Fact Sheet

GRACE Team Care is a cost-effective team care model that has been proven to improve the health of frail, lower income, older adults by working with patients in their homes and communities to manage health problems, track changing care needs, and leverage needed social services. Studies show that GRACE can improve care quality and outcomes and lower the cost of medical care for this vulnerable population.

The GRACE Care Model

In collaboration with the primary care physician, a care team composed of a nurse practitioner and social worker perform an in-home geriatric assessment of each patient. The care team then develops a custom care plan, with input from a larger team that includes a geriatrician, pharmacist, mental health worker, and community resource expert. Working closely with the patient and the primary care doctor, the care team provides ongoing care coordination. If the patient is admitted to the hospital, the care team provides transitional care and integrates new treatment needs or medications into the care plan.

In addition to ongoing team care support, GRACE patients benefit from:

- Evidence-based care protocols for evaluation and management of geriatric conditions
- An integrated EMR for documentation
- A web-based care management tracking tool
- Home-based and proactive care management
- Pharmacy, mental health, hospital, home health, and community services

GRACE Outcomes

In a randomized controlled clinical trial of 951 adults age 65+ with incomes less than 200% of the federal poverty level, GRACE received high ratings by physicians for being helpful, and better ratings on quality indicators for both general healthcare and geriatric conditions. Quality of life ratings were also higher for GRACE patients. [1]

Among high risk patients, those enrolled in GRACE had fewer emergency department visits, decreased number of hospitalizations, fewer hospital readmissions, and reduced hospital costs. By the second year GRACE saved money for high risk patients and in the third year, a year after the intervention ended, it saved even more.[2]

To date, more than 3,500 people and 300 primary care physicians have benefited from the GRACE model at diverse sites and systems, including:

- Wishard Health Services–Indianapolis, Indiana
- HealthCare Partners–Los Angeles, CA
- VA Healthcare System–Indianapolis, Indiana
- ADRC Evidence-Based Care Transition Programs

[1] Counsell SR, et al. JAMA 2007; 298(22):2623-2633.

[2] Counsell SR, et al. J Am Geriatric Soc 2009; 57:1420-1426.

Services Available for Replication of GRACE Team Care™

- **Pre-Implementation Webinars:** A series of webinars are offered to provide an overview of GRACE Team Care, discuss specific organizational goals and identified target populations, and review the implementation process. Information on the business case for GRACE Team Care is provided to aid in program planning.

- **Indianapolis Site Visit:** Participants are invited to visit a GRACE Team Care program to meet with organizational leadership and GRACE Team Care staff.

- **Implementation Conference Calls:** Conference calls are offered to provide support, instruction and problem solving toward implementation of GRACE Team Care.

- **Intensive Training Session:** A 12-16 hour in-person training session is offered for nurse practitioners, social workers, physicians and other interdisciplinary team staff. During this training, participants learn the key components of the model, including the roles of various GRACE team members, the GRACE in-home assessment tools, and applying the GRACE protocols.

- **GRACE Training Manual:** Each individual attending the 12-16 hour in-person training session receives a GRACE Training Manual.

- **On-Line Tools & Resources:** A variety of tools and resources are available on the GRACE Team Care website through a Member Forum.

- **GRACE Dashboard:** Assistance is provided to develop a customized GRACE Dashboard to monitor program implementation and improvement in quality measures pertaining to targeted geriatric conditions.

- **Evaluation & Sustainability Conference Calls:** Conference calls are offered to provide assistance in program evaluation, business planning and long-term program sustainability.

- **Evaluation & Sustainability Session:** This 6-8 hour in-person session focuses on program evaluation and strategic planning for sustainability and expansion of GRACE Team Care where applicable.

- **GRACE Tracking System:** A robust care management web-based program used by the GRACE Team Care members to build and manage care plans using the GRACE protocols and evidence-based interventions. The tracking system also includes a number of report functions and ability to customize it for specific organizations.

For additional information and assistance with proposal development and budgeting, please contact:

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