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AREA OF FOCUS
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CASE STUDY / OCTOBER 5, 2021

MODELS OF CARE FOR HIGH-NEED, HIGH-COST PATIENTS

Living Independently with GRACE

The Geriatric Resources for Assessment and Care of Elders Model

TOPLINES

The GRACE model helps primary care practices provide geriatric care management for high-need, high-cost patients while reducing costs over time

The GRACE model deploys a multidisciplinary team to meet health and social needs and works best under value-based payment arrangements

AUTHORS

Douglas McCarthy, Lisa Waugh, Paige Nong

KEY FEATURE +

TARGET POPULATION +

WHY IT'S IMPORTANT +

BENEFITS +

CHALLENGES +

Introduction

The Geriatric Resources for Assessment and Care of Elders (GRACE) model was created for patients like Elizabeth, a patient with cognitive impairment and diabetes. After she was discharged home from the hospital after a stroke, her elderly husband found his new role as a caregiver to be challenging.

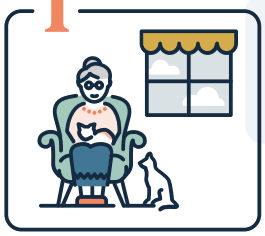
Carrie Ortwein, a nurse practitioner, and Olivia Dole, a social worker, were assigned to work with Elizabeth as part of a GRACE care team at Indiana University Health Medicare Advantage Plan. During home visits, they educated Elizabeth's husband about her cognitive impairment and provided support for her other medical and social needs so she could continue living at home safely and independently.

The GRACE model was developed by geriatrician Steven Counsell, M.D., at Indiana University School of Medicine to help primary care providers overcome the limitations of delivering care to older patients in an outpatient setting.[1] Exhibit 1 outlines the hallmarks of the model. "GRACE was designed to bring a comprehensive geriatric focus to what is essentially an intensive patient-centered medical home (PCMH) model for patients with complex needs," he says.[2]

EXHIBIT 1

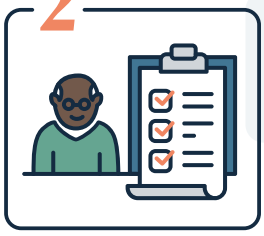
Key Features of GRACE

1



In-home geriatric assessment of health and social needs by a nurse practitioner and social worker.

2



Development of an individualized care plan informed by geriatric care protocols and patient goals.

3

Collaboration with the primary care physician to review and implement the care plan.

4

Weekly interdisciplinary team conferences including a geriatrician, pharmacist, and mental health liaison.

5

Proactive care management to ensure coordination of care and smooth care transitions.

The GRACE model augments the PCMH, a collaborative primary care model designed to improve care coordination and patient access, with in-home visitation by a care team. This team is supported by geriatric protocols and other professionals who understand the unique needs of aging patients and offer recommendations for care and follow-up.

Amid a growing number of care management programs, the GRACE model stands out for its enhanced primary care, with a focus on geriatric conditions and medication management, and its integrated approach to meeting health and social needs. The care model has been proven in a controlled trial and applied in multiple sites and settings including home-based primary care, which is of growing interest because of the COVID-19 pandemic.[3]

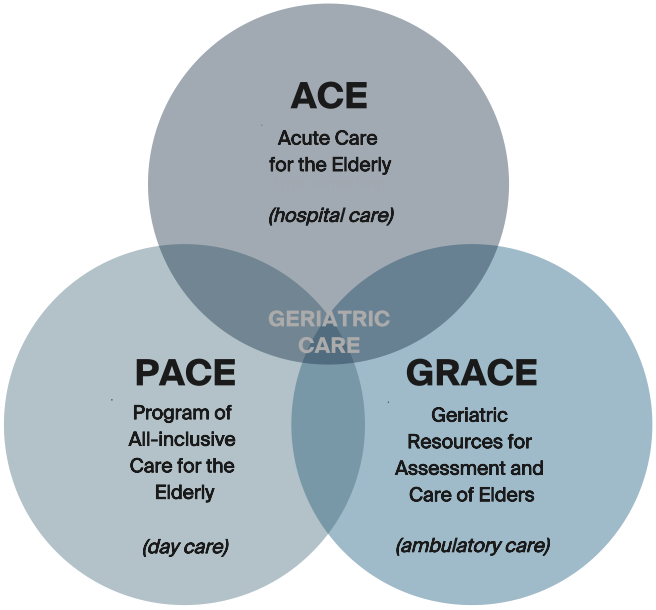
This case study — one in a series describing models of care for high-need, high-cost patients — illustrates how the GRACE model has been used in diverse settings to improve care and reduce costs.

How Grace Works

The GRACE model was inspired by other geriatric care models delivered in hospitals and day-care settings (Exhibit 2). With its focus on ambulatory care, the model allows patients to maintain relationships and continuity with their primary care providers.

EXHIBIT 2

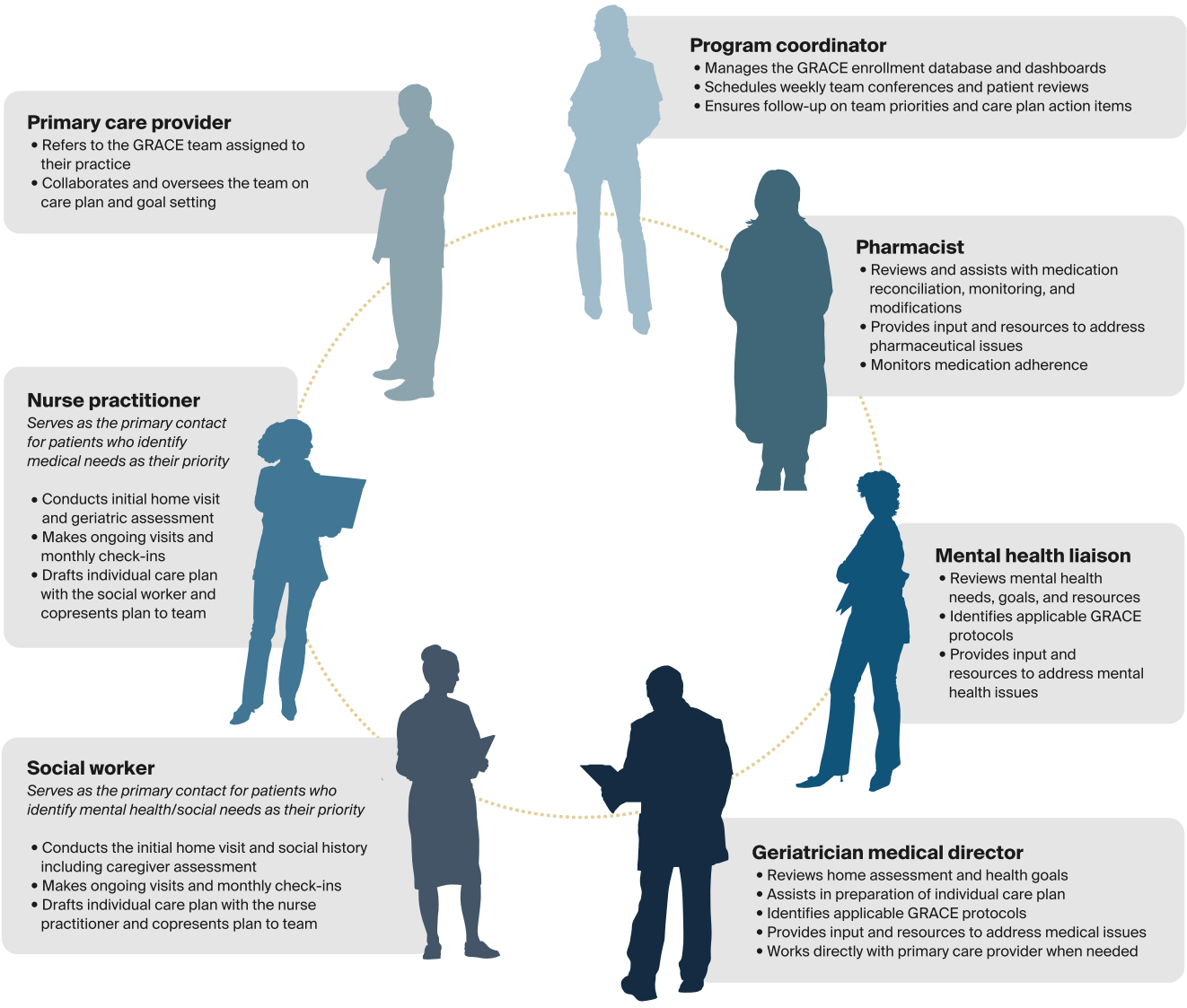
Geriatric Care Models



The primary goals of GRACE are to optimize the health and functional status of patients living at home while reducing their need for hospital care.[4] At the heart of the model is a nurse practitioner–social worker dyad. Together, they provide care management to patients in coordination with the primary care provider and a cross-disciplinary team (Exhibit 3). The nurse practitioner–social worker dyad addresses the physical, mental, and social needs of patients with multiple chronic conditions who may have functional limitations that require the support of a caregiver. Notably, GRACE specifically addresses the geriatric needs of older patients with dementia and depression, who may not be well served by routine care management programs.

EXHIBIT 3

GRACE Cross-Disciplinary Team Roles and Responsibilities



Source: Douglas McCarthy, Lisa Waugh, and Paige Nong, *Living Independently with GRACE: The Geriatric Resources for Assessment and Care of Elders Model* (Commonwealth Fund, Oct. 2021). https://doi.org/10.26099/y9s0-c314

The Nurse Practitioner–Social Worker Care Management Dyad

Carrie Ortwein, a nurse practitioner, worked for several years with Olivia Dole, a clinical social worker, to manage a caseload of 100 patients with complex needs enrolled in the GRACE program sponsored by the Indiana University Health Medicare Advantage Plan.

Ortwein prescribed medications and managed medical care, relieving primary care providers of extra workload while bringing geriatric expertise to the primary care setting. For each patient, she focused first on a thorough geriatric assessment and then worked with the pharmacist and physician to reduce unnecessary or inappropriate use of medications (such as drugs that may raise fall risks in the elderly).

Dole managed the client's mental health and social issues, including the possible need for guardianship or adult protective services. She also linked patients to community resources, such as food security programs, to support them at home.

Many clients enter the GRACE program with untreated depression, anxiety, or other mental health issues, which can complicate the management of chronic illnesses. A mental health liaison supports the social worker in accessing the patient's mental health history, referring patients for mental health services, and informing the primary care provider of relevant history to inform care choices.

GRACE care protocols (Appendix A) guide decisions related to geriatric issues such as falls, dementia, depression, anxiety, and chronic pain. Some sites have added protocols to address other general health issues like obesity and substance use.

Ortwein and Dole met weekly with the cross-disciplinary team and maintained close, efficient communication with patients' primary care providers through the electronic health record (EHR) system and by email.

"The care team doesn't wait for the patient to reach out to them. They reach out proactively to ensure that the documented goals are being addressed and the client's needs are attended to before a crisis occurs. "

Steven Counsell, M.D.
Mary Elizabeth Mitchell Professor and Chair in Geriatrics at Indiana University School of Medicine

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Patients are active partners with the GRACE care team in identifying and achieving their health goals. "The care team doesn't wait for the patient to reach out to them," Counsell says. "They reach out proactively to ensure that the documented goals are being addressed and the client's needs are attended to before a crisis occurs."

Key Implementation Steps

The model designers have defined seven steps (some of which are ongoing and recursive) for implementing the model and supporting patients living at home. These steps incorporate the five features of the GRACE model described in Exhibit 1, as well as steps such as targeted enrollment that are common to implementing all effective care management programs.[5] The GRACE model brings a specific geriatric focus to all these steps.[6]

1. Targeted enrollment. Sponsoring organizations design risk assessment criteria to identify those participants likely to realize the greatest benefit from the program. Enrollment criteria can include *utilization* risk factors such as a number of emergency department (ED) visits or hospitalizations in a given time period, and/or *clinical* risk factors such as multiple chronic conditions, functional decline, cognitive impairment, or depression. Enrolling appropriate high-risk patients also helps ensure that the program reduces health care spending through improved care coordination.[7]

2. Comprehensive geriatric assessment. The nurse practitioner and the social worker perform an initial medical, social, and mental health assessment in the patient's home. The nurse practitioner assesses risk of falls and records all medications. The social worker evaluates the patient's functional status and caregiver support needs. Such home-based assessments also offer an opportunity to identify potential food insecurity, social isolation, and other social issues.

3. Care plan development. With input from the cross-disciplinary team, the nurse practitioner and social worker develop a care plan and implement GRACE care protocols that address the patient's issues, goals, and preferences. These protocols cover evaluation, management, consultation, and patient education, as well as the integration of mental and physical health care, from the standpoint of clinical geriatrics (Appendix A).

4. Cross-disciplinary care conferences. Most sites have weekly care conferences to review patient progress, monitor social supports, and brainstorm solutions to patients' day-to-day problems. The team also discusses advance directives and long-term planning, medication management, nutritional status, and caregiver burden. The program designers recommend routine case reviews at one, two, three, six, and nine months, and additional case reviews when an ED visit or hospital admission occurs. Some sites also use the EHR to share information within the cross-disciplinary team.

5. Consultation with primary care provider. After the initial referral, the care team consults with the primary care provider (PCP) to develop the care plan and approve its execution. The PCP also reviews changes to the care plan and oversees the care management process. Meetings may be in person, though many teams have found it efficient to communicate with the PCP electronically.

6. Care management and caregiver support. Through regular contacts (typically at least once a month), the care team focuses on educating and coaching the patient and caregiver, reducing secondary risks such as falls, and addressing ongoing issues related to cognitive decline and other mental health challenges. The team also attends to a patient's social needs such as transportation to medical appointments.

Additionally, the care team gives special attention to medication reconciliation and management. This includes working with the pharmacist and physician to ensure that all prescribed drugs are safe and necessary, providing a new medication list as appropriate, and working with patients and their caregivers to make sure they understand how to properly take medications.

7. Ensure continuity and coordination of care, including smooth care transitions. This includes checking hospital alerts for admissions or ED visits; communicating baseline status and care plan to hospital staff; collaborating in planning and delivering transitional care, including a home visit; and ensuring the implementation of postdischarge arrangements, including a PCP follow-up visit.

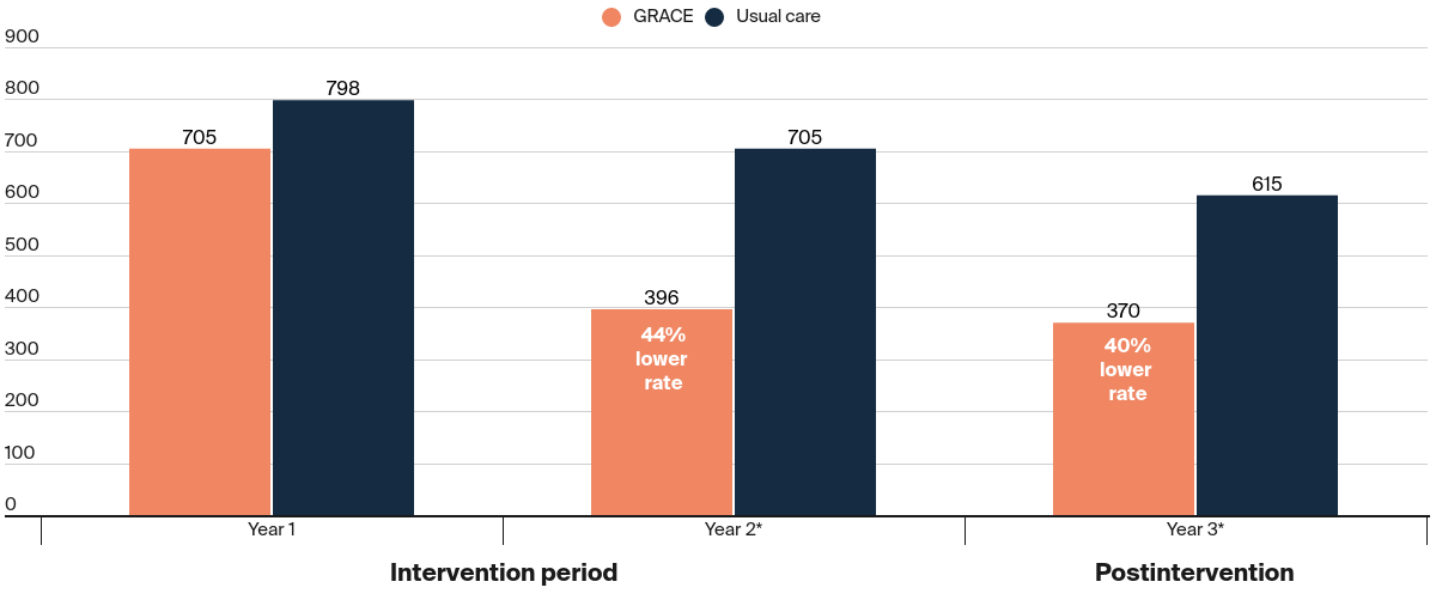
Original Program Results

In 2007, Counsell and his colleagues at Indiana University School of Medicine completed a randomized controlled trial to assess the effects of the GRACE model among low-income patients age 65 and older served by community health centers affiliated with Eskenazi Health, an urban, public safety-net health system.[8] Patients at higher risk of hospitalization achieved the best results, with a 35 percent lower rate of ED visits and a 44 percent lower rate of hospital admissions by the second year (Exhibit 4). GRACE participants also received improved quality of care and reported enhanced quality of life — including general health, vitality, social functioning, and mental health — compared with patients in the control group.

EXHIBIT 4

Randomized Controlled Trial Results for GRACE

Annual hospitalization rates per 1,000 high-risk patients



* Statistically significant difference between intervention and control groups at $p < 0.05$.

Data: Steven R. Counsell et al., "Geriatric Care Management for Low-Income Seniors: A Randomized Controlled Trial," *JAMA* 298, no. 22 (Dec. 12, 2007): 2623–33. Year 3 data courtesy of Indiana University.

Source: Douglas McCarthy, Lisa Waugh, and Paige Nong, *Living Independently with GRACE: The Geriatric Resources for Assessment and Care of Elders Model* (Commonwealth Fund, Sept. 2021). https://doi.org/10.26099/y9s0-c314

A cost analysis found that, among high-risk patients, savings from reduced hospital utilization paid for the cost of the intervention ($1,432 per patient per year) during the two years of the trial. In the third (postintervention) year, savings of $1,487 per high-risk patient were realized from a sustained lower rate of hospital utilization, compared with a control group (Exhibit 4).[9] Another analysis of the trial results, conducted by Avalere Health, showed that when the model is targeted to the high-risk group, it can yield a return on investment of 95 percent and a net program savings of $174 per member per month.[10]

"What we really liked about the GRACE model was its flexibility. While fidelity to the core model is important, it sets up 'guardrails' while still allowing programs to adapt the model to the infrastructure, needs, and resources within an organization. This allows programs to bring the outline or the structure of the GRACE model and fit it to the organization so that it has the most meaningful outcomes. "

Erin Westfall
program officer, SCAN Foundation, which sponsored the technical support for several GRACE replication sites

Replicating the Model

The GRACE model has been adopted in a variety of settings, including community health centers, academic medical centers, capitated medical groups, regional physician organizations, accountable care organizations (ACOs), Medicare Advantage plans, Veterans Affairs medical centers, and home-based primary care and care transition programs.[11]

For model adopters, the GRACE Training and Resource Center at the Indiana University (IU) School of Medicine offers technical assistance, such as training, protocols, manuals, and dashboards; assessment of organizational readiness; business case development; implementation guidance; and program evaluation support. Based on its experience, the IU team has developed an implementation approach to maximize success (Exhibit 5).

EXHIBIT 5

The ABCs of GRACE Implementation

AGREE on the need for GRACE by key stakeholders and that GRACE is a winning solution for patients, providers, and the health system.

BUILD the model with strong physician leadership and an interdisciplinary team approach to planning and development.

COMMENCE care management with a focus on patient-centered care and attention to provider issues.

DOCUMENT implementation of the model to ensure that changes in the process of care take place as planned.

EVALUATE the program for anticipated benefits to patients, providers, and the health system.

FEEDBACK results to key stakeholders to update them on progress of the program for sustained support.

GROW the program to serve more patients.

Data: Adapted from Steven R. Counsell et al., "Dissemination of GRACE Care Management in a Managed Care Medical Group," presentation at the Annual Scientific Meeting of the American Geriatrics Society, 2011.

Source: Douglas McCarthy, Lisa Waugh, and Paige Nong, *Living Independently with GRACE: The Geriatric Resources for Assessment and Care of Elders Model* (Commonwealth Fund, Oct. 2021). https://doi.org/10.26099/y9s0-c314

"I think of the many instances where just having a care manager call the patient or meet them in the office is not enough. I want to actually know what's happening in the home. The ability to assess for home safety and review medications in the home is an incredibly powerful tool that GRACE offers that we otherwise would not have. "

Richard Bernhardt, M.D.
population health medical director, Indiana University Health Physicians

Adapting the Model

Replication sites may adapt the model to comply with available staffing, funding, and other requirements of their particular setting. For example, some sites employed a registered nurse in lieu of a nurse practitioner on the care team, while others added a care team member to answer participants' calls and schedule appointments.

A key implementation decision involves whether to limit the program to patients that can be served by home-visiting teams or to modify the program to include participants who are not visited at home. Some care teams conduct assessments by phone or meet with patients at the physician's office when home visits are not feasible, whether because of COVID-19 restrictions, excessive driving times, or other factors.

Financing the Model

The GRACE model has been adopted in organizations under financing ranging from capitation payment (per member per month) to fee-for-service reimbursement supplemented by monthly care-coordination fees or performance incentives. The experiences of four replication sites that adapted the model are highlighted in Exhibit 6 and described more fully in Appendix B.

EXHIBIT 6

Profiled GRACE Replication Sites

Site	HealthCare Partners (Optum)	Indiana University Health Plans	UCSF Health	Blue Cross Blue Shield of Michigan
Location	Southern California	Indianapolis	San Francisco	Michigan
GRACE-based program name	Home Care and High-Risk Clinics	GRACE Program	Care Support Program	High Intensity Care Management (HICM) Model
Year started	2010	2011	2012	2014
Setting	Medical group of employed and contracted physicians	Medicare Advantage plan and Next Generation Medicare ACO	Academic medical center	Regional provider organizations participating in a Medicare Advantage plan
Financing arrangement	Capitation from Medicare Advantage and commercial health plans	Capitation and fee-for-service with Medicare performance incentives	Fee-for-service and Medicaid pay-for-performance incentives	Fee-for-service with codes for care coordination bundled into a global monthly fee per patient
Target patient population	Homebound and chronically ill older adults (age 70+) accounting for the top 5% of inpatient costs	High-risk, frail older adults (age 65+) discharged home after a hospitalization or living at home with geriatric conditions	Adults (age 18+) with multiple chronic conditions that include diabetes or heart failure, plus two inpatient stays or three emergency department (ED) visits in the past 6 months	High-need, high-cost older adults (age 65+) with multiple chronic conditions
Average length of enrollment	Nine months	18 months to two years	Six to nine months	Variable
Results	Improved patient satisfaction and quality of life Utilization impact after 12 months: • 22% fewer ED visits • 34% fewer hospital admissions • 44% fewer admissions to subacute care	In the two-year period after implementing the program: • 43% reduction in rate of inpatient admissions • 30% decrease in total costs equal to $627 per member per month	Reductions in hospital admissions and ED visits driven primarily by an increase in the proportion of patients with no hospital use 64% of patients reported better health at nine months compared with 36% who did so at enrollment	Some provider organizations reported cost-savings and decreased ED visits and hospital use

Data: See notes for Appendix B.

Source: Douglas McCarthy, Lisa Waugh, and Paige Nong, *Living Independently with GRACE: The Geriatric Resources for Assessment and Care of Elders Model* (Commonwealth Fund, Oct. 2021). https://doi.org/10.26099/y9s0-c314

Insights and Lessons

The GRACE model can be adapted to a variety of settings, with potential trade-offs in scope depending on program objectives. Cost-effective implementation of the program in its original form, with care team home visits, requires targeting the high-risk frail elders for whom the program was primarily designed, specifically those who are likely to benefit from integrated care that addresses geriatric health conditions and social needs. The experience of replication sites shows that telephonic contacts or office-based visits can be substituted for home visits to reduce program costs and complexity, thereby allowing the program's scope to be widened. Doing so, however, sacrifices the key insights that home-based assessments offer into patients' environment and functioning, which may affect program effectiveness.

Enrollment criteria should be tailored to the goals of each site. The target population needs to be clearly defined to ensure that those referred are a good fit for a particular program. For example, some programs target patients at hospital discharge with a focus on reducing 30-day readmissions, while others proactively enroll patients from primary care to better meet their long-term health goals. All study sites employed risk-assessment tools and predictive analytics to identify high-risk patients. Some sites also benefited from the clinical judgment of primary care providers in determining appropriate referrals to the program.

Provider engagement is necessary to integrate the GRACE model in primary care. Program acceptance among primary care providers tended to increase as they saw the value of information gleaned from the GRACE care team as well as the positive

effects of team support on patient outcomes. PCPs also realized increased productivity as the GRACE care team augmented the capabilities of their practice. Although the nature or extent of integration with primary care varied among sites, the success of several programs appeared to reflect the degree to which primary care providers were engaged in referral, care planning, and follow-up of their patients.

The nurse practitioner–social worker dyad is a key to the success of the GRACE model. The complex needs of older adults typically involve both medical and social issues, which may require varying levels of support over time, says Counsell. Sites that added a social worker to complement an existing nurse care manager noted that the combination enhanced the value of care management for patient populations that might not otherwise have been effectively served.

Assembling skilled professionals for the care team can be challenging. Nonacademic sites found that it took time to recruit advanced practice nurses with geriatrics experience, especially in underserved rural areas. And even academic sites reported that they did not have the depth of resources to fully meet the needs of patients with serious mental illnesses. Ideally, the care team should have both clinical credentials and cultural competence in working with patients of diverse ethnicities, languages, and backgrounds. This combination of skills and expertise is in short supply in many places, however, suggesting the need for workforce development to fill this gap.

Adopting organizations need to consider how the GRACE model fits into an overall care management strategy. GRACE was sometimes adopted as part of a portfolio of care management programs used by a site to meet the needs of particular population segments. Some provider organizations reported that they did not adopt the model because it would be too costly to reconcile with other care management programs in which they already participated on behalf of multiple payers.

Technical assistance facilitates program implementation. Replication sites reported that technical support from Indiana University, including site visits and remote guidance over the course of several months, enhanced the success of program implementation.

Financial incentives can spur adoption of the model but may require adaptations to achieve cost savings in a desired timeframe. It is unlikely that primary care practices could finance the GRACE model under traditional fee-for-service reimbursement because many of its services are not reimbursed and savings flow to payers. However, the model has been successfully adopted by health plans and provider organizations that recouped the cost of the program by sharing in savings under capitated, or value-based, payment.

The GRACE model was designed to engage patients in primary care over one to two years, which may not always be feasible. Adaptation of the model to a shorter time horizon may increase its feasibility under an incentive-based program that enrolls patients at hospital discharge to reduce readmissions. However, shorter program enrollment may make it difficult to achieve long-term health goals. All of this illustrates the challenge of reconciling clinical and financial objectives.

Conclusion

The GRACE care model can help improve outcomes for adults with complex health and social needs and yield long-term cost savings for the health care system. The model also serves as a touchstone for enhancing geriatric care management generally, and it has been adapted and scaled to meet the needs of different contexts and financing arrangements.

The diversity of sites adopting the model highlights its flexibility. The model may have particular appeal for home-based primary care programs. The COVID-19 pandemic demonstrated the importance of home-based models for patients with complex care needs and has led to growing interest among policymakers and health systems in investing in such programs.

Continued tracking of programs that adopt a common approach like the GRACE model will generate knowledge about how to adapt their design and implementation to meet the needs of specific settings. Health plans may find it advantageous to develop common objectives for care management programs that engage primary care providers participating in multiple plans, or to create and participate in multipayer initiatives so that providers can apply consistent approaches to managing their high-risk patient populations.

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University Health Plans; Carrie Ortwein, M.S.N., R.N., G.N.P., and Olivia Dole, M.S.W., L.S.W., formerly with Indiana University Health Plans; Gina Intinarelli, R.N., Ph.D., vice president of population health at UCSF Health; Christine Ritchie, M.D., M.S.P.H., the Kenneth L. Minaker Chair in Geriatrics at Massachusetts General Hospital; Amy L. McKenzie, M.D., vice president and associate chief medical officer, Blue Cross Blue Shield of Michigan (BCBSM); Vicki Boyle, R.N., director, Provider Group Incentive Program, BCBSM; Barb Brady, manager, Patient-Centered Medical Home/Provider-Delivered Care Management, BCBSM; and Julia Adler-Milstein, Ph.D., professor of medicine and director of the Center for Clinical Informatics and Improvement Research at the University of California, San Francisco.

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NOTES

1 All five key features shown in Exhibit 1 must be included in a replication program for it to be called the GRACE model. See Dawn E. Butler, Kathryn I. Frank, and Steven R. Counsell, "The GRACE Model," in *Geriatrics Models of Care: Bringing "Best Practice" to an Aging America*, Michael L. Malone, Elizabeth A. Capezuti, Robert M. Palmer, eds. (Springer International Publishing Switzerland, 2015): 125–38.

2 The Patient-Centered Medical Home model seeks to strengthen partnerships between patients and primary care teams by enhancing practices' capacity to offer accessible, high-quality, comprehensive, and coordinated care; see Agency for Healthcare Research and Quality, *The Patient-Centered Medical Home Resource Center* (AHRQ, last updated Aug. 2013).

3 Steven R. Counsell et al., "Geriatric Care Management for Low-Income Seniors: A Randomized Controlled Trial," *JAMA* 298, no. 22 (Dec. 12, 2007): 2623–33. This study was selected as one of 27 deemed to have helped shape the practice of geriatric medicine over a quarter century; see Camille P. Vaughan et al., "Identifying Landmark Articles for Advancing the Practice of Geriatrics," *Journal of the American Geriatrics Society* 62, no. 11 (Nov. 2014): 2159–62.

4 Steven R. Counsell et al., "Geriatric Resources for Assessment and Care of Elders (GRACE): A New Model of Primary Care for Low-Income Seniors," *Journal of the American Geriatrics Society* 54, no. 7 (July 2006): 1136–41.

5 Clemens S. Hong, Allison L. Siegel, and Timothy G. Ferris, *Caring for High-Need, High-Cost Patients: What Makes for a Successful Care Management Program?* (Commonwealth Fund, Aug. 2014).

6 While some individual components are common to many care models, their combination and geriatric focus is unique to the GRACE model. Adapted from Steven R. Counsell, "Grace Team Care," presentation to the SNP Alliance, Oct. 2013; Agency for Healthcare Research and Quality, "Team-Developed Care Plan and Ongoing Care Management by Social Workers and Nurse Practitioners Result in Better Outcomes and Fewer Emergency Department Visits for Low-Income Seniors," AHRQ Health Care Innovations Exchange, last updated Jan. 11, 2021.

7 Because the controlled trial demonstrated the importance of enrolling patients with higher levels of complexity, the program designers developed enhanced methods for assessing risk levels among prospective enrollees.

8 All results described in the text were statistically significant; see Counsell et al., "Geriatric Care Management," 2007.

9 Steven R. Counsell et al., "Cost Analysis of the Geriatric Resources for Assessment and Care of Elders Care Management Intervention," *Journal of the American Geriatrics Society* 57, no. 8 (Aug. 2009): 1420–26. A separate study of 179 veterans enrolled in a GRACE program at the Roudebush Veterans Affairs Medical Center in Indianapolis found the program saved an estimated $200,000 per year after program costs; see Cathy C. Schubert et al., "Implementing Geriatric Resources for Assessment and Care of Elders Team Care in a Veterans Affairs Medical Center: Lessons Learned and Effects Observed," *Journal of the American Geriatrics Society* 64, no. 7 (July 2016): 1503–9.

10 Sally Rodriguez et al., *Effective Management of High-Risk Medicare Populations* (Avalere Health LLC, Sept. 2014).

11 The SCAN Foundation sponsored the provision of technical support by Indiana University to several California organizations that adopted the GRACE model including HealthCare Partners, Health Plan of San Mateo, Central Health Medicare Advantage Plan, and UCSF. Separately, the GRACE model was adapted by two of five Veterans Affairs medical centers (San Francisco and Atlanta) participating in a randomized controlled trial of intensive care management for high-risk patients; see Evelyn T. Chang et al., "An Operations-Partnered Evaluation of Care Redesign for High-Risk Patients in the Veterans Health Administration," *Contemporary Clinical Trials* 69 (June 2018): 65–75.

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