Geriatric Resources for Assessment and Care of Elders

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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 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
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

Home ➔ ED or Hospital
Hospital or ED ➔ Home
Hospital ➔ Nursing Facility ➔ Home
No Assistance ➔ Medicaid HCBS Waiver
Specialty Care ➔ Primary Care
Primary Care ➔ Specialty Care
Transitional Care

Communicate baseline status and care plan
Collaborate in planning transition
Deliver transitional care including home visit
  • Proactive support of Veteran 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 Results
Better Quality and Outcomes

• High ratings by physicians for being helpful
• 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

High risk patients in the GRACE program had:

• Fewer ED visits
• Decreased hospital admissions by Year 2
• Lower hospital readmission rates
• Lower overall program costs
  • Reduced hospital costs offset the program costs

High Risk Patients: Decreased Admissions

GRACE Intervention

*P<.05
High Risk Patients: Fewer Readmissions

*P<.05
High Risk Patients – Lower Costs

GRACE Intervention

*P<.05

Year 1 (n=226) | Intervention: $10,700 | Usual Care: $10,500
Year 2 (n=210) | Intervention: $7,500 | Usual Care: $9,000
Year 3 (n=196) | Intervention: $5,100 | Usual Care: $6,600

All Together Better Care
Keys to Success

1. Created by collaboration of geriatrics and primary care
2. NP/SW team assigned by physician and practice site
3. Focused on geriatric conditions to complement care
4. Provided recommendations for care and resources for implementation and follow-up
5. Incorporated proven care transition strategies
6. Provided home-based and proactive care management
7. Integrated with community resources and social services
8. Developed relationships through longitudinal care
GRACE Dissemination
GRACE Team Care Implementations

Wishard Complete Care – Indianapolis
  • ADVANTAGE Health Solutions MA Plan

HealthCare Partners – Southern California
  • The SCAN Foundation

VA Healthcare System – Indianapolis
  • VHA Office of Geriatrics and Extended Care

ADRC Evidence-Based Care Transition Programs
  • ACA: U.S. Administration on Aging & CMS
  • Tech4Impact: Center for Technology and Aging
2010 ADRC Care Transition Grant

ACA funding to expand ADRCs; GRACE one of four selected models
Indiana ADRC Care Transitions Program

A collaboration between
- Indiana FSSA Division of Aging
- CICOA Aging & In-Home Solutions,
  - The largest ADRC and Area Agency on Aging in Indiana
- Wishard Health Services and IU Medical Group
  - A safety net healthcare system (~7,000 seniors)
- Indianapolis VA Medical Center
- IU Geriatrics
  - A John A. Hartford Foundation Center of Excellence in Geriatric Medicine

All Together Better Care
Indiana ADRC “Integration” Model

• ADRC care manager assumes GRACE social worker role with GRACE team
• Identify HCBS waiver clients on admission
• Collaborate in discharge planning
• Provide GRACE transitional and ongoing care
• Assume HCBS waiver case management

Patient centered care transition, better care coordination, and reduced readmissions and nursing home placements.
Indiana ADRC Care Transitions Program

GRACE Primary Care

WHS Hospital Transition Team

CICOA Aging & In-Home Solutions

GRACE Primary Care

VA Hospital Transition Team

IU Geriatrics