



**Care That Works:  
Geriatric Resources for  
Assessment and Care of  
Elders (GRACE)**

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# Care That Works: Geriatric Resources for Assessment and Care of Elders (GRACE)

*This is the second in an occasional series highlighting promising strategies for person-centered care for people with complex care needs.*

## WHAT IS GRACE?

The [Geriatric Resources for Assessment and Care of Elders \(GRACE\) model](#) was initially developed and implemented more than a decade ago by the Indiana University School of Medicine's Center for Aging Research. Designed as a solution to the health care challenges faced by low-income older adults with multiple chronic conditions, this home-based care program supports the office-based primary care physician and offers an integrated approach to improve care management; coordinate with mental health and social services; and prevent unnecessary emergency department visits, hospitalizations, and long-term nursing home placement. A particular focus of the model is on care transitions, which can cause serious issues for older adults with multiple chronic conditions.

The catalyst for the GRACE intervention is the GRACE Support Team, consisting of a nurse practitioner and a social worker. Upon enrollment, the GRACE Support Team meets with the patient in the home to conduct an initial comprehensive geriatric assessment. The support team then meets with the larger GRACE interdisciplinary team (including a geriatrician, pharmacist, and mental health liaison) to develop an individualized care plan including activation of the GRACE protocols for evaluating and managing common geriatric conditions. The Support Team implements the care plan in collaboration with the patient's primary care physician (PCP).

GRACE enrollees are seen by their Support Team, as needed, to implement the care plan and provide ongoing care management. At a minimum, enrollees are visited in their home or contacted by phone at least once a month. If an enrollee is hospitalized or has an emergency room visit, a Support Team member will visit the enrollee at home and revise the care plan as needed. Scheduled reviews of the care plan are built into the model at one, two, three, six, nine and twelve months to ensure care plan implementation, determine progress toward goals, problem solve and prioritize interventions.

### Quick Facts about GRACE

- GRACE serves frail older adults with complex needs
- The interdisciplinary team is led by a geriatrician and includes a nurse practitioner, social worker, pharmacist, and mental health liaison
- The team collaborates with the patient's primary care physician
- Patients and their families participate in developing an individual care plan
- The program utilizes a web-based care management tracking tool and an integrated electronic medical record
- To date, 23 organizations in seven states have implemented the GRACE model

### Eligibility Criteria

- GRACE has been adapted to a variety of clinical settings. In general, the target population for the model is 65 years or older with functional limitations and/or geriatric conditions (e.g., falls, depression, dementia) and a high risk for hospitalization

The GRACE program was originally developed as a longitudinal model. However, GRACE has been replicated in many settings as a care management program with an average length of stay of 12 months (range of 6-18 months, depending upon individual patient needs and progress toward achieving care goals). Discharge criteria for the program include: permanent placement in a long-term care facility, moving out of the geographic region of the GRACE team, or the patient no longer needs the GRACE level of service as determined by stability of geriatric and social conditions.

The GRACE model has demonstrated positive results:

- Older adults and their primary care physicians are highly receptive to the GRACE model of care.<sup>1</sup>
- Low-income enrolled in the GRACE program, compared to usual care, received better quality of care for geriatric conditions (e.g., falls and depression) and general health processes (e.g., preventive care and advance directives).<sup>2</sup>
- Compared to usual care, GRACE participants had improvements in measures of general health, vitality, social function and mental health.<sup>2</sup>
- Emergency department visits and hospital admissions were significantly reduced in year two compared to usual care among the subgroup of GRACE participants identified at baseline as being at high risk of hospitalization.<sup>2</sup>
- A cost analysis of the GRACE model revealed that for high-risk GRACE participants, the program was cost neutral in the first two years, and cost saving in the third (post-intervention) year.<sup>3</sup>
- The GRACE model can yield a positive return on investment (ROI) when implemented in high-risk Medicare populations. Avalere estimated for GRACE an ROI per year of 95 percent and \$174 per member per month savings.<sup>4</sup>
- The GRACE model has been successfully implemented within a variety of health systems with similar results in reductions of acute care utilization.<sup>5,6,7</sup>

## The Consumer Experience: Ms. Helen Carson's Story



*Ms. Helen Carson (right) with Natalie Stafford, her GRACE program nurse practitioner.*

Helen Carson – an 81-year-old Indianapolis resident who enjoys word searches in her free time – joined GRACE in mid-2016. She describes her transition from managing her own care to enrolling into GRACE as a wonderful experience.

She heard about the GRACE program from a close friend from her church. Ms. Carson was having trouble getting around due to osteoarthritis in her knees. Although having regular phone contact with her children and attending church, Ms. Carson was feeling socially isolated and anxious about being alone, especially at night. She was also having difficulty affording her medications which led to poor medication plan adherence. Her friend – already a GRACE member – suggested calling the program. As Ms. Carson said, “they came out to see me and talk with me and they enrolled me in it.”

An immediate benefit of the GRACE program for Ms. Carson was getting connected to “CICOA,” the local Area Agency on Aging and a partner with the GRACE program. GRACE helped her enroll in Medicaid, enabling her to get a full set of dentures. It also helped her get a personal emergency response system, which she did not have before, and which helped alleviate her nighttime anxiety. And more recently, the GRACE program helped her get a lift chair and replacement rollator walker which has helped with her mobility. Additionally, the GRACE team has helped Ms. Carson with medication management by conducting a thorough medication reconciliation, creating a patient-friendly medication list, and providing education on each of her

medicines. The GRACE team has also provided education on pain management to help her maximize her activities.

In addition to the regular GRACE team visits, CICOA also provides Ms. Carson with an aide who sees her once or twice a week. Her aide also helps her with cleaning. She also regularly participates in the weekly community outings organized by a local senior center.

“I did not know that this existed before. My nurse practitioner comes to see me every two to three months for whatever I need. All I have to do is call them, and they see that I get it. I have nothing but good things to say about GRACE.” GRACE has helped Ms. Carson identify her personal goals and work towards accomplishing them. Since joining the program, she has experienced an enhanced quality of life due to improved mobility and increased socialization.

**GRACE Team Care provides person-centered care through:**

- Individualized, goal-oriented care plans based on patients’ preferences;
- Ongoing review of the patient’s goals and care plan;
- Care supported by an interdisciplinary team, including geriatrics expertise;
- Active coordination among all health care and social support providers; and
- Integrated and continued information sharing among all providers.

Natalie Stafford, nurse practitioner, and Jenny Grover, social worker, are Ms. Carson’s Support Team. They described how a new patient’s intake process works. “When Jenny and I get a new patient request, we will go out and see them together as a team. As a social worker, Jenny will do a depression and memory screen; I focus on medications and the medical aspect. We go back to the team to report findings, abnormalities, and we come up with a care plan and choose a protocol. Our geriatrician will give feedback on the plans, and the pharmacist will offer suggestions as needed.”

Home visits are critical. One of the keys to effectiveness of the in-home assessments is it’s geriatrics-focused. The team members do a functional status check, medication reconciliation, and gait and balance evaluation. The social worker checks on the psychosocial aspects of care, including the caregivers who are involved. The visit includes a caregiver assessment and a home safety evaluation. A tremendous benefit of a home visit is that it provides a full picture of the participant’s individual function and living status, according to Dawn Butler, center director for GRACE Team Care at Indiana University.

Both Natalie and Jenny stressed the importance of communicating with the patient’s primary care physician (PCP). Sometimes, this involves giving the PCP an update on what is going on in the home or things that may have changed with the patient’s family dynamics. Regular updates to the PCP helps get the PCP’s buy-in on home health and referrals to other support services.

“Improving the smallest aspects of our patients’ lives can make a huge impact,” Jenny Grover remarked. “One simple thing can make a huge difference to the patient. We consider moments like that successes.”

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