Guided care worth a look in general practice

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How a patient copes in the aftermath of a hospital discharge can make a big difference to their health and in costs to the system.

There has been a lot talked about over the past couple of years regarding the way in which a patient navigates the health system. The patient journey is often regarded as the yardstick by which we measure care.

But how often is the patient journey smooth - without bumps or wrong turnings or, even more commonly, heading down the same direction repeatedly but wastefully?

I'm sure we can all recognise the flaws in most journeys.

To give you a brief example - that of a 70-year-old male who has chronic obstructive pulmonary disease (COPD) and diabetes (long-term conditions) and then gets admitted to hospital with an acute cerebrovascular accident (CVA), which leaves him with residual but minor disabilities.

After his discharge home (he lives alone but is deemed safe to manage his activities of daily living independently), he gets a call the following day from a person who is part of a local transition-of-care project (DHB managed) but his medical home (general practice) doesn't receive the discharge summary for another three days.

He is meant to have some home help but unfortunately the assessment hasn't taken place yet and, again, the medical home knows nothing of this.

He has been started on some new medications but didn't fill the prescription before leaving hospital and hasn't got around to it yet.

He took all his medications into hospital with him so hasn't been taking any, and, on the second day after discharge, develops an acute exacerbation of his COPD and is readmitted to hospital. Sound familiar?

Now imagine if there was an individual attached to your practice who had been notified at the time of his discharge, someone who could have ensured the home help was in place, could have rung him and arranged for his medications to be delivered, and could have monitored him for a couple of days to ensure his care was appropriate and timely.

This same person could then also ensure his follow-up appointments were kept and, where possible, coordinated.

Such people do exist but currently there is no funding stream for them. They have a variety of names including health navigator, care coordinator and guided care nurse.

The concept of guided care nurses came out of Johns Hopkins University, and has been a major success both clinically and financially. The concept involves a nurse whose role it is to assess the needs and preferences of the patients she is caring for, and then create a care guide. In the Johns Hopkins model, this process uses an evidence-based software tool developed by them, but the HSA Global care plan software could conceivably also...
be adapted.

From that, an action plan is developed and involves proactive monitoring, supporting chronic condition self-management, smoothing the transition between different sites of care, communicating with all providers involved in care, eg, hospitals, outpatient clinics, home care, hospice, community agencies etc, educating and supporting caregivers, and facilitating access to community agencies.

In the US, the role of guided care nurses has been estimated to reduce hospital admissions by 50 per cent, but increase primary care visits by 8 per cent. They generally manage 50-60 patients, although this number could be increased if some tasks were delegated, for example, to primary care practice assistants, and if the number of phone calls once the patient stabilises were reduced.

In whanau ora the role of navigator is somewhat similar, although it has more of a coordinating function with less clinical input.

Of course, the issue is always funding. Costs to the health system have been shown to reduce with the guided care model, but in New Zealand that would require an integrated approach with the DHBs, as much of the saving is in reduced admissions, but the costs are associated with primary care.

There are some DHBs that are interested in the model and are trialling it - but using different nurses at different times in the patient journey.

Whatever the method, and whatever the name, the concept is one that deserves attention both in primary care and at the DHB level.

Furthermore, the patient deserves it in order to have a better journey through the health system.

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