



The Processes of Guided Care

Guided Care is a practical, interdisciplinary model of health care designed to improve the quality of life and efficiency of resource use for persons with medically complex health conditions. In Guided Care, a registered nurse, who is based in a primary care office, works closely with 2-5 physicians and other members of the care team to provide coordinated, patient-centered, cost-effective care to 50-60 of their chronically ill patients.

1. Comprehensive Assessment: The GCN performs a multifaceted health assessment of the patient through a structured home visit and a review of the medical record. The assessment includes medical conditions, medications, functional ability, cognition, nutrition, physical activity, the home environment, social support, and the patient's priorities and preferences for health care.

2. Evidence-based Care Planning: The GCN enters the assessment data into a web-based electronic health record (EHR), which "knows" the evidence-based guidelines for managing most chronic conditions. The GCN then uses the EHR to create a personalized Care Guide that lists medical and behavioral plans for managing and monitoring each of the patient's chronic conditions. The GCN and the primary care physician then personalize it so it aligns with the unique circumstances of the individual patient. Next the GCN discusses it with the patient and caregiver and modifies it further for consistency with their preferences, priorities, and intentions. The final Care Guide provides a concise summary of the patient's status and plans; it is updated regularly by the GCN. A patient-friendly version, called "My Action Plan" is written in lay language and displayed prominently in the home.

3. Self-Management: The GCN promotes the patients' self-efficacy in managing their chronic conditions by referring them to a free, local 15-hour (6 sessions) chronic disease self-management (CDSM) course, which is led by trained lay persons and supported by the GCN. In this course, developed at Stanford University, patients learn to refine and implement their Action Plans. Following the course, the GCN reinforces the patient's self-mgmt skills in improving diet, exercise, functional ability, use of medications, and self-monitoring of chronic conditions.

4. Monthly Proactive Monitoring: With reminders from the EHR, the GCN monitors each patient at least monthly by telephone to detect and address emerging problems promptly. When problems appear, the GCN discusses them with the primary care physician and takes appropriate action. The GCN uses motivational interviewing to facilitate the patient's participation in his/her care and to reinforce adherence to the Action Plan. During coaching sessions, the GCN expresses empathy, clarified discrepancies between current behavior and health goals, avoids arguing, and support self-efficacy.

5. Coordinating Efforts of all Providers: The GCN coordinates the efforts of all health care providers who treat Guided Care patients in emergency departments (EDs), hospitals, rehabilitation facilities, offices, nursing homes, and at home. Using the Care Guide as a tool, the GCN ensures that all providers are aware of the patient's complete medical status and plan of care.

6. Smoothing Transitions between Sites of Care: The GCN smoothes the patient's path between all sites and providers of care, focusing most intensively on transitions through hospitals, and keeping the primary care physician informed of the patient's status.

7. Educating and Supporting Caregivers: For the family or other unpaid caregivers, the GCN offers individual assistance, including an in-person assessment and ad-hoc telephone consultation.

8. Access to Community Resources: The GCN facilitates access to community resources to meet the patient's and caregiver's needs, and assists the patient in accessing them efficiently. The GCN may suggest that the patient or caregiver contact a transportation service, Meals-on-Wheels, the Area Agency on Aging, or a local Alzheimer's Association.