Linking Primary Care With Adult Care Homes

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(See the commentary by Lyn and Johnson on pages 205-206 and the commentary by Fretwell and Old on pages 209-211.)

This commentary describes a pilot program wherein a community health center is partnering with Community Care of North Carolina to create a system of integrated care management and "treatment-in-place" visits for aged residents and disabled residents of adult care homes, with the goal of improving the quality of care and reducing unnecessary visits to emergency departments.

Adult care homes are assisted-living residences for aged adults and disabled adults who require 24-hour supervision and assistance with personal care needs. In North Carolina's 1,400 adult care homes, frail elderly residents are frequently co-located with younger residents who have a mental illness or intellectual and developmental disabilities. Residents often have several chronic medical conditions and are taking multiple medications from different prescribers. Adult care homes are staffed by caregivers who assist with personal care needs and dispense medication but have no formal medical training and are not able to assess or treat medical or mental health problems. Adult care homes are under pressure to keep beds full and need to make admission decisions quickly, and often they do not have adequate information to make appropriate decisions about admission [1]. If routine medical issues arise, such as hyperglycemia, cold symptoms, or dizziness, residents often are taken directly to an emergency department for care, instead of accessing care at the medical home.

For North Carolina to control health care costs while improving the quality of care and reducing health disparities, new models of care must be developed that will defragment the health care system for high-risk patients. Residents of adult care homes who are dually eligible for Medicare and Medicaid have poor continuity with primary care, visit the emergency department more frequently, and lack coordinated care [2]. Often, these patients fall through the cracks between multiple care providers, including primary care physicians, specialist physicians, mental health professionals, home care providers, and pharmacies. In this commentary, I describe a pilot program wherein a community health center, Piedmont Health, is partnering with Community Care of North Carolina (available at: http://www.communitycarenc.com) to create a system of integrated care management and "treatment-in-place" visits for residents of adult care homes, with the goal of improving the quality of care and reducing unnecessary visits to emergency departments.

The Reaching Out to Enhance Lives of Adults in Area Care Homes (REACH) Program

In 2009, we partnered with our local Community Care of North Carolina network (AccessCare) to develop a care management system to improve health care quality and the use of health care services for dually eligible residents in the adult care homes linked to our 6 health centers. A registry of 107 individuals residing in 28 adult care homes was created by accessing the North Carolina Medicaid Provider Portal [3], querying our electronic medical record, and obtaining referrals from providers. The registry enabled the care managers to easily identify gaps in care that needed to be addressed and to develop a care plan for each resident. The adult care homes were contacted, and with colleagues from the Department of Family Medicine at the University of North Carolina–Chapel Hill School of Medicine, we performed 3 structured interviews to assess the barriers encountered by administrators at the adult care homes. Consistently, the administrators reported poor communication with our health centers and with local hospitals, as well as barriers to appropriate medical and mental health services for their residents. They especially struggled with patients in transition from hospitals or other care homes. They asked for a "point of contact" with our health centers, so that problems could be solved in a timely manner and that communication could be improved between adult care homes and medical providers.

At the beginning of the REACH program, 2 registered nurse (RN) care managers were assigned to the adult care homes and were available during daytime hours, via cellular telephone, to problem-solve and ensure timely access to care. If a resident became ill or if questions arose about the care plan, the RN care manager communicated directly with the primary care provider, so that problems could be solved expeditiously. RN care managers performed home visits for each resident, during which they conducted a

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comprehensive health assessment and reconciled medications with data in the resident's electronic medical record. Patients with gaps in care or poor follow-up were scheduled for appointments with their primary care provider.

Soon after initiation of the pilot program, adult care home residents with mental health, behavioral, or mobility problems still had difficulty accessing care at our health centers. Residents often waited for long periods before they received care, and because adult care home staff were not always available during the visit, the provider struggled to obtain an adequate history and synthesize an effective treatment plan. In 2010, we began sending a physician and an RN care manager to 2 rural adult care homes, where they provided care in the residents' home environments, using laptops with Wi-Fi cards and our Web-based electronic medical record. After the visits, the physician, the RN care manager, and the pharmacist met in a multidisciplinary team meeting to ensure that patient-care plans were followed.

Preliminary Results of the Pilot Program

Administrators reported that the program improved continuity of care, decreased wait time for appointments, improved communication regarding test results, and decreased the likelihood of medication errors. Administrators noted several examples in which they were able to solve acute problems because of timely assessment and treatment. The adult care home visits seemed to reduce anxiety and behavioral problems for residents with mental illness and made visits less burdensome for elderly residents with mobility problems.

Adult care home administrators provided several anecdotes about situations in which they were able to defer emergency department visits for acute care issues because they had access to the RN care manager or the primary care physician. Although an evaluation of claims data has been planned, we have not been able to access both Medicare and Medicaid claims, to measure rates of use and costs before and after the intervention.

Conclusions

Improvements in clinical support to and communication with adult care homes and performance of treatment-in-place home visits improved care for frail elderly and disabled residents. Adult care homes benefitted from care management that was integrated into the medical home, where members of primary care and other health care services work as a team. This model may be most effective in rural areas, where mobile technology can be used to synchronize information from the electronic medical record with information collected during the adult care home visit, to improve patient safety and the efficiency of communication. Although this model has great promise in our local environment, policymakers will need to further develop reimbursement models, such as accountable care organizations, to sustain such programs. NCMJ

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