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# Fragmentation in Care and Hospital Admissions of Older Adults

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# FRAGMENTATION IN CARE AND HOSPITAL ADMISSIONS OF OLDER ADULTS

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# ABSTRACT

The large population of older adults in America has many medical needs which creates a large economic burden. People who are more negatively affected by fragmented care need advocates for them in the field of healthcare. The research question of this study is "what is the relationship between fragmented care and hospitalizations in older adults with mental illness?" The research hypothesis is that fragmented care and hospitalizations have a statistically significant relationship for older adults with mental illness.

The hope of this study is to advocate for decreased fragmentation in care for older adults who receive Assertive Community Treatment (ACT) care at Trilogy. The purpose of this study is to examine the relationship between fragmentation in care and hospital admissions in adults 65 and older with chronic conditions who receive ACT care from Trilogy.

Data will be gathered from adults 65 and older who currently receive or have received ACT care from Trilogy. This population consists of people who have been diagnosed with a mental illness and will contribute to the existing literature on older adults by adding to the sparse literature on older adults with mental illnesses and how they experience healthcare. The researcher will utilize a phone survey method to collect the data from clients.

The sample size is 5 participants who are 65 or older and currently receive or have received ACT care from Trilogy. The data was analyzed using 4 chi square tests that compared fragmented care to hospitalizations. The care fragmentation was measured by unique doctor visits and different primary care providers in 2018 and 2019. Those responses were cross-tabulated with hospital admissions in 2018 and 2019. The researcher's claim was that Trilogy's

ACT clients with higher care fragmentation will likely have more hospitalizations, and there would be a clear relationship between these variables.

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# INTRODUCTION

## Historical Background

For over 30 years, the healthcare system in the U.S. has been very inefficient. The U.S. spends 17% of its GDP on healthcare alone and does not have results that equal this expenditure (Kent, 2018). In particular, the U.S. has one of the highest rates of avoidable hospitalizations for chronic conditions in adults (Kent, 2018). One contributing factor to this high rate of avoidable hospitalization "is the overuse of specialty care rather than appropriate, consistent use of primary care" (Kent, 2018). The overuse of specialty care creates fragmentation in care, which is when patients are seeing many unique providers rather than having a dominant provider. Fragmentation in care causes many avoidable hospital admissions among people with a chronic condition or multiple chronic conditions (Kern, 2018). The population of people who most commonly have chronic health conditions is older adults, and adults 65 and older are able to receive Medicare.

Medicare is an entitlement program that started in the 1960s. It was implemented at a time when America had different demographics and medical technology. Today, the population of older adults is much larger, and their needs are much more varied than what Medicare covers (Gross, 2011). Due to improved medical technology and treatments for chronic conditions, people are able to live longer than they were in the 1960s (Gross, 2011). This means that people are able to live with chronic health conditions for longer, and there is a larger impact of fragmentation in care.

People with mental illness constitute a particularly vulnerable portion of Medicare recipients. People with mental illness who have Medicare or Medicaid experience difficulties

with these entitlement programs. Poor communication between providers can cause a loss of healthcare for older adults with mental illnesses (Bartels, 2015). This study focuses on the healthcare experiences of adults 65 and older who have a mental illness.

**Purpose of the study**

The purpose of this study is to examine the relationship between fragmentation in care and hospital admissions in adults 65 and over with chronic conditions who receive Assertive Community Treatment (ACT) care from Trilogy. The hope of this study is to advocate for decreased fragmentation in care for older adults with chronic health conditions who receive ACT care at Trilogy. ACT care is an integrated approach that Trilogy uses to deliver community mental health treatment. ACT care includes a team of recovery counselors, nurses, employment specialists, and interns who help clients with mental illness. At the end of this study, there will be a suggestion of how to change agency policies to benefit this vulnerable population.

**Rationale or significance of the study**

Fragmented care is more important now than ever before due to the demographic shift in recent years (Gross, 2011). The expanding population of older adults has many medical needs and this creates a large economic burden. Efficient and effective healthcare for this population is important for everyone, but the social work profession is most concerned with the most vulnerable people. People who are more negatively affected by fragmentation in care desperately need advocates for them in the field of healthcare. Social workers will be more efficient in their work if they have a better understanding of their client's healthcare experiences.

**Research question**

The research question of this study is: does higher fragmentation in care correlate with an increase in hospital admissions in ACT clients who are 65 and older and have chronic health conditions?

**Research hypothesis**

Higher fragmentation in care for adults 65 and older who receive ACT care from Trilogy correlates to more frequent hospital admissions if they have one or more chronic health conditions. This is a directional, one tail hypothesis.

## LITERATURE REVIEW

Fragmentation in care is when patients do not have one dominant healthcare provider, and they see many unique doctors over time. Fragmentation in care is proven to correlate positively with hospital admissions in patients with chronic health conditions (Kern, 2018). As specialization in care has increased, and primary physicians have become less common, more avoidable hospital admissions occur each year (Cheung, 2011). This literature review will discuss specialization in care, the barriers to primary care, and how fragmentation in care affects people with chronic conditions.

### Specialization and Barriers to Primary Care

Over the past 30 years, specialization in U.S. medicine has increased significantly (Kent, 2018). One factor encouraging this change is the higher pay for specialty providers, especially surgeons (Bernstein, 2015). Specialization has benefits because patients are able to visit very experienced physicians for their problems, but there are drawbacks to specialization. Since patients no longer see one dominant provider for the majority of their healthcare needs, the

system is more inefficient. Not only do patients have to pay for a higher volume of visits, there is also a higher likelihood of miscommunication between providers (Bernstein, 2015).

In addition to the increased specialization of physicians in the U.S, there are many other barriers to accessing primary care. Since the U.S. has a shortage of primary care providers, and there has recently been more insured people due to the Affordable Care Act (ACA), it has recently become more difficult to access primary care (Cheung, 2011). Although there are more Americans each year who have insurance, emergency department visits have actually increased 90 million in 1996 to 124 million in 2008 (Cheung, 2011).

In a 2011 cross-sectional household interview survey, patients identified different barriers to primary care (Cheung, 2011). Among these barriers were not getting through to the provider on the phone, long wait times, not having an open appointment soon enough, and not having transportation (Cheung, 2011). These barriers are more navigable for people who are healthy, but for those with chronic conditions it can be the difference between getting preventative care and being admitted to the hospital.

**Fragmentation in Care for People with Chronic Conditions**

One chronic condition that exemplifies the adverse effects of fragmentation in care is chronic pain. Chronic pain is a public health issue that affects more Americans than diabetes, heart disease, and cancer combined (McGee, 2011). This issue mainly affects the elderly, who receive Medicare past the age of 65. In addition to Medicare, many of these people receive Medicaid. These programs are not effective in treating chronic pain in the elderly. The coverage provided is for ineffective acute care treatments and long-term care is not given. There are policy options that can improve the current system.

The economic impact of chronic pain in the U.S. is larger than that of other conditions that receive more attention. There is not enough attention paid to chronic pain, and more education on the subject would benefit society. In 2008, an estimated 100 million adults in the U.S. were affected by chronic pain. Using data from a Medical Expenditure Panel Survey, Gaskin and Richard conducted research published in The Journal of Pain for the American Pain Society. Their findings were that healthcare costs for this issue were between $560 and $635 billion. This estimate was conservative because they did not include nursing home residents, military, or incarcerated people in their research (Gaskin & Richard, 2012).

The good news is that there are effective treatments for chronic pain that are already being offered on a limited basis. In 2008, Mirko Pavlek conducted a trial of chronic pain treatment in group settings. He used an integrative pain therapy model that included support groups and progressive relaxation. In 6 month and 12 month follow-ups, participants reported a greater sense of control over their pain (Pavlek 2008). Chronic pain is not easily treated with drugs or costly surgeries. The effective treatments for it are interdisciplinary and give patients multiple coping strategies to decrease their feelings of powerlessness (Pavlek, 2008). Interdisciplinary treatments like these are only stymied by the fragmentation in care that occurs in patients with chronic pain. This serves as more evidence that people with chronic medical conditions are particularly affected by fragmentation in care.

In a cohort study that took place over the course of 3 years, fragmentation in care and hospital admissions were analyzed (Kern, 2018). This study focused on patients who had Medicare, meaning they were almost all 65 and older (Kern, 2018). There was found to be no significant correlation between fragmentation in care and hospital admissions for people who had

no chronic conditions (Kern, 2018). However, there was a significant positive correlation between fragmentation in care and those with multiple chronic conditions (Kern, 2018).

Over the past few decades, there has been increased fragmentation in care in the U.S. Patients have been seeing more unique providers and do not have a dominant provider who they see a majority of the time. There are barriers to accessing primary care due to a high demand and lower supply. Fragmentation in care is particularly damaging for people with chronic conditions, such as chronic pain, due to the unique treatments needed for them. The relationship between fragmented care and hospital admissions in patients with chronic conditions is worth exploring further in more specific populations.

Although doctors themselves contribute to the problem, the main culprit in creating barriers between pain patients and effective treatments is the health insurance system. While doctors take a Hippocratic oath and have to operate according to medical ethics, insurance companies and programs like Medicare or Medicaid do not. They try to contain their costs and stay afloat financially (Schatman, 2011).

Three ways that insurance can create barriers to treatment are outlined in Schatman's research in 2011. Insurers refuse to reimburse patients when they pay for services that are evidence-based, and only cover costly interventions that are less effective. Insurers also remove certain effective services from interdisciplinary programs of treatment. They also delay treatment in ways such as requiring preauthorization of prescriptions. The delays they create are aimed at demoralizing patients and making them give up on seeking coverage and treatment. The author concludes that the outlook for these patients is not positive as long as we are in a for-profit, multi-payer system. He recommends a move toward a not-for-profit, single-payer system (Schatman, 2011).

**Barriers to Care due to Medicare/Medicaid**

Cost-sharing rules for Medicaid and Medicare create inefficiencies and more importantly, worse healthcare for dual eligible patients. Medicare is the primary payer for hospital visits and other acute care, but for dual eligible patients, Medicaid has to pick up some of the copay for those treatments. Cost-sharing rules in most states allow Medicaid to pay the equivalent of the copay for the Medicaid rate for the service. Since Medicaid has much cheaper rates, this means the co-pays are not even close to being covered. As a consequence of Medicaid bearing a smaller amount of the burden for acute care, this program has little incentive to prevent transfers of patients from long-term to acute care. If Medicaid's cost-sharing rules in most states required the entire co-pay to be met, the program would be more likely to prevent these transfers. Preventing transfers from long-term to acute care necessitates better long-term care (Grabowski, 2007).

One example of conflicting interests between Medicare and Medicaid is the inefficiency of Home and Community Based Services (HCBS). These state-run programs provide services to dual eligible patients in their own homes and communities and are funded by Medicaid. While these programs provide savings for Medicare because it focuses on prevention of the need for acute care, it provides no incentive for states to prevent hospitalization. As one state official said in response to a bill promoting prevention of hospitalizations, "Why would we want to do that? Those are Medicare dollars. For us that's development money. We don't want to reduce Medicare expenditures in our state" (Grabowski, 2007).

Since many states, including Illinois, are facing budget crises and attempting to cut costs wherever possible, federalizing Medicaid for dual eligible patients is a valid policy solution. If dual eligible patients are covered totally by Medicare, there will be no more conflicting interests between programs, and many inefficiencies will be reduced. In addition to shifting and estimated

$25.8 billion from the states to the federal government, this measure would save taxpayers money. In eliminating the conflict between Medicaid and Medicare interests, it will reduce hospitalizations, and therefore the overall costs of healthcare for older adults (Grabowsi, 2007).

Another policy approach that has been proven to be effective in a small sample size was the Comprehensive Primary Care Initiative. This was a four-year trial that took place in over 400 primary care practitioners' locations in the U.S. It focused on five different goals for primary care but the most relevant goal was improving planned care for chronic conditions. It was stressed that patients with chronic conditions were treated using evidence-based guidelines. As discussed earlier, interdisciplinary approaches are more effective for chronic conditions, whereas surgery and drugs are less effective. As a result, during this trial, patients were referred to behavioral health services for counseling, and saw improvement in their functioning (Peikes, 2018).

If the CPCI guidelines are put in place for Medicare/Medicaid patients with chronic conditions, their treatments will be more effective. It will provide patients access to cheaper and more effective treatments, which improves the efficiency and cost-effectiveness of Medicare and Medicaid. In improving the access to long-term care for patients who need it, more equity will be achieved. Currently, patients who only require acute care are being treated effectively while other patients are not. In addition, it will provide more options to patients with chronic conditions, and the more options they have will lead to more empowerment for them (Peikes, 2018).

The existing literature on the areas of fragmented care in older adults and policies that affect fragmented care provide important context and a place to start for this research. It has been shown that older adults with more fragmented care experience increased hospital admissions, but

only if they have chronic conditions. However, there is no literature in the area of fragmented care for older adults with mental illness diagnoses or older adults who receive ACT care or other long-term care. One desired effect of ACT care is that fragmented care is mitigated, which might actually lower hospital admissions for clients. Another consideration is that people with mental illness diagnoses have more difficulty accessing and communicating with health care providers. This research will explore the presence and effects of fragmented care in the unique population of older adults who receive ACT care.

# METHODOLOGY

## Description of Research Design

My research design is a group-level design. It is a non-random cross-sectional survey, with the notation O. There is no intervention, just a survey of Trilogy clients. This study is focused on the fragmentation of care in clients 65 years or older with a chronic health condition in the past 2 years. It is also concerned with the number of hospital admissions clients have and if there is a correlation between that number and their fragmentation in care.

## Research Sample

The population my research can be generalized to is adults 65 years or older who receive Assertive Community Treatment (ACT) care. My research sample includes Trilogy clients on ACT teams who are 65 years or older. These research participants receive care from one of three different ACT teams - one on the Northside of Chicago, one in Lawndale, and one on the Southside of Chicago. Two of the Northside ACT teams have over 70 clients, and those teams are staffed by two nurses, two peers, two certified alcohol and drug counselors (CADCs), two employment specialists, recovery counselors, and one intern. The other ACT teams have smaller

caseloads and only have one of each of the specialized positions along with less recovery counselors.

Altogether there are 43 clients on these ACT teams who are 65 or older. These are the people who qualify for the sample based on the criteria of being 65 or older and receiving ACT care. The only clients who are included in the total sample are the five clients who completed the phone survey. It is also limited to those Trilogy clients on ACT teams who are 65 years or older and successfully complete a short phone survey about their healthcare experiences. These clients all qualify for Medicare and receive Medicaid, Medicare, or both. They also receive long term treatment on an assertive community treatment team.

The sample was drawn from clients that receive ACT services at Trilogy. Trilogy is a community mental health agency that provides case management, counseling, and a 24-hour crisis line for ACT clients who qualify for the highest level of care based on the severity of their mental illness. The researcher is an intern on an ACT team at Trilogy and used purposive sampling. The participants had to meet the requirements of being 65 or older and receiving ACT care from Trilogy. Possible participants were identified with help from Trilogy's data department who compiled a list of Trilogy clients who met the criteria. The researcher recruited the participants by calling them on the phone and explaining that they were invited to answer a brief phone survey. The initial target for a sample size was 10 participants but there were only five participants who completed the phone survey.

**Research Instrument**

My research instrument is a short phone survey with questions about client experiences with Medicare/Medicaid. It has open-ended and closed-ended questions with a multiple-choice

response format. Some questions are yes or no answers, while some are open-ended. All of these questions are pre-written and will be asked over the phone. The questions ask the clients whether they are 65 and older, if they are enrolled in Medicare, Medicaid, or both, and if they receive or have ever received ACT care. The clients will also be asked how many chronic health conditions they have, number of doctor visits total, number of unique doctor visits, and hospital admissions.

**Data Collection Method**

The data collection method for this research project is the telephone survey method. I will first attend an ACT team lead meeting at the Paulina office of Trilogy in the Northside and let the team leads know I will be calling some of their clients with a survey, which I will explain to the team leads. The team leads will let their teams know about the survey and they will mention it to their clients. This way the clients will know to expect a phone call with questions about their healthcare. I will spend time during my workday at Trilogy looking up clients' phone numbers and calling them, leaving voicemails explaining my survey.

**Data Analysis**

The variables this study is concerned with are fragmentation in care and hospital admissions. The data for fragmented care are client responses about unique doctors visited and different primary care providers in 2018 and 2019. The data for hospital admissions are drawn from client responses to questions about the number of hospital admissions in 2018 and 2019. These are paired into 4 chi square tests that attempt to determine if there is a relationship between fragmented care and hospital admissions. The researcher utilized SPSS to aggregate the data and run the chi square tests.

## RESULTS

The research question of this study is: does higher fragmentation in care correlate with an increase in hospital admissions in ACT clients who are 65 and older and have chronic health conditions? Higher fragmentation in care for adults 65 and older who receive ACT care from Trilogy correlates to more frequent hospital admissions. More specifically, the research questions are "is there a relationship between hospital admissions and number of different primary care providers in 2018 and 2019," and "is there a relationship between hospital admissions and number of unique doctors seen in 2018 and 2019?" One hypothesis was that there is a relationship between hospital admissions and number of different primary care providers in 2018 and 2019. Another hypothesis was that there is a relationship between hospital admissions and number of unique doctors seen in 2018 and 2019.

The researcher analyzed the data by utilizing 4 chi-square tests. The alpha value for significance was set to 0.05. The two indicators of fragmented care were different primary care providers and unique doctors seen. These fragmented care indicators were paired with the hospital admissions for the corresponding year. Two years were chosen to make the client's description of their care fragmentation and hospital admissions more specific. The degree of freedom was 1 because it was calculated for a 2x2 table.

The first test evaluated if there was a relationship between hospital admissions and unique doctors seen in 2018. The $\chi^2$ value for the chi-square test of unique doctor visits and hospitalizations in 2018 was .833 and the p value was .361. This test failed to reject the null hypothesis.

**Table 1**

**Chi-Square Test- Unique Doctors and Hospital Admissions in 2018**

| | Value | Df | Asymptotic Significance (2-sided) | Exact Sig. (2-sided) | Exact Sig. (1-sided) |
|---|---|---|---|---|---|
| Pearson Chi-Square | .833[a] | 1 | .361 | | |
| Continuity Correction[b] | .000 | 1 | 1.000 | | |
| Likelihood Ratio | 1.185 | 1 | .276 | | |
| Fisher's Exact Test | | | | 1.000 | .600 |
| Linear-by-Linear Association | .667 | 1 | .414 | | |
| N of Valid Cases | 5 | | | | |

a. 4 cells (100.0%) have expected count less than 5. The minimum expected count is .40.

b. Computed only for a 2x2 table

Another test evaluated if there was a relationship between hospital admissions and different primary care providers in 2018. The $\chi^2$ value for the chi-square test of different primary care providers and hospitalizations in 2018 was .833 and the p value was .361. This test failed to reject the null hypothesis.

**Table 2**

**Chi-Square Test- Different Primary Care Providers and Hospital Admissions in 2018**

| | Value | Df | Asymptotic Significance (2-sided) | Exact Sig. (2-sided) | Exact Sig. (1-sided) |
|---|---|---|---|---|---|
| Pearson Chi-Square | .833[a] | 1 | .361 | | |
| Continuity Correction[b] | .000 | 1 | 1.000 | | |
| Likelihood Ratio | 1.185 | 1 | .276 | | |
| Fisher's Exact Test | | | | 1.000 | .600 |
| Linear-by-Linear Association | .667 | 1 | .414 | | |
| N of Valid Cases | 5 | | | | |

a. 4 cells (100.0%) have expected count less than 5. The minimum expected count is .40.

b. Computed only for a 2x2 table

Another test evaluated if there was a relationship between hospital admissions and unique doctors seen in 2019. The $\chi^2$ value for the chi-square test of unique doctor visits and hospitalizations in 2019 was 2.22 and the p value was .136. The frequency of people having

between 1 and 3 hospital admissions in 2019 was 2. The frequency of people having 0 hospital admissions in 2019 was 3. The frequency of 0-10 unique doctors seen in 2019 was 3. The frequency of 11-30 unique doctors seen in 2019 was 2.

**Table 3**

**Chi-Square Test- Unique Doctors and Hospital Admissions in 2019**

| | Value | Df | Asymptotic Significance (2-sided) | Exact Sig. (2-sided) | Exact Sig. (1-sided) |
|---|---|---|---|---|---|
| Pearson Chi-Square | 2.222[a] | 1 | .136 | | |
| Continuity Correction[b] | .313 | 1 | .576 | | |
| Likelihood Ratio | 2.911 | 1 | .088 | | |
| Fisher's Exact Test | | | | .400 | .300 |
| Linear-by-Linear Association | 1.778 | 1 | .182 | | |
| N of Valid Cases | 5 | | | | |

a. 4 cells (100.0%) have expected count less than 5. The minimum expected count is .80.

b. Computed only for a 2x2 table

The last test evaluated if there was a relationship between hospital admissions and different primary care providers in 2019. The $\chi^2$ value for the chi-square test of different primary care providers and hospitalizations in 2019 was 5.00 and the p value was .025. The frequency of

people having between 1 and 3 hospital admissions in 2019 was 2. The frequency of people having 0 hospital admissions in 2019 was 3. The frequency of people who had 1 primary care provider in 2019 was 2. The frequency of people who had 2 or more primary care providers in 2019 was 3.

**Table 4**

**Chi-Square Test- Different Primary Care Providers and Hospital Admissions in 2019**

| | Value | df | Asymptotic Significance (2-sided) | Exact Sig. (2-sided) | Exact Sig. (1-sided) |
|---|---|---|---|---|---|
| Pearson Chi-Square | 5.000[a] | 1 | .025 | | |
| Continuity Correction[b] | 1.701 | 1 | .192 | | |
| Likelihood Ratio | 6.730 | 1 | .009 | | |
| Fisher's Exact Test | | | | .100 | .100 |
| Linear-by-Linear Association | 4.000 | 1 | .046 | | |
| N of Valid Cases | 5 | | | | |

a. 4 cells (100.0%) have expected count less than 5. The minimum expected count is .80.

b. Computed only for a 2x2 table

The only result with a p value low enough to reject the null hypothesis came from the test for different primary care providers and hospital admissions in 2019. The 3 people who saw more than one primary care provider had no hospital admissions and the people who saw only one primary care provider had 1-3 hospital admissions. The sample size for all of these are too small to make a claim that there is a relationship between these measures of fragmented care and hospital admissions. The researcher failed to reject the null hypotheses except for the test with different primary care providers and hospital admissions in 2019.

## DISCUSSION

The purpose of this research was to examine if higher fragmentation in care correlates with an increase in hospital admissions in ACT clients who are 65 and older and have chronic health conditions. The research question of this study was: does higher fragmentation in care correlate with an increase in hospital admissions in ACT clients who are 65 and older and have chronic health conditions? This was inspired by a desire to connect clients to the best possible care for their medical conditions. Many older adults suffer from chronic conditions that require interdisciplinary care and it is important to know if their care is fragmented. The ACT team should have the effect of reducing fragmented care and hospitalizations.

The findings of this survey were that 3 of 4 chi square tests failed to reject the null hypothesis. The only test that was able to reject the null hypothesis was the Chi square test for different primary care providers and hospitalizations in 2019. However, this did not support the hypothesis that there would be increased hospitalizations with increased fragmented care. It only supported that there was a relationship between those two variables. The participants who had fewer primary care providers, which means less fragmented care, actually had more hospitalizations in 2019 than those who had more fragmented care. The other chi square test

results showed that there was no statistically significant relationship between other measures of fragmented care and hospitalizations in 2018 or 2019.

The findings for this research project show that high fragmented care measured by the number of primary care providers in 2019 actually reduced hospital admissions. Since the existing literature shows a clear correlation that fragmented care increases hospital admissions in older adults, it is important to consider why this research contradicts previous findings. It is possible that, while seeing multiple primary care providers usually causes miscommunications between providers, ACT clients have less of the negative impacts of fragmented care. It is very possible that having a team of professionals coordinating their medical needs mitigates the effects of fragmented care that can lead to hospital admissions in people who do not receive ACT care.

If this can be proven, ACT care should be valued even more highly in the area of preventing hospital admissions. Trilogy is committed to preventing hospital admissions and ACT care is part of their approach in achieving that goal. ACT care and reducing the impact of fragmented care has not been studied and this should inform social work practice by promoting ACT care as a means of preventing hospital admissions in older adults with chronic conditions who are most vulnerable to fragmented care.

One limitation of this study is that the survey only measured client perceptions of their healthcare experience and had no record of the exact numbers. One recommendation for future research in this topic area is to conduct research using data from ACT clients' insurance companies with exact figures for doctor appointments and hospital admissions. Another recommendation for further research is to expand this survey to more participants and gather

more data from other ACT clients at different social service agencies. There is further research needed in examining the level of care fragmentation in ACT clients.

Fragmented care is a ubiquitous characteristic of the U.S. healthcare system which usually does not lead to hospital admissions in patients. However, older adults with chronic conditions are adversely affected by fragmented care and experience more hospital admissions as a result. This is unique research because it focuses on fragmented care in older adults who receive ACT care. The research found that fragmented care did not lead to more hospital admissions, and in fact more fragmented care was linked to fewer hospitalizations. This means that ACT care is effective in mitigating the negative health effects of fragmented care. While ACT care was intended for adults with mental illness diagnoses, some principles used in its implementation may be effective in dampening the effects of fragmented care for all older adults with chronic conditions.

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