# Just for Us:
## In-Home Care for Frail Elderly and Disabled Individuals With Low Incomes

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(See the commentary by Wroth on pages 207-208 and the commentary by Fretwell and Old on pages 209-211.)

**In response to increasing concerns about health care access, cost, and quality, Duke University Medical Center began a community-engaged, iterative, data-driven process in 1998 to develop innovative models to provide care earlier, more effectively, and at a lower cost. This commentary reviews Just for Us, an in-home care program launched in 2002 for low-income, frail elderly and disabled individuals.**

In 1998, in response to increasing concerns about health care access, cost, and quality, Duke University Medical Center began a community-engaged, iterative, data-driven process to develop innovative models to provide care earlier, more effectively, and at a lower cost. The models that emerged use teams of traditional and nontraditional providers; stratify populations according to medical, social, and environmental risk factors; and use information technology to coordinate community, primary, and specialty care for some of the community's most vulnerable populations around Durham County, North Carolina [1]. One such model, Just for Us, was launched in 2002 [2]. Just for Us is an in-home care program for low-income, frail elderly and disabled individuals that was created through a collaboration between Duke University Medical Center; Lincoln Community Health Center; the City of Durham Department of Social Services, the local area mental health entity; and the Durham Housing Authority [1].

Through Just for Us, an interdisciplinary team of providers offers medical care, manages chronic illnesses, and provides case management in the homes of participating clients. Each participant receives a home visit every 5 weeks, unless there is an acute episode or a hospital discharge for which a visit is scheduled immediately. Activities performed during visits include medication reconciliation, discussion of social issues, referral to support services, management of chronic disease, and posthospitalization care. The health care team consists of a clinical provider (ie, a physician assistant, nurse practitioner, or physician), an occupational therapist, a registered dietitian, a social worker, a phlebotomist, and a community health worker.

Among participants, annual enrollment averages 350 individuals, and the mean age is 71 years. Sixty-three percent of Just for Us participants are women, 81% are African American, and the average annual income of participants is less than $7,000 [2]. Most participants rely on personal care assistance, public transportation, and food assistance. The typical participant has multiple comorbidities, the most common of which are diabetes, heart disease, and chronic obstructive pulmonary disease. Forty-four percent of participants have a mental health or substance abuse diagnosis [2]. Quarterly surveys of participants reveal that provision of medications and provision of diet and nutritional information are considered to be the most important services provided through the program.

A review of clinical and health care utilization data for a 1-year period found that, by the end of the study period, ambulance, emergency department, and inpatient costs each decreased by almost half among participants, while prescription and home health costs increased by 25% and 52%, respectively. In addition, 79% of participants who were hypertensive at baseline had this condition under control (defined as a systolic blood pressure of <140 mm Hg and a diastolic blood pressure of <90 mm Hg) at the end of the study period, and 84% of participants with both hypertension and diabetes at baseline had both conditions under control by the end of the study period [2].

Changes in the utilization of care and in health outcomes are reflected in the substantial shift from hospital utilization to increased use pharmacy services, increased use of outpatient care, and increased use of community in-home services, which enable participants to remain independent and thereby avoid nursing home placement. The sentinel diseases for evaluative purposes are diabetes and hypertension. Every participant receives a blood pressure check at every visit; 76% of Just for Us patients with diabetes have had their hemoglobin $A_{1c}$ level measured; of these, 84% had a value of less than 9.5% of the total hemoglobin level [2]. A recent analysis found that, for the 225 individuals with

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hypertension at baseline/entry, the average systolic pressure decreased by 7.73 mm Hg and the average diastolic pressure decreased by 4.41 mm Hg. The average blood pressure decreased across all subgroups studied, with African Americans experiencing the greatest absolute reduction [3].

The model is flexible: participants do not have to participate in an entire package of services under a single capitated amount. The model also relies solely on the fee-for-service reimbursement system.

The most challenging aspect of Just for Us is also what makes it feasible under current reimbursement mechanisms: the integrated care team is composed of providers from partner organizations, each drawing on the reimbursement mechanisms available to them through their owning entities. The partners have to respond to the program's needs, expectations, and regulatory process, as well as to those of their respective agencies. Staff report to 2 different organizations, which is a daunting administrative task when working hours, time off, reporting and training requirements, and daily accountability must be addressed. Commitment to the Just for Us participants and to providing quality service form the glue that keeps everyone communicating and working from the same page [2]. Currently, intensive care management, which most participants require, is performed by a combination of the Just for Us Department of Social Services social worker, the local Community Alternatives for Disabled Adults social worker, the local mental health agency, the Just for Us community health worker, and the Medicaid Carolina Access case manager. Other than new models for delivering integrated clinical care, the geriatric disabled patient requires intensive ongoing psychosocial support from a seamless, coordinated system of care. However, clinical providers and social workers are not reimbursed for time spent conducting joint case reviews and implementing integrated care plans.

A successful in-home model for aging and disabled individuals requires a financial mechanism that covers the cost of direct care and the time for providers to plan and work together. It also requires the medical provider to accept and adopt the paradigms of the mental health and social services systems. The capacity and ability of aging and disabled persons to perform activities of daily living and instrumental activities of daily living should be every provider's first and foremost concern. With this focus, we can design effective transitional care strategies.

In the fall of 2011, Just for Us will celebrate its 10th year of service in Durham County. With the development of electronic medical records and health information exchanges, home visits by integrated teams will become more accessible in more communities. With future payment structures, such as bundled payments, payers and hospital systems will be reaching out to integrate these programs into their transitional care systems. The future success of in-home clinical care will depend on how well these entities effectively and efficiently integrate palliative care into their clinical and behavioral teams and how well they can impact their local health systems' transitional care outcomes. NCMJ

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