Geriatric Resources for Assessment and Care of Elders

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Background

- Older persons with multiple chronic illnesses and geriatric conditions:
  - Often do not receive recommended standards of care
  - Account for a disproportionate share of expenditures

- New models of care are needed that:
  - Improve quality without increasing costs
  - Optimize the roles of primary care and geriatrics healthcare professionals
  - Integrate medical and social care

Background

- PCPs have limited time and resources to provide comprehensive care to older patients

⇒ GRACE

Geriatric Resources for Assessment and Care of Elders
Unique Features of

- In-home assessment and care management by team of experts
- Specific care protocols to manage common geriatric conditions
- Integrated EMR documentation
- Web-based care management tracking
- Integrated pharmacy, mental health, hospital, home health, and community-based services
GRACE Team Care

1. In-home geriatric assessment by a NP and SW team
2. Individualized care plan using GRACE protocols
3. Weekly interdisciplinary team conference
   • Geriatrician
   • Pharmacist
   • Mental Health Liaison
GRACE Team Care

4. NP and SW meet with PCP

5. Implement care plan consistent with participant’s goals

6. Ongoing care management and caregiver support

7. Ensure continuity and coordination of care, and smooth care transitions
Transitional Care

- Check hospital and ED alerts
- Communicate baseline status and care plan
- Collaborate in planning transition
- Deliver transitional care including home visit
  - ✓ Proactive support of participant and family/caregiver
  - ✓ Reconcile medications/provide new medication list
  - ✓ Ensure post-discharge arrangements implemented
  - ✓ Inform PCP and schedule follow-up visit
- Review in GRACE team conference
GRACE Protocols

- Advance Planning
- Health Maintenance
- Medication Management
- Difficulty Walking/Falls
- Depression
- Dementia
- Caregiver Burden
- Chronic Pain
- Malnutrition/Weight Loss
- Urinary Incontinence
- Visual Impairment
- Hearing Impairment
GRACE Trial: Better Quality and Outcomes

• Better performance on ACOVE Quality Indicators
  ✓ General health care (e.g., immunizations, continuity)
  ✓ Geriatric conditions (e.g., falls, depression)

• Enhanced quality of life by SF-36 Scales
  ✓ General Health, Vitality, Social Function & Mental Health
  ✓ Mental Component Summary

• Lower resource use and costs in high risk group
  ✓ Fewer ED visits and hospitalizations
  ✓ Reduced acute care costs offset program costs

Keys to Success

1. NP/SW team assigned by physician and practice site
2. Focused on geriatric conditions and medication management to complement primary care
3. Provided recommendations for care and resources for implementation and follow-up
4. Incorporated proven care transition strategies
5. Provided home-based and proactive care management
6. Integrated with community resources and social services
7. Developed relationships through longitudinal care
Model of Care for Adults with Complex Health Care Needs

- Evidence-based
- Flexible
- Integrated
- Reduces high cost utilization
- Infuses geriatrics principles
- Includes mental health
- Collaborative team approach
- Patients and physicians are highly receptive
GRACE Training and Resource Center

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Website
http://graceteamcare.indiana.edu

Implementation Support

- Webinars
- Indianapolis Site Visit
- On-Site Team Training
- GRACE Training Manual
- Assessment Forms
- GRACE Care Protocols
- GRACE Dashboard
- Physician Collaboration Guide
- Business Case Tool
**What:** GRACE Team Care

**Offered By:** Indiana University School of Medicine

**First Launched:** 2002

**Why GRACE:** The GRACE program goes well beyond traditional care coordination by demonstrating how a high-intensity care-team approach outside of the hospital setting can improve the patient experience, particularly for low-income seniors, dual-eligibles and others with complex medical and social needs. GRACE has been shown to enhance quality of geriatric care in ways that optimize health and functional status, decrease excess healthcare use, reduce healthcare costs, and may prevent or delay long-term nursing home placement.

**Available To:** The GRACE program is currently offered through the Medicare Advantage program of IU Health Plans and is being successfully applied at several other health plans, medical groups and VA hospitals in select markets around the country. To date, more than 5,000 people and 400 primary care physicians have benefited from the GRACE model.

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The Five Most Commonly Asked Questions About GRACE

1. **What is GRACE Team Care?**
   GRACE Team Care™ (Geriatric Resources for Assessment and Care of Elders) from Indiana University School of Medicine represents a fresh approach and a new model of care for effectively managing the health and well-being of high-risk Medicare populations. The catalyst for the GRACE model is the nurse practitioner and social worker referred to as the GRACE Support Team. The GRACE Support Team meets with each older adult in his or her home to conduct an initial geriatric assessment. Following the in-home assessment, the support team meets with the GRACE Interdisciplinary Team composed of a geriatrician medical director, pharmacist, and mental health liaison to develop an individualized care plan using the GRACE protocols. The GRACE Support Team then meets with the older adult’s primary care physician to review, modify and prioritize the plan. The care plan is implemented by the GRACE Support Team in collaboration with the primary care physician and consistent with the older adult’s goals.

2. **Why is GRACE important?**
   With Medicare-eligible citizens now representing the fastest-growing segment of the American population, the value GRACE brings to the individual patient, the healthcare industry as well as society as a whole has never been greater. With a special emphasis on the unique and ongoing needs of frail, older adults, GRACE has been proven to enhance quality of geriatric care in ways that optimize health and functional status, decrease excess healthcare use, including avoidance of hospitalization and visits to the emergency department. GRACE may also prevent or delay the need for long-term nursing home placement by allowing seniors to stay in their homes with better support. GRACE has also been shown to deliver proven value as it relates to higher quality of life, better care coordination, and lower overall healthcare costs.

3. **What differentiates GRACE from other care coordination programs?**
   The catalyst for the GRACE program is a unique and specially trained support team headed by a nurse practitioner and a social worker who support the primary care physician in fully addressing a patient’s health conditions and achieving a patient’s goal from the comfort of their own home. This team provides patients with specialized care for geriatric conditions (e.g. falls, depression, memory problems); healthcare education; medication management; and coordination of care between specialty physicians, the emergency department, hospitals and a broad array of community support services.

4. **How else do GRACE patients benefit?**
   In addition to ongoing team care support, GRACE patients benefit from:
   - Evidence-based care protocols for evaluation and management of geriatric conditions.
   - An integrated EMR for documentation.
   - A Web-based care management tracking tool.
   - Home-based and proactive care management.
   - Pharmacy, mental health, hospital, home health and community services.

5. **How do I know GRACE works?**
   The efficacy of the GRACE solution in smartly coordinating care for vulnerable seniors has been documented in a 2014 study from Avalere Health as well as in recent articles in *JAMA, Health Affairs, the Journal of the American Geriatrics Society, Healthcare Business Today, Physician’s Practice* and many other places. In addition to providing significant value to the patient, studies have shown that GRACE can produce a 95 percent ROI per year for the sponsoring health plan. In doing so GRACE generates cash flow and cost savings for sponsoring organizations while at the same time enhancing quality care provided to its members.

www.graceteamcare.indiana.edu
Services Available for Replication of GRACE Team Care™

Comprehensive training and technical assistance is available through the Indiana University (IU) Geriatrics GRACE Training and Resource Center.

◆ **Pre-Implementation Webinars**: A series of webinars are offered to provide an overview of GRACE Team Care, discuss specific organizational goals and identified target populations, and review the implementation process. Information on the business case for GRACE Team Care is provided to aid in program planning.

◆ **Indianapolis Site Visit**: Participants are invited for a six-hour visit to a GRACE Team Care program to meet with organizational leadership and GRACE Team Care staff and see the model in practice including observing an interdisciplinary team meeting.

◆ **Implementation Conference Calls**: Conference calls are offered to provide support, instruction and problem solving toward implementation of GRACE Team Care.

◆ **Intensive In-Person Team Training**: A 12-hour in-person training session is offered for future GRACE Team Care members including nurse practitioners, social workers, program coordinator, geriatrician, pharmacist, mental health liaison, primary care physician, and project manager. During this training participants will review educational needs based on self-assessments, discuss principles and concepts underlying GRACE Team Care, learn the key components of the model, review the roles of various GRACE team members, become familiar with the GRACE in-home geriatric assessment tools, demonstrate effective interdisciplinary team care planning, apply GRACE protocols and corresponding interventions, and understand strategies for care coordination and transitional care. Teaching strategies will include small-group interactive sessions and applied learning using case-based simulations.

◆ **GRACE Training Manual**: Each individual attending the 12-hour in-person training session receives a GRACE Training Manual. In addition to providing detailed information on GRACE Team Care, the manual includes the evidence-based GRACE protocols and corresponding team interventions. Copies of the in-home assessment tools used by the GRACE nurse practitioner and social worker are included in the manual along with sample copies of completed GRACE assessments and care plans.
◆ **On-Line Tools and Resources**: A variety of tools and resources are available for GRACE Team Care training participants through a Member Forum on the GRACE Team Care website. Available tools and resources include:

- Guidelines for Steering Committee and Implementation Teams
- GRACE Team Member Job Descriptions
- Implementation Checklist
- Enrollment Criteria (High-Risk and Transition)
- GRACE Training Manual
- Assessment Forms
- GRACE Protocols
- Primary Care Physician Introduction Materials
- GRACE Business Case Guide
- Simple Business Case Tool
- Professional Development Resources

◆ **GRACE Dashboard**: Assistance is provided to develop a customized GRACE Dashboard to monitor program implementation and improvement in quality measures pertaining to targeted geriatric conditions.

◆ **Evaluation & Sustainability Conference Calls**: Conference calls are offered to provide assistance in program evaluation. Information and materials on business planning for GRACE Team Care will guide replication sites in developing plans for long-term program sustainability.

◆ **Evaluation & Sustainability Session**: This six-hour in-person session focuses on program evaluation and strategic planning for sustainability and expansion of GRACE Team Care within the organization where applicable.

◆ **GRACE Tracking System**: A robust care management Web-based program used by the GRACE Team Care members to build and manage care plans using the GRACE protocols and evidence-based interventions. The tracking system also includes a number of report functions and ability to customize it for specific organizations.

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GRACE
A new model of care for effectively managing the health and well-being of high-risk Medicare populations, with a special emphasis on the frail and most vulnerable.

KEY ELEMENTS OF THE GRACE MODEL OF CARE:
- Nurse practitioner and social worker team
- In-home geriatric assessment
- Individualized care plan
- Support of primary care physician
- Mental health and pharmacy
- Better care coordination
- Address common geriatric conditions
- Smooth care transitions
- Caregiver support

GRACE HAS BEEN PROVEN TO:
- Provide person-centered care
- Enhance quality of life
- Optimize health and functional status
- Decrease excess healthcare use

THROUGH THE GRACE PROGRAM:
- 30% reduction in hospitalization rates
- 50% reduction in hospital readmission rates
- 25% reduction in emergency room visits

COST SAVINGS THROUGH GRACE:
- Nearly $4,300 in annual savings per person
- ROI per year of 95 percent

All Together Better Care

GRACE TEAM CARE
Geriatric Resources for Assessment and Care of Elders
from Indiana University School of Medicine
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*Independent study by Avalere Health, September 2014

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