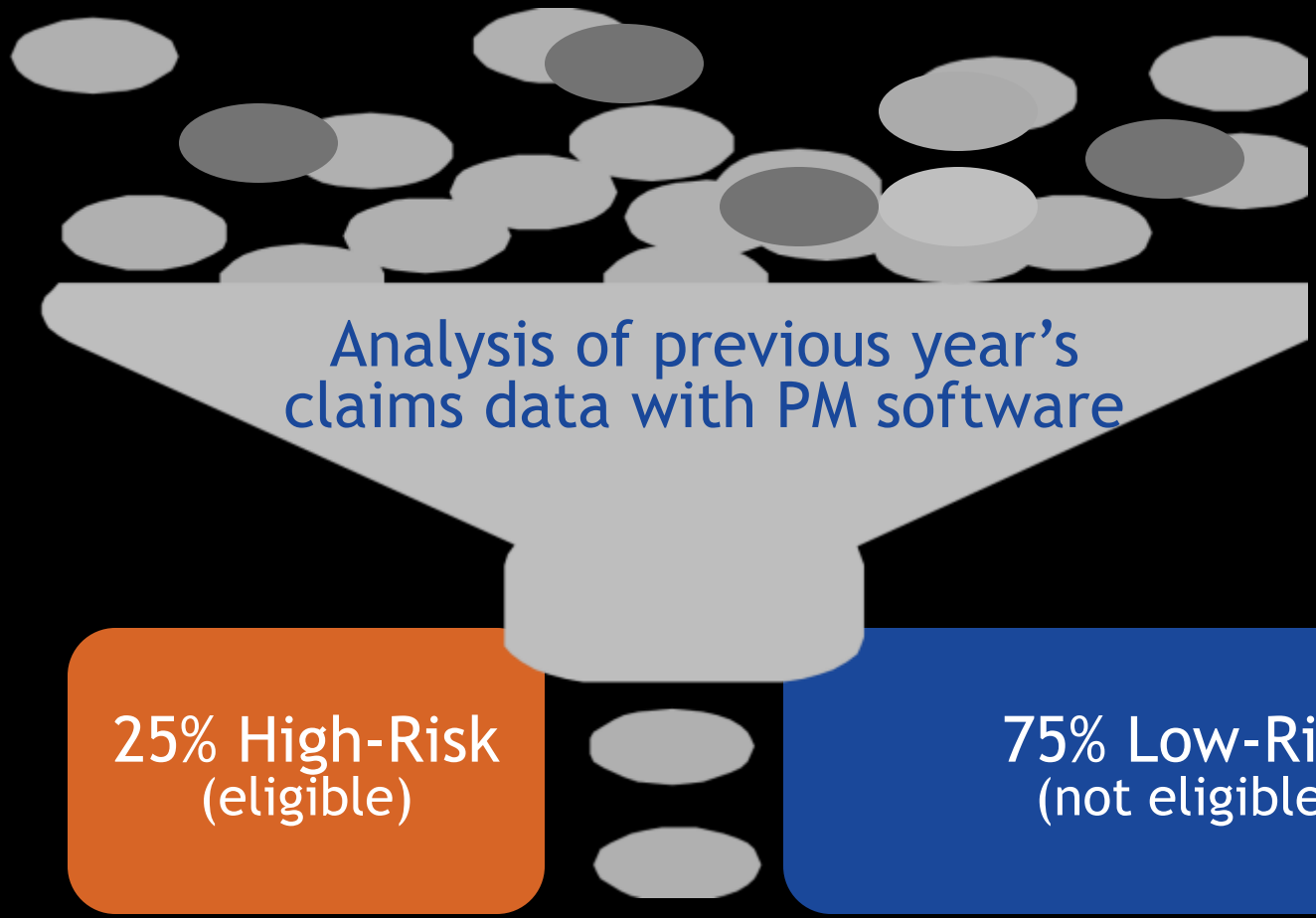
Boyd et al. *Gerontologist* 2007

Three-year randomized trial

- 904 high-risk older patients of 49 community-based primary care physicians practicing in 14 teams.
- Physician/patient "clusters" randomly assigned to receive either Guided Care or "usual" care.
- Multiple outcomes assessed from claims and surveys:
  - Quality of care
  - Health and function
  - Satisfaction with care (patients, physicians, nurses)
  - Utilization of EDs, hospitals and SNFs

Boult et al. *J Gerontol* 2008

Who is Eligible?



Baseline Characteristics

All Participants

- Age 77.5
- 51 % were white
- 55 % were female
- 45 % had 12+ years of education
- 32 % lived alone
- 4.3 chronic conditions
- 2.02 average HCC score
- 26 % had difficulty with 2+ IADL

Patient Perceptions on Quality of Care

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

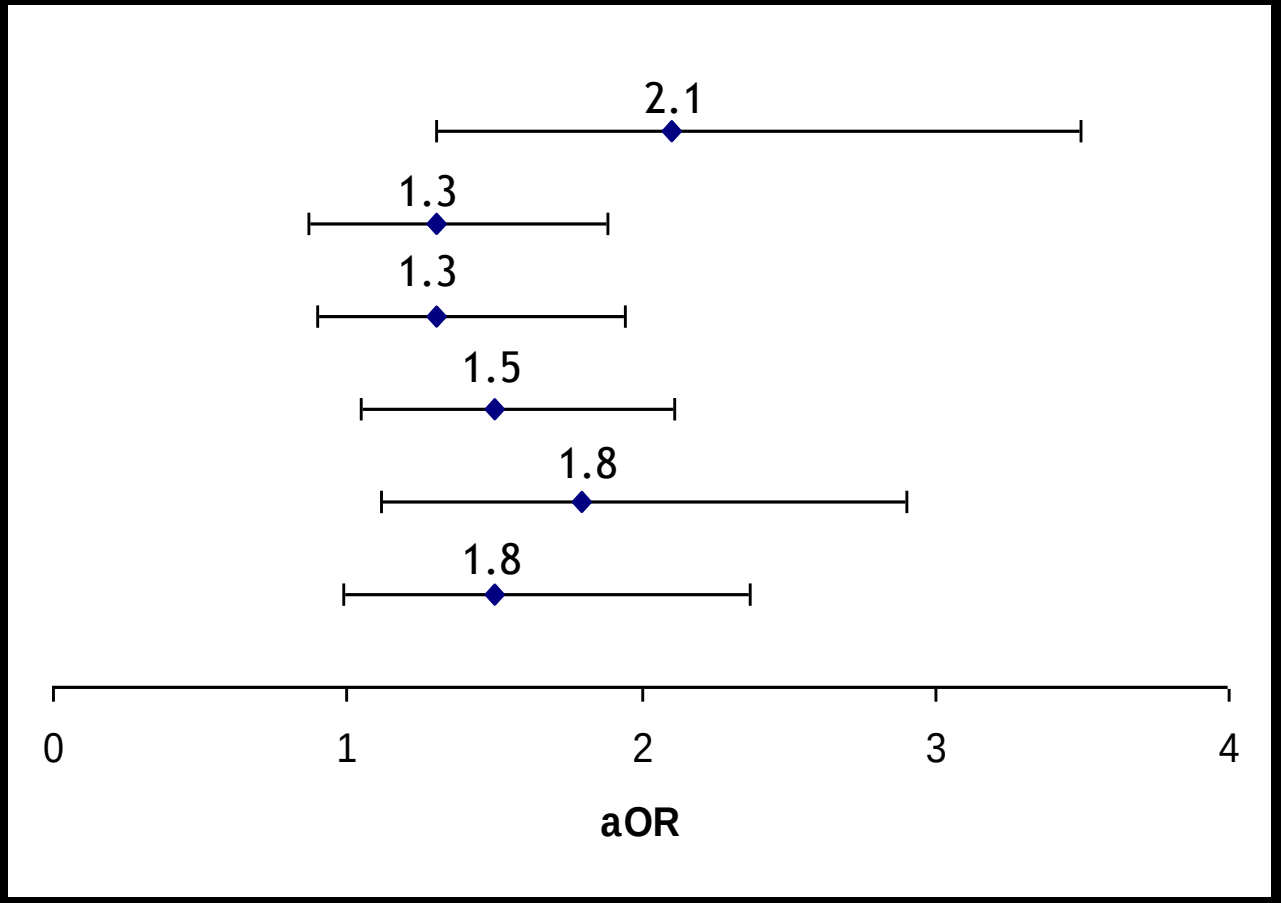
Boyd et al. *J Gen Intern Med* 2010

Quality of Care at 18 months

PACIC scales

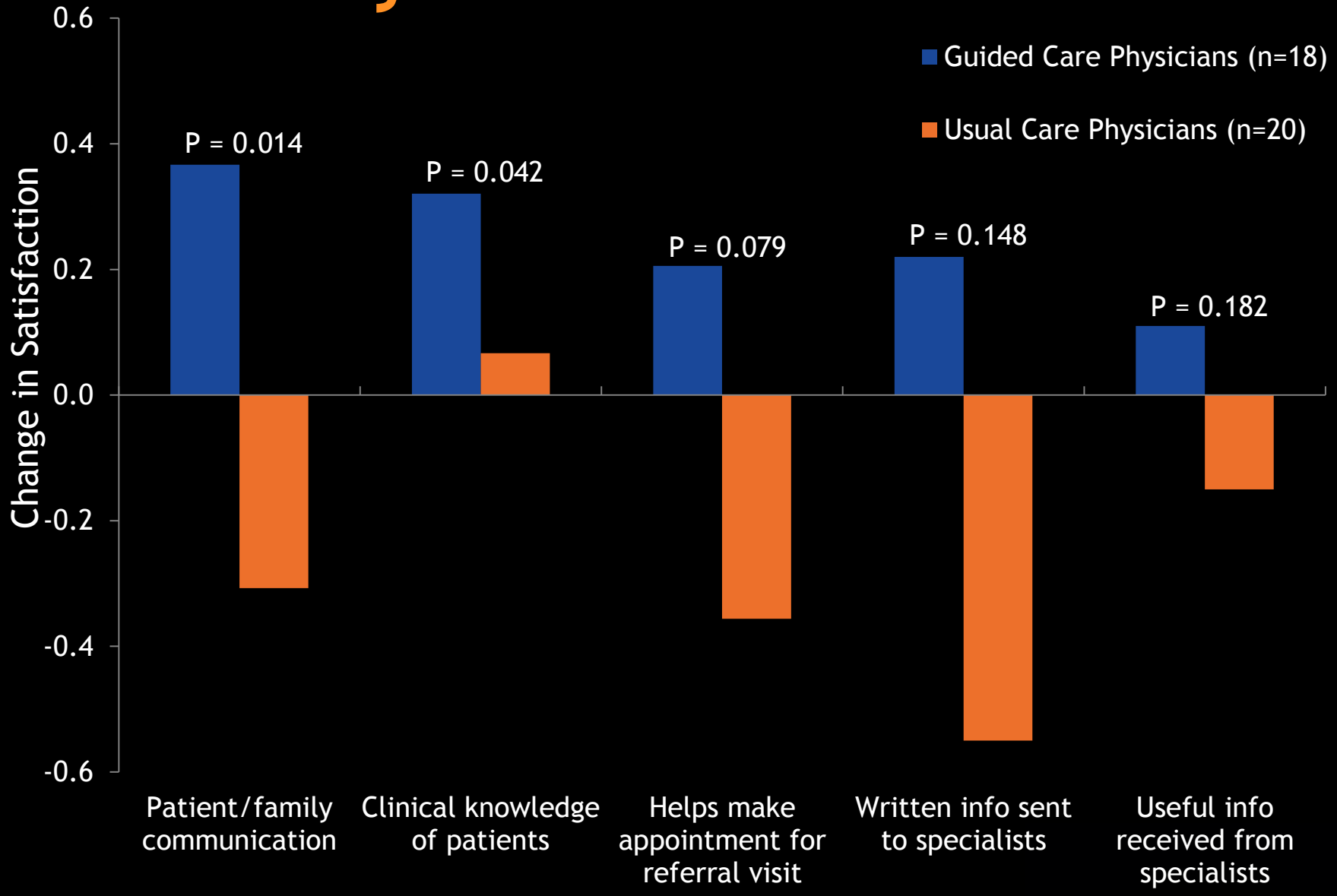
AGGREGATE

- Activation
- Problem Solving
- Decision Support
- Coordination
- Goal Setting



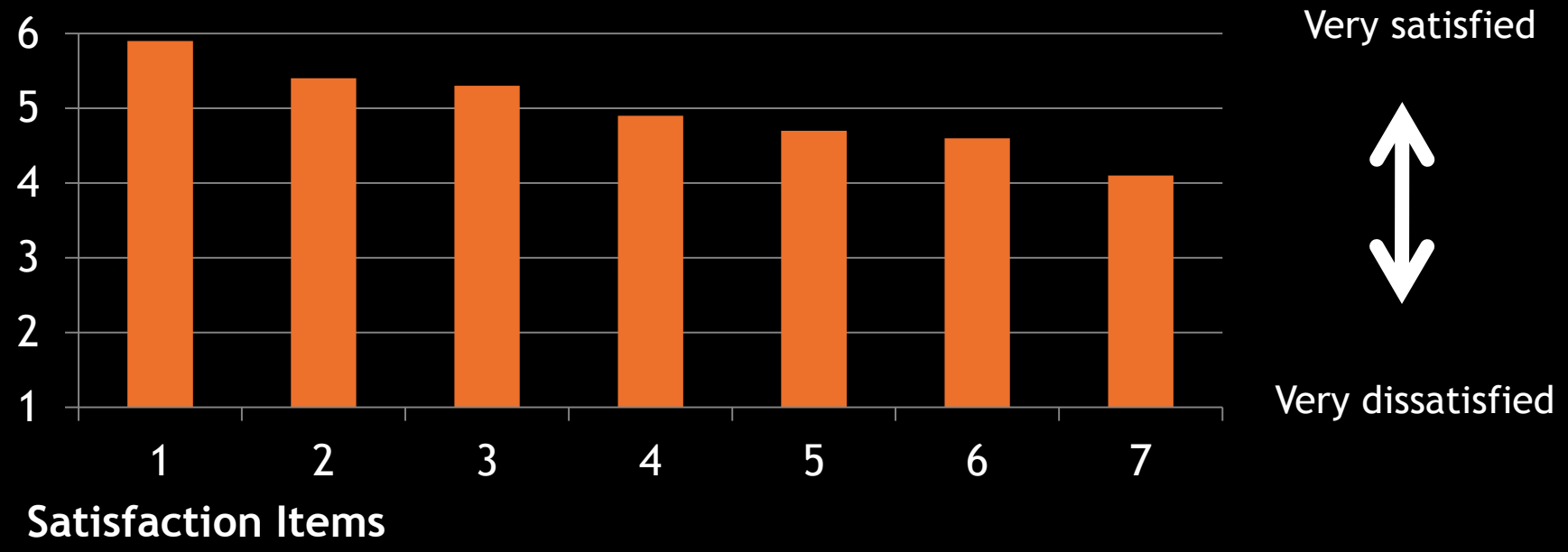
Boyd et al. *J Gen Intern Med* 2010

Physician Satisfaction



Marsteller JA et al. *Ann Fam Med* 2010

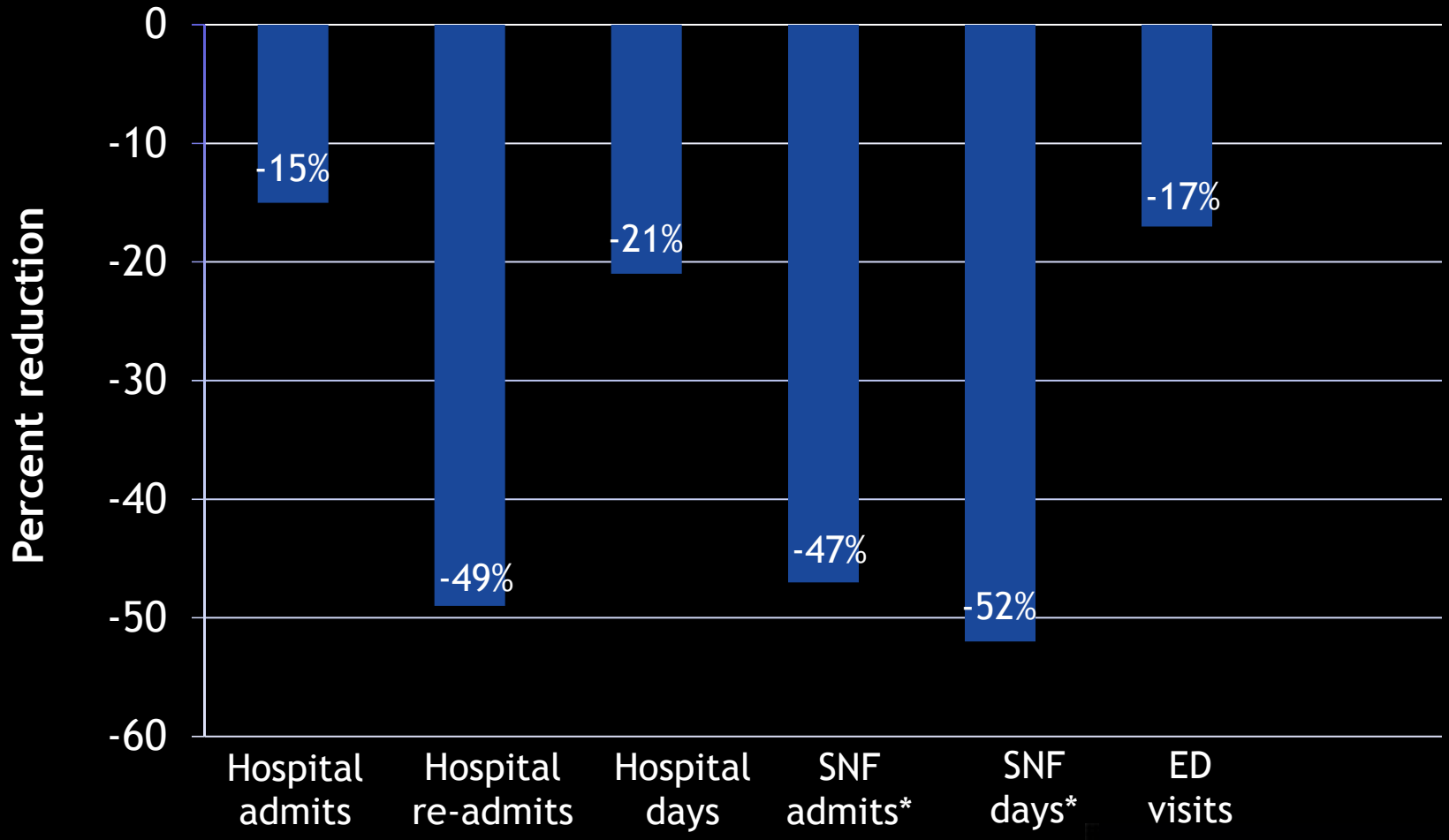
Nurses' Job Satisfaction



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 Gerontol* 2008

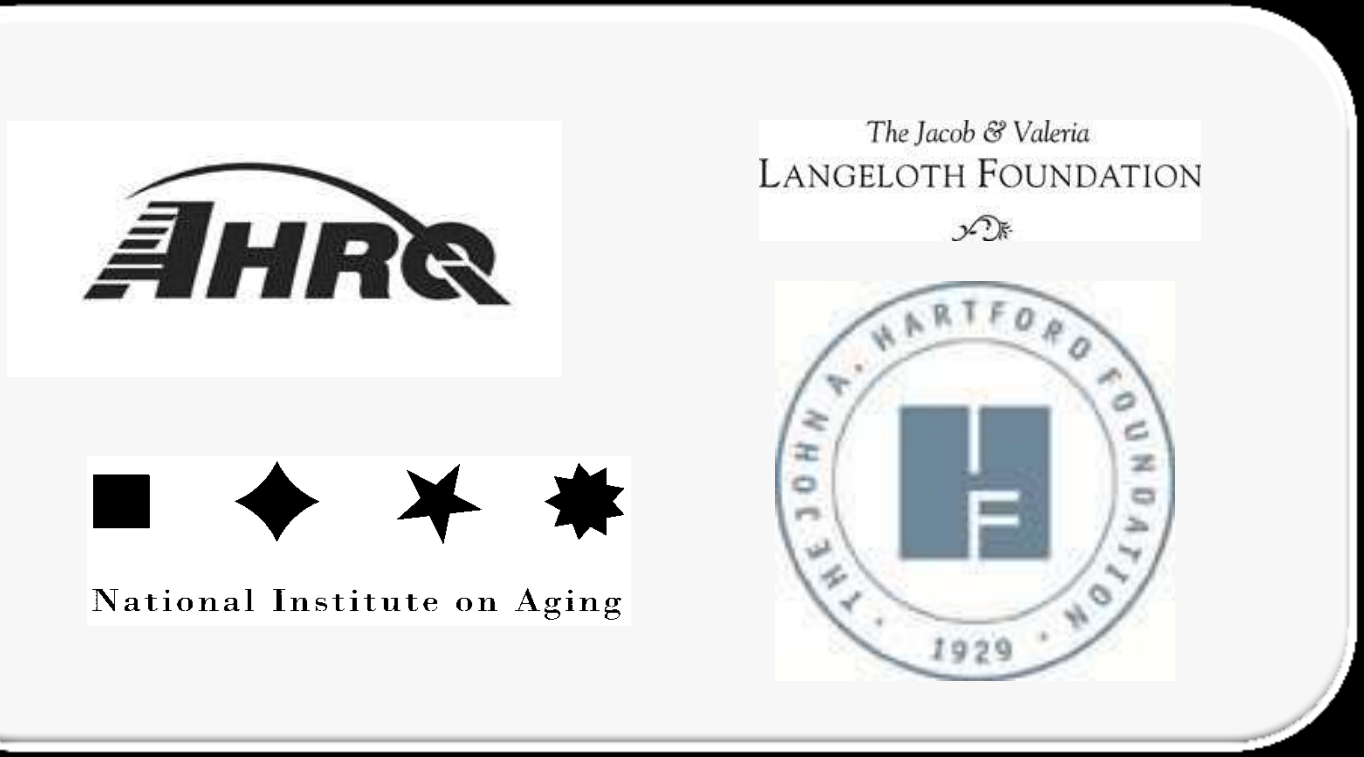
Utilization



* Statistically Significant

Boult C et al. *Arch Intern. Med 2011*

Guided Care Study Supported By



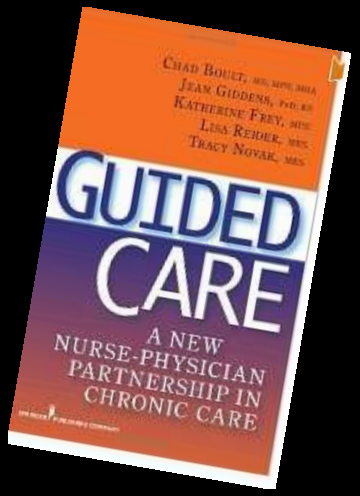
Technical Assistance

- Implementation Manual
  - *Guided Care: A New Nurse-Physician Partnership in Chronic Care* (Springer Publishing Co. 2009)
- Online course for RNs (scholarships available now)
- Online course for physicians and practice leaders
- Orientation booklet for patients and families

For details, visit

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.

Online Course for Nurses in Guided Care Nursing

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

Online Course for Practice Leaders

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

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

Booklet 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.

Care coordination teams in ACOs

Investment strategy

- Subsidy for primary care
- Dividends for ACO
  - Savings to be shared
  - Loyalty of patients, families, physicians, nurses

Care coordination teams in ACOs

Infrastructure

- Accurate targeting
  - Predictive modeling
  - Clinical judgment
- Interoperative HIT
- Management of targeting and coordination
- Financial rewards for desired outcomes

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Questions?

Comments?