

Population Health NEWS

Making a Case for Population Health

A Selected Case Study in Population Health Management...

Serving Senior Populations With Chronic Conditions

by Steven Counsell, M.D.

Program Objectives: With more than 10,000 Americans turning 65 every day, Medicare-eligible citizens presently represent the fastest-growing segment of the American population. Included among these seniors are those with multiple chronic conditions, dual eligibles and those grappling with any number of socioeconomic stressors, including language barriers that potentially lead to low health literacy and compounding complications. Of particular concern is the 20% of seniors, who have chronic conditions and also need help with basic activities of daily living. These seniors represent 40% of all healthcare spending by those over age 65, who are living in a community and outside a nursing home setting.¹

Indiana University (IU) School of Medicine believed that there must be a better, more efficient and more patient-focused way to serve this population's complex healthcare needs. That resulted in the launch of GRACE Team Care™ (Geriatric Resources for Assessment and Care of Elders) whose objectives include:

- Enhancing quality of geriatric care.
- Optimizing health and functional status.
- Decreasing excess healthcare use.
- Preventing long-term nursing home placement.
- Improving quality of life.
- Lowering overall healthcare cost.
- Improving quality of care coordination.

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Program Description: Eskenazi Health in Indianapolis first developed and tested GRACE nearly 10 years ago. In 2011, it was introduced to the Medicare Advantage program of IU Health Plans and has since taken hold and been applied at several other health plans, medical groups and Veterans Administration hospitals around the country. The catalyst for the GRACE program is an innovative and specially trained support team headed by a nurse practitioner and a social worker, who support a primary care physician in fully addressing a patient's health conditions and achieving patients' goals from the convenience of their own homes.

Going well beyond traditional care coordination or case management, the GRACE program includes:

- Close interaction between an outpatient care team and hospital discharge planners (and other hospital staff) to optimize a smooth care transition. This includes communicating baseline status, a care plan, patient history, psychological considerations, medication management, availability of caregiver/family support and any other information that can impact a successful recovery.

- Weekly interdisciplinary team conferences involving not only the nurse practitioner and social worker, but also a care team’s geriatrician medical director, pharmacist, mental health liaison and others to gain input into the care plan and coordinate care between these critical disciplines and a primary care physician.
- A strong focus on patient education, including teaching patients about their disease and learning how to recognize symptoms, along with the importance of adherence to diet, exercise and medication regimens.
- Coordination of care between specialty physicians, the emergency department, hospitals and a broad array of community support services.
- Specialized care and considerations for common geriatric conditions, such as diabetes, heart failure, depression, chronic pain and diminished physical and/or mental capacities including falls and dementia. Quality care for these patients requires the development and implementation of individualized care plans and often calls for further evaluation, treatment, referrals and patient and caregiver education. In addition, coordination usually involves managing care transitions across multiple settings, working with primary and specialty care providers and arranging community-based services as appropriate.

Evaluation Process: The GRACE model of care is currently being successfully applied at a select number of hospitals around the country, serving thousands of older adults and working in conjunction with hundreds of primary care physicians. One example is the University of California at San Francisco (UCSF) Medical Center, which embraced GRACE as a demonstration project to ascertain to what degree this intensive outpatient model of care could reduce emergency department visits and hospital admissions, improve overall health status and serve as a logical complement to a population health management strategy.

To find out, UCSF enrolled in the program 152 high-risk patients—those characterized as having experienced five or more emergency department visits or two or more hospitalizations within the past 12 months. Average age of participants was 65 (range, 20-98), 60% were women and 25% lived alone. In addition, among this cohort there was a predominance of diabetes, renal disease, congestive heart failure and chronic obstructive pulmonary disease. Nearly 70% of participants reported fair or poor health, and more than half needed help in activities of daily living.

For these individuals and in keeping with the original GRACE model, a social worker/nurse practitioner team provided an in-home assessment and developed an individualized care plan. An interdisciplinary care support team comprised not only a social worker and nurse practitioner but also a geriatrician medical director and clinical pharmacist.

Results: The GRACE model of care at UCSF was able to significantly impact healthcare utilization. During the evaluation period, more than 50% of patients did not require emergency department visits (as compared to 40% previously), while those not requiring hospitalization almost doubled compared to those without the GRACE intervention. Patients also reported significantly better self-rated health after the program was introduced.

Looking more globally, a 2014 study from Avalere Health focused on ways for payers and providers to better manage the cost of high-risk Medicare beneficiaries—typically older adults with multiple chronic conditions and functional impairment. The study revealed that to be successful in this effort, health plans and physicians need to not only focus on treating a person’s medical condition but also must have strategies in place for managing a broad array of care needs across multiple settings.

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In looking at best practice models, the study said that the GRACE program “not only engaged a wide variety of healthcare providers in the care transition process, but also provided appropriate care management through continuous patient education as well as health assessment, monitoring and counseling. These efforts resulted in substantial reductions in emergency department visits and hospitalizations.”²

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Lessons Learned: As it pertains specifically to UCSF, this demonstration project found that the patients who benefited most from the program fell primarily into three categories:

- Patients with high needs, including multiple complex conditions and poor care coordination. The GRACE model was able to provide a hand-picked team of expert care providers to address these needs and concerns.
- Patients with little community support, including those who lived alone and did not trust and/or resisted care. The care support team at UCSF worked hard to build trust with this group of individuals and helped them develop important self-management skills.
- Patients with mild anxiety as reflected in frequent visits to the local emergency department with pain and stomach issues. The GRACE model encouraged patients to call their care support team first to provide reassurance and then to help develop self-management skills.

GRACE Team Care continues to refine its product as the program is implemented through a growing number of hospitals and health plans around the country. As the industry moves toward a population-health management strategy and America continues to age, the lessons learned and the efficacy of the GRACE solution will be increasingly valuable in managing high-risk Medicare populations.

¹ Johnsen M. "Seniors Managing Chronic Conditions and Daily Living Needs Command 40% of Health Cost." *Drug Store News*. May 11, 2015. Grace Team Care infographic.

² "Effective Management of High-Risk Medicare Populations." Avalere. September 2014.

³ *Ibid.*

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