– The GRACE Team Care Approach –

Managing High-Need High-Cost Populations

NAACOs Medicaid Learning Lab Webinar
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Regenstrief Institute

INDIANA UNIVERSITY

ESKENAZI HEALTH

Overview

A. Identify older persons who stand to benefit most from integrated care.

B. Describe the GRACE Team Care™ model and clinical trial results.

C. Discuss lessons learned from replications of GRACE Team Care.

D. Describe training and technical assistance available for GRACE implementation.

Implementation of Complimentary Models of Primary Care for Medicare Populations

- Past – Office-based primary care physician
- Present – Patient Centered Medical Home
  - Office-based nurse care manager
  - Care transitions by RN or SW
- Future – High Intensity Care Management
  - Home-based APN/RN and SW team
  - Transitional care by APN

⇒ **GRACE Team Care**

GRACE TEAM CARE

All Together Better Care

Older People with Chronic Diseases and Functional Limitations

- Need more medical services and social supports
- Geriatric conditions (e.g., dementia, depression, falls)
- Socioeconomic stressors, low health literacy, limited access and fragmented healthcare
- Have high healthcare costs
  - The **20 percent** of older adults with chronic conditions and receive help in basic or instrumental ADLs represent **40 percent** of all health spending by community residents 65 and over.

Older Person with Chronic Diseases and Functional Limitations

- Multiple chronic illnesses: HTN, CHF, and DM
- Geriatric conditions: dementia, falls, and ADLs
- Family and caregiver support needs
- Home & community-based services case manager
- Primary and specialty care physicians
- Limited geriatrics expertise of healthcare providers
- Poor communication and coordination of care

GRACE
Team Care Model

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

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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

Counsell SR, et al. J Am Geriatr Soc 2006;54:1136-1141.

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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

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GRACE Protocols

- Advance Care Planning
- Health Maintenance
- Medication Management
- Difficulty Walking/Falls
- Depression
- Dementia
- Caregiver Burden
- Chronic Pain
- Malnutrition/Weight Loss
- Urinary Incontinence
- Visual Impairment
- Hearing Impairment

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GRACE Protocol: Difficulty Walking / Falls

PCP Review

- Confirm diagnosis and update EMR
- Evaluate and treat causes
- Order lab evaluation (check CMP, CBC, TSH, B12)
- Optimize pain medication
- Consult physical therapy
- Consult Geriatrics or Neurology

Routine Team

- Monitor orthostatic vital signs
- Increase fluid intake
- Prescribe walking program
- Provide patient education on falls prevention

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GRACE Results

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

Counsell SR, et al. JAMA 2007;298(22):2623-2633.
Counsell SR, et al. J Am Geriatr Soc 2009;57:1420-1426.

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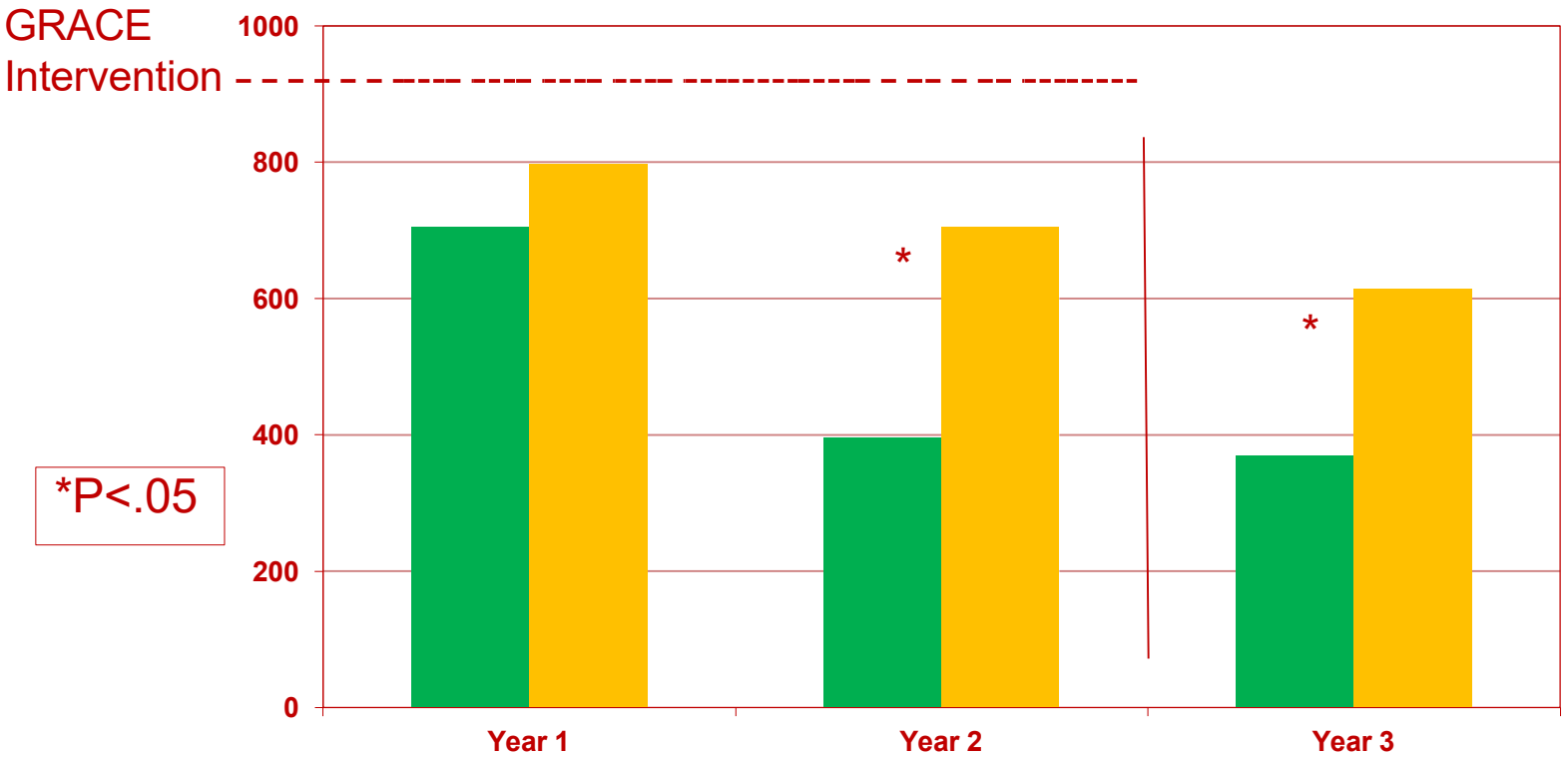
High Risk Patients: Decreased Admissions



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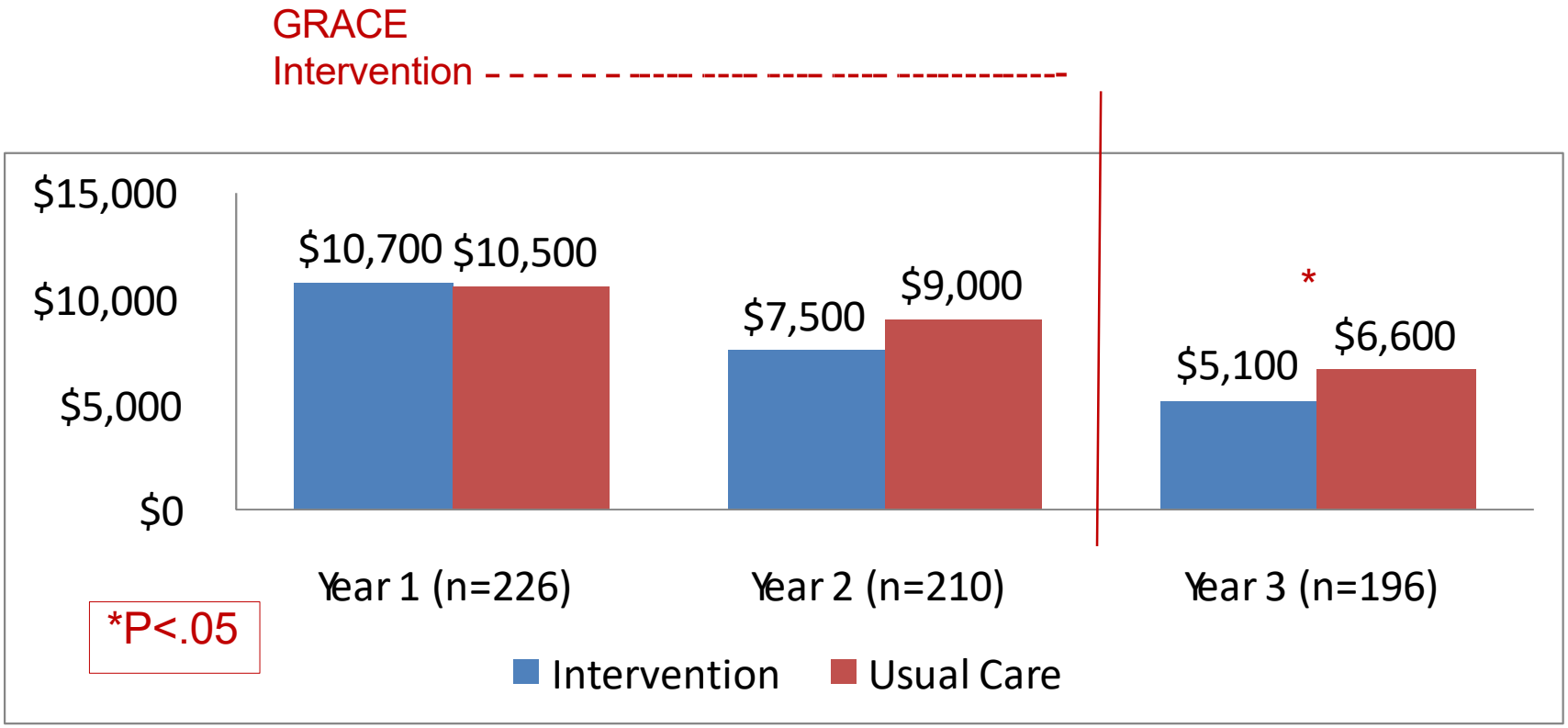
High Risk Patients: Lower Costs



GRACE TEAM CARE

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

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GRACE
Replication

GRACE Team Care: First 3 Replications

HealthCare Partners Medical Group – Los Angeles

- Population: Homebound
- Setting: Home-Based Primary Care

VA Healthcare System – Indianapolis

- Population: Hospital to Home Transition
- Setting: Office-Based Primary Care

IU Health Medicare Advantage Plan – Indianapolis

- Population: High Risk Medicare
- Setting: Office-Based Primary Care

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HealthCare Partners

HealthCare Partners
Medical Group and Affiliated Physicians

Demographics (n=171)

- Mean Age, 85 years (range, 48-109)
- 74% Female
- 94% enrolled from high risk chronic care – HomeCare Program (mean 6.0 months)
- 6% enrolled post-acute

Satisfaction (>90% agreed)

GRACE model…

- Increased overall patient satisfaction
- Improved quality of life
- Very helpful in providing care to older patients
- Led to better follow-up and coordination of care

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HealthCare Partners

HealthCare Partners
Medical Group and Affiliated Physicians

Quality (>95% performance)

- Screened for falls and depression
- Used protocols for falls and depression when indicated
- Medication list to patient
- Surrogate decision-maker documented

Outcomes (n=172)

Before/After (12 months)

Reduced Utilization

- ▼ 34% Hospital Admissions
- ▼ 29% Hospital Bed Days
- ▼ 44% Sub Acute Admits
- ▼ 53% Sub Acute Bed Days
- ▼ 22% ED Visits

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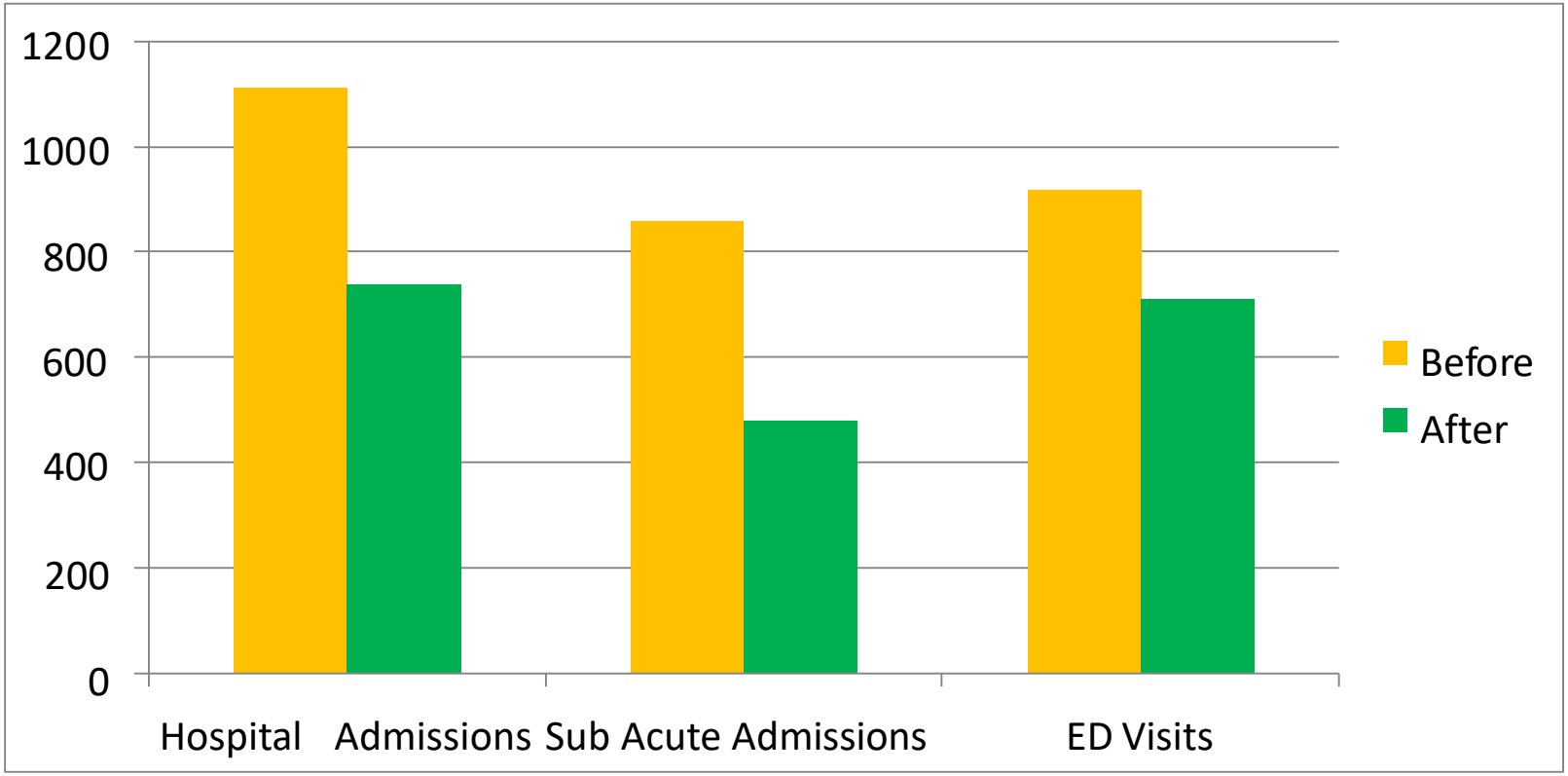
Utilization Rates Before and After GRACE

HealthCare Partners
Medical Group and Affiliated Physicians



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VA GRACE: Care Transitions Plus

Over 500 Veterans and 300 caregivers served

Care Enhancements

- Continuity and coordination of care
- Medication reconciliation and appropriateness
- Falls prevention
- Depression management
- Dementia identification and management
- Caregiver support

DEPARTMENT OF VETERANS AFFAIRS
RICHARD L. ROUDEBUSH VA MEDICAL CENTER
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Readmission and Hospitalization Rates

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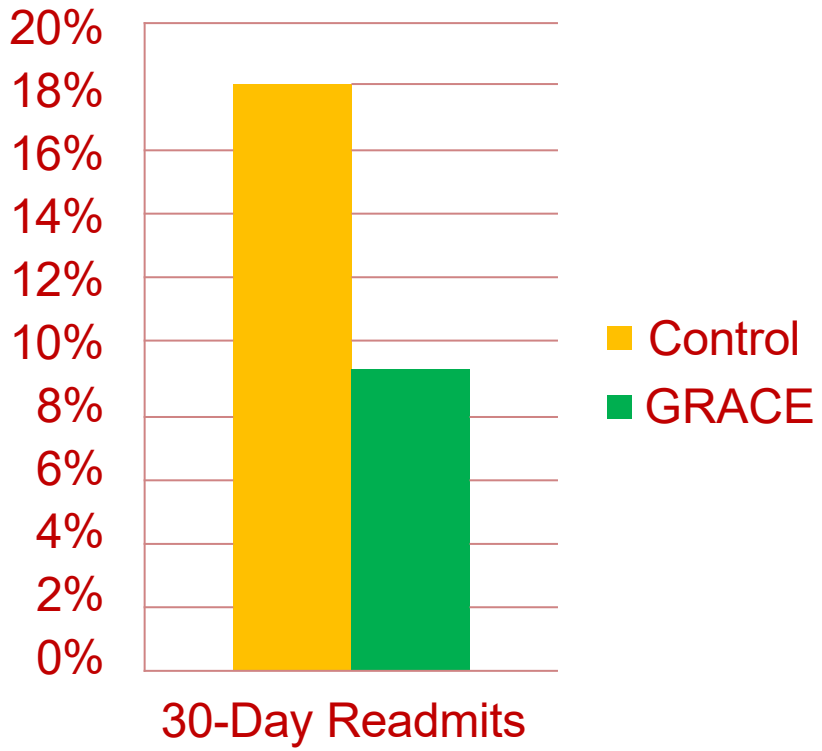

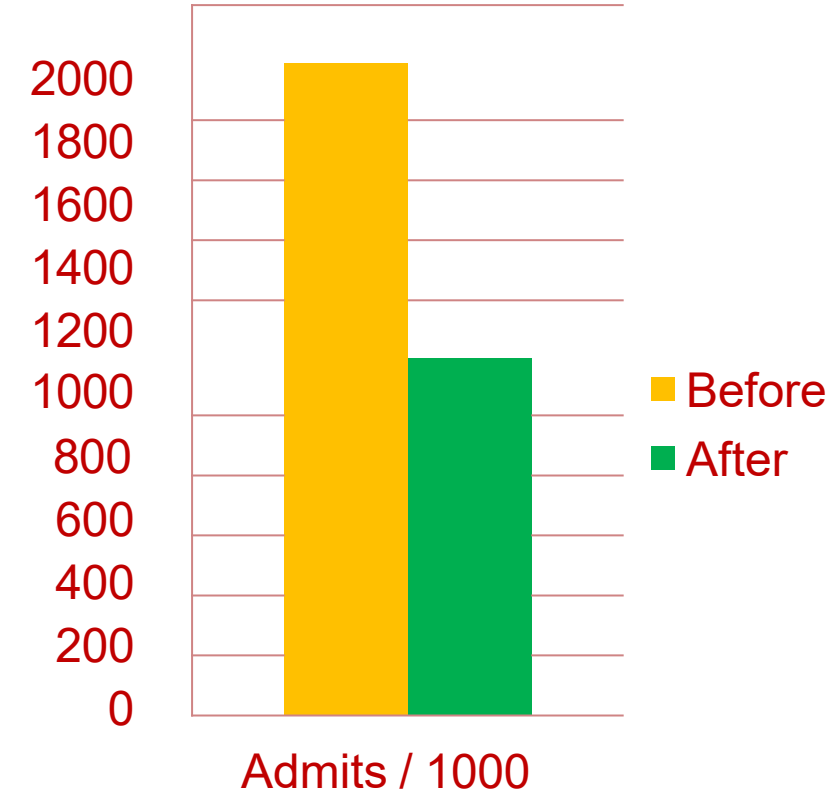

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Indianapolis VA Medical Center

Veteran - *"I am amazed at how you guys keep track of me! GRACE is amazing! I surely do appreciate you guys. You are a great team to have caring for me."*

Caregiver - *"The GRACE team saved my husband's life and my sanity. I had hit rock bottom when the team came to our home and didn't know how we were going to continue like this. The entire team is warm and sensitive to our needs. I would like to thank GRACE from the bottom of my heart for giving me my old husband back!"*

PCP - *"Thank goodness GRACE is involved on this patient!"*

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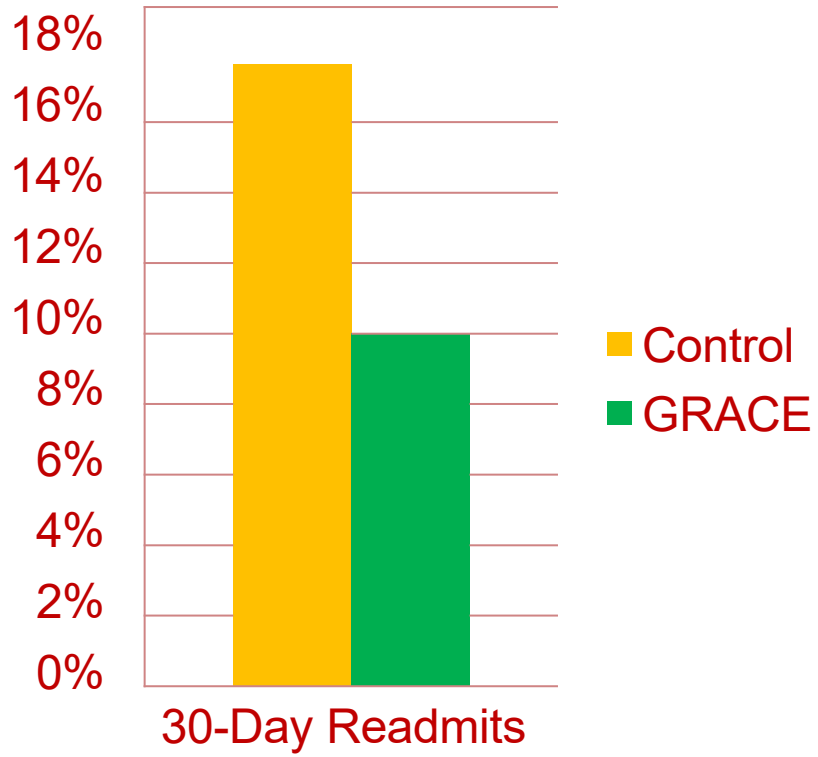
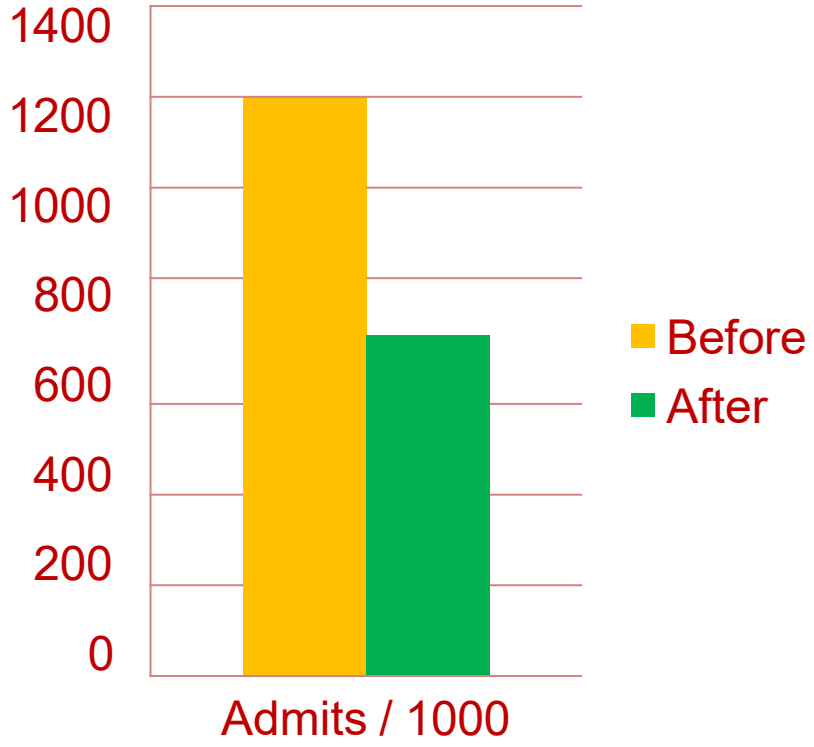
Readmission and Hospitalization Rates

IU Health Physicians





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IU Health – Medicare Advantage Plan

Metric	Before (12 Months)	After (25.5 Months)
Inpatient Admits	1,226 per 1,000	699 per 1,000 ***43% Improvement***
Inpatient Costs	$984 PMPM	$480 PMPM ***51% Improvement***
Total Costs	$2,107 PMPM for GRACE Members	$627 PMPM cost reduction ***30% Improvement***
Premium Increase	$1,526 PMPM for GRACE Members	$156 PMPM increase ***11% Improvement***

GRACE TEAM CARE

Business Case for GRACE

Costs

- 7 FTE (3 NP, 3 SW, 1 Coordinator)
- 0.3 FTE (0.1 Med Dir, 0.1 MH, 0.1 Pharm)
- Caseload of 300

➢ Total Cost: **$630,000**

Projected Savings

➢ **$1,080,000**

- 30% reduction in hospitalizations or 108 avoided hospital admits

Assumptions: Baseline admit rate of 1,200 per 1,000; $10,000 per admit

Enhanced Revenue

➢ **$480,000**

•10% increase in premiums

Assumptions: Baseline monthly premium $1,333; annual $16,000.

Avalere's ROI Analysis of GRACE

- *"Effective management of key populations – e.g., older adults with multiple chronic conditions and functional impairment – not only improves outcomes for plan members, but can yield a positive return on investment (ROI)."*
- Avalere's ROI analysis indicates that the GRACE model can yield an ROI of 95%.

Annual Cost/Member	= $2,201
Annual Savings/Member	= $4,291
ROI Per Year	**= 95%**
PMPM Savings	= $174

Effective Management of High Risk Medicare Populations, Avalere Sept 2014

Less Quantifiable Benefits of GRACE

1. Improved patient experience and patient loyalty.
2. Reduction in 30-day readmission rates.
3. Better performance on quality metrics and star ratings.
4. Greater PCP efficiency and job satisfaction.
5. Increased revenue from identification of geriatric conditions, and appropriate risk adjustment.

Less Quantifiable Benefits of GRACE

6. Assistance to patients to optimize health insurance coverage (e.g., Medicaid) and benefits that offset out-of-pocket costs.
7. Improved access to community resources and services.
8. More appropriate utilization of HCBS and LTSS.
9. Prevention or delay of institutional long-term care.

GRACE TEAM CARE

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GRACE Team Care Training and Technical Assistance

California

- UCSF Medical Center
- Health Plan of San Mateo
- Whittier Hospital Medical Center & Central Health Plan

VA Healthcare System

- San Francisco VAMC
- Cleveland VAMC
- Atlanta VAMC

Michigan

- University of Michigan Health System
- Blue Cross Blue Shield of Michigan

ABC's of GRACE Implementation

A. **Agree**… on the need and that GRACE is a "win-win-win"
B. **Build**… with strong MD leadership and team approach
C. **Commence**… with focus on patient-centered care and attention to provider issues
D. **Document**… process of care to ensure fidelity to model
E. **Evaluate**… benefits to patients, providers & health system
F. **Feedback**… results to key stakeholders for sustained support
G. **Grow**… the GRACE program to serve more patients

GRACE 12-Month Implementation Plan

Months 1-6

- Implementation webinar
- Indianapolis site visit
- Twice monthly conference calls
- 2-day in-person GRACE training
- GRACE enrollment
- Access to web-based tools and resources

GRACE 12-Month Implementation Plan

Months 7-12

- Twice monthly conference calls
- Booster webinar
- GRACE Dashboard
- 1-day in-person sustainability session
- Plan for tracking outcomes
- Access to web-based tools and resources

GRACE Training and Resource Center

- Consultation
- On-Site Training & Sustainability Planning
- GRACE Website & Member Forum
  - ✓ Implementation Checklist
  - ✓ Enrollment Criteria
  - ✓ GRACE Training Manual
  - ✓ Assessment Forms and GRACE Protocols
  - ✓ GRACE Dashboard
  - ✓ Primary Care Physician Introduction Materials
  - ✓ GRACE Business Case Guide & Tool

Summary

1. Older persons with multiple chronic illnesses and functional limitations have complex healthcare needs and high costs.
2. GRACE provides person-centered care planning and implementation; and integrates medical and social care.
3. GRACE Team Care is evidence-based with proven value:
   - Higher quality of life
   - Better quality performance
   - Lower total costs
4. GRACE is scalable and has been implemented in various healthcare environments with similar results and ROI.
5. We would be thrilled to work with you!

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