



CHRONIC ILLNESS AND AGING

SECTION 2: THE ROLE OF SOCIAL WORK IN MANAGING CHRONIC ILLNESS CARE

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Synopsis

Managing chronic illness presents a profound challenge to the social work profession, not only because of the myriad formal and informal services required by the increasing number of chronically ill elders, but also because the caregivers, too, require our support and empowerment. As professionals, social workers experience first-hand the effects of the met and unmet patient needs, which brings with it a responsibility to insure that practice and policy decisions give full recognition to the impact of psychosocial aspects and services that provide total care to chronically ill older adults and their caregivers.

This section describes some of the most recent literature addressing the role of social workers in managing chronic illness care specifically related to conducting biopsychosocial assessments, providing interventions, and in designing and implementing effective models of health services delivery such as care coordination.

Characteristics of Chronic Illness as They Impact the Social Work Role

Three important characteristics of chronic illnesses among older adults need to be considered as they affect the social work role and function.

1. The trajectory for many serious illnesses has changed from an acute terminal course to a much longer chronic period, with episodes of exacerbations and remissions interspersed with extended periods of good functioning.
2. The trajectory of advanced chronic and terminal illnesses has changed from a relatively brief period to a longer period in which both curative and palliative treatments are combined. Research suggests that a long, advanced chronic illness can be highly stressful for both patients and their families.
3. The increase in the total number of older people with advanced chronic and terminal illnesses will require more curative and palliative care being provided in the home, with greater reliance on provision by family members.

Advances in medical care have changed the illness trajectory in ways that dramatically alter the older adult's experience of chronic illness. Facilitating and enhancing positive health behaviors at all stages of life as well as effective management of chronic illness is central to the social worker's role, knowledge, value, and skill base in health care.

The specific role of social workers in health care is to address psychological, behavioral, and social factors by (1) assessing patient and family psychosocial health needs, (2) providing interventions required to address their psychosocial needs and promote their adaptation to illness and disability, and (3) developing and implementing effective models of health services delivery. The following sections provide an overview of issues related to Biopsychosocial Assessment of older persons with chronic conditions; a description of the range of social work interventions relevant to the management of chronic conditions; and a description of the evidence base of one model of service delivery: care coordination for older persons.

Psychosocial Assessment of Older Adults with Chronic Conditions

Because of the frequency of multiple chronic conditions in older adults, a comprehensive biopsychosocial assessment of needs and resources has become the most important part of service delivery and is the beginning of the intervention process to address the management of chronic conditions among them. The National Association of Social Workers (NASW, 2005) and the American Geriatrics Society (AGS, 2005) recommend a biopsychosocial approach to the assessment of older adults. This section reviews the evidence supporting comprehensive geriatric assessments and, using a biopsychosocial framework, describes the rationale or evidence supporting seven typical domains of psychosocial assessment for social workers in the management of chronic illnesses.

Comprehensive Assessments

- ◆ Comprehensive geriatric assessment (CGA) and geriatric evaluation and management (GEMs) programs have shown positive impact on improving or maintaining cognitive and physical function (Urdangarin, 2000).

These programs have shown increased likelihood of patients living at home, decreased likelihood of hospitalization during follow-up, and a reduction in mortality.

- ◆ The primary component of CGA and GEM programs is an interdisciplinary team consisting primarily of physicians, nurses, and social workers.

Comprehensive assessment and management programs for the care of older adults in the health care system have been evaluated in the U.S. over the last decade and have shown positive outcomes. For example, the CGA programs without follow-up care and

the GEMS programs that incorporate follow-up care and management have reported favorable effects on cognitive and physical functioning, an increased likelihood of living at home, a decreased likelihood of hospitalization during follow-up, and a reduction in mortality (Urdangarin, 2000). The primary component of these programs is an interdisciplinary team consisting mainly of physicians, nurses, and social workers, but also can include specialists from fields, such as occupational and physical therapy, nutrition, pharmacy, audiology, and psychology (Agostini, Baker, & Bogardus, 2001; Wieland & Hirth, 2003).

CGA is more effective when it is targeted to older adults with functional impairments, geriatric syndromes, or high use of hospital and nursing home care. The American Geriatrics Society (AGS) issued the following position statement in 2005: "Comprehensive geriatric assessment has demonstrated usefulness in improving the health status of frail, older patients. Therefore, elements of CGA should be incorporated into the care provided to these elderly individuals" (<http://www.americangeriatrics.org>). The degree to which those elements have an impact on patients is still being evaluated, but components of CGA have already become an accepted part of geriatric primary care and inpatient consultation services, especially in managed health care programs.

- ◆ Comprehensive assessment, however, is not feasible for all older persons; therefore, programs have developed criteria to target individuals most likely to need such assessments.

These criteria include people who have functional impairments in their ability to perform activities of daily living (ADLs); have one or more geriatric syndromes, such as falls, depression, dementia, delirium, or weight loss; or show patterns of high use of hospital or nursing home placements (AGS, 2005).

- ◆ With increasing numbers of elders with chronic illness living in the community, screening and assessment has become increasingly important to the provision of continuity of care to identify those with biopsychosocial needs.

Social workers provide health and mental health services to the elderly in a variety of settings across the continuum of care (Berkman, Maramaldi, Breon, & Howe, 2002). They help older people who are active and healthy, as well as those who have poor health, and address the needs of the elderly who live in the community, as well as those hospitalized or in long-term care institutions. Many people are not aware of available social services, and families with serious social problems are not finding the community resources and services they need. Regardless of site, screening and assessment of need for psychosocial help are still the most important part of service delivery and mark the beginning of the intervention process (Berkman et al., 2002).

Process of Conducting Geriatric Assessments

Conducting comprehensive geriatric assessments involves using general social work clinical interviewing skills as well as knowledge of special conditions that may apply to working with specific populations. Geron (2006) and Berkman and colleagues (2002) summarize these skills and processes as:

- Establishing rapport with the respondent
- Explaining the purpose of assessment
- Using observation and clinical judgment
- Assessing the client's preferences (Kane & Degenholtz, 1997)
- Knowing human behavior and caregiver dynamics
- Demonstrating cultural competency in addressing and understanding diverse groups of older persons

For a review on the social work processes involved in conducting geriatric assessments and a discussion of special issues in working with older persons, see Geron (2006).

Biopsychosocial Framework for Seven Domains of Assessment

- ◆ The conceptual framework that supports comprehensive geriatric assessment, evaluation, and management is a biopsychosocial approach to understanding chronic illness care.
- ◆ To develop a substantive understanding of an older adult's needs and resources there are seven typical domains of assessment that are important for social workers.
 - 1) Physical well-being and health
 - 2) Psychological well-being and mental health
 - 3) Cognitive capacity
 - 4) Ability to perform basic ADLs and instrumental activities of daily living (IADLs)
 - 5) Social Functioning
 - 6) Physical environment
 - 7) Assessment of family caregivers

These domains of assessment along with the rationale or evidence supporting specific areas of assessment are adapted from Diwan & Balaswamy, (2006) and presented in Table 1.

Table I. Biopsychosocial Assessment Domains and Specific Areas of Assessment Related to Chronic Illness Care

Major Domains of Assessment	Current Evidence or Rationale Supporting Specific Areas of Assessment Within Each Domain
Physical well-being and health	<ul style="list-style-type: none"> ▪ The prevalence of chronic diseases increases significantly with age, with the most common health problems being arthritis, cardiovascular disease, cancer, and diabetes (Administration on Aging, 2007). ▪ Important areas of assessment are overall health status; the presence of pain; nutritional status; risk for falling; incontinence; sleep; alcohol and drug use; dental or oral health; sensory perception, especially vision and hearing (McInnis-Dittrich, 2004); and use and misuse of medications (Kane & Kane, 2000). ▪ These health conditions may significantly influence other domains: for example, by lowering psychological well-being, limiting functional ability, and diminishing quality of life.
Psychological well-being and mental health	<ul style="list-style-type: none"> ▪ Depression, anxiety, and dementia are frequently under-diagnosed in elders, in part because symptoms can be misattributed to health problems, and in part because of stereotypical beliefs that aging is associated with increased negative affect. ▪ Substance use, misuse, or abuse (particularly of alcohol, prescription drugs, and over-the-counter medications) is also under-diagnosed, often because decreased activity among the elderly is attributed to other age-related factors. Consequently, substance abuse is not seen as the cause of a disruption from work or social activities (Widlitz & Marin, 2002). ▪ As an indicator of mental health problems, the rate of completed suicide in the U.S. is highest among people over 65 years of age (DHHS, 1999)
Cognitive capacity	<ul style="list-style-type: none"> ▪ Two distinct types of cognitive changes occur as people age: The first is the gradual decline in memory, selective attention, information processing, and problem-solving ability that occurs with normal aging; the second is a progressive, irreversible, global deterioration in capacity that occurs as a result of illnesses or diseases such as Alzheimer's, Huntington's, Parkinson's, and AIDS; or vascular dementia, often caused by strokes or tumors. ▪ As the dementia progresses, significant changes occur in memory, language, object recognition, and executive functioning: the ability to plan, organize, sequence, and abstract. Behavioral symptoms, such as agitation, hallucinations, and wandering also are common. Individuals exhibiting these behaviors require increased supervision by family members and others, which often causes considerable strain and burden on caregivers, both formal and informal.
Ability to perform various ADLs	<ul style="list-style-type: none"> ▪ Functional ability is measured through performance in the ADLs, which include dressing, bathing, eating, grooming, toileting, transferring from bed or chair, mobility, and continence; and performance in the IADLs, which include cooking, cleaning, shopping, money management, use of transportation, telephone, and administration of medications. ▪ Increasing disability in performing these activities predicts a person's movement along the continuum of care, ranging from independent living to assisted living to nursing home care. ▪ A variety of physical, psychological, cognitive, and environmental factors influence a person's ability to perform ADLs and IADLs. Therefore, an evaluation of all factors that may contribute to a person's disability is recommended.

Table I continued...

Major Domains of Assessment	Specific Areas of Assessment Within Each Domain
Social functioning	<ul style="list-style-type: none"> ▪ Social integration (having social ties, roles, and activities) is associated with better health outcomes, such as lower risk of mortality, cardiovascular disease, cancer mortality, and functional decline (Unger, McAvay, Bruce, Berkman, & Seeman, 1999). ▪ Health also affects social functioning because people who are confined to bed or have severely impaired mobility are likely to disengage from social activities. ▪ Satisfaction with one's social support is more strongly related to psychological well-being than are objective indicators of social functioning, such as frequency of social contact (Krause, 1995).
Physical environment	<ul style="list-style-type: none"> ▪ The risk of falling increases exponentially with age and, among older adults, falls are the leading cause of deaths caused by injury and are the most common cause of injuries and hospital admissions for trauma. For people ages 65 and older, two-thirds to one-half of falls occur in or around the home (CDC, 2006). ▪ Thus, assessing the fit between the older person's capabilities and his or her home environment is an important assessment domain, and the prevention of falls is a critical area of intervention. Typical home assessments will examine the condition, adequacy, and accessibility of lighting, flooring, and carpeting, including obstacles or potential hazards for falling; bathing and toileting, including the need for assistive devices; kitchen; heating and cooling; access to the home from outside; access to rooms within the home; and personal safety issues, such as neighborhood conditions. ▪ Older adults may prefer to live in an environment regarded as inadequate by a professional, but one that permits them more freedom and social connection. Kane & Kane, (2000) suggest integrating the concept of "negotiated risk," into the assessment process whereby older persons have a voice in determining their level of risk-taking,
Assessment of family caregivers	<ul style="list-style-type: none"> ▪ Approximately 66% of community-dwelling people who need long-term care rely solely on family and friends for help, and 28% receive a combination of informal and formal care (Liu, Manton, & Aragon, 2000). ▪ With declining functional ability associated with chronic illness and dementia, increasing numbers of older people are in need of care. The need for increased vigilance puts considerable strain on caregivers, which in turn not only puts the elderly person at greater risk for entering a nursing home but also increases the likelihood of abuse or neglect. ▪ Thus, assessing both objective and subjective components of caregivers' strain is important for gaining a better understanding of their needs. ▪ Objective components of burden refer to the disruption in finances, family life, and social relations, whereas subjective components refer to caregivers' appraisal of their situation as stressful (Gaugler, Kane, & Langlois, 2000).

ADLs: activities of daily living; IADLs: instrumental activities of daily living

Adapted from Diwan & Balaswamy (2006).

Biopsychosocial Needs and Services for Chronic Illness Care

- ◆ Aging populations require diverse biopsychosocial services from both formal and informal sources.

Biopsychosocial services are defined as those psychological, social, and health care services that enable patients, their families, and health care providers to manage the psychological, behavioral and social aspects of illness and its consequences and thus promote better health (Institute of Medicine, 2007). When informal support is insufficient to address a patient's needs, more formal services are needed. Table 2 lists the common biopsychosocial health needs of elders with chronic illnesses together with typical community-based services that can be helpful in meeting these needs (Institute of Medicine, 2007).

- ◆ The evidence supporting the effectiveness of various biopsychosocial services is mixed.

In a comprehensive review of the literature on the effectiveness of psychosocial health services for patients with cancer, the Institute of Medicine (2007) notes that there is generally good evidence (through meta analyses of randomized controlled trials) of the effectiveness of psychotherapeutic services, especially cognitive behavioral therapy, that help ameliorate emotional distress that co-occurs with many chronic illnesses. A similar level of evidence exists for behavioral interventions that help individuals manage their symptoms and improve their overall health. However, many interventions, such as the provision of transportation, financial assistance, and medication assistance, have not been examined specifically for effectiveness but are widely accepted as humanitarian services necessary to address basic needs. Many of the services and studies reviewed in this report address not just cancer, but a number of other chronic illnesses as well.

Table 2. Biopsychosocial Health Needs of Chronically Ill Older Adults and Evidence-Informed Services

Biopsychosocial Health Needs	Evidence Informed Services for Addressing Needs
Information and education about illness, treatments, costs, health maintenance, and services available for patients.	<ul style="list-style-type: none"> ▪ Continuous access to information and education about illness, treatments, and their effects, costs, health maintenance, and psychosocial and financial services. ▪ Decision-making support for patients and family who are considering options for treatment and care arrangements. ▪ Useful information and support through services such as health education classes, disease management seminars, and health coaches.
Help in managing illness throughout its different phases: e.g., prevention, diagnosis, treatment, remissions and exacerbations, and advanced illness.	<ul style="list-style-type: none"> ▪ Care coordination interventions to facilitate more appropriate delivery of services and assist with transitions in care. ▪ Comprehensive disease management/self-care programs. ▪ Interventions vary by characteristics of the disease (e.g., life threatening) degree of functional and role impairment, amount of pain and discomfort, and available supports.
Help in coping with emotions accompanying illness and treatment.	<ul style="list-style-type: none"> ▪ Community and peer support programs. ▪ Coaching/supportive counseling for patient and family. ▪ Pharmacological treatment for depression/anxiety coupled with psychotherapy. ▪ Pain and coping skills training for pain and discomfort.
Assistance in changing behaviors to minimize impact of disease and treatment and manage their effects.	<ul style="list-style-type: none"> ▪ Health promotion interventions such as: <ul style="list-style-type: none"> • Assessment/monitoring of key health behaviors such as diet, smoking, exercise. • Medication counseling/brief physician counseling.
Material and logistical resources such as transportation, home care.	<ul style="list-style-type: none"> ▪ Community and financial resources. ▪ Access to home care and environmental alterations. ▪ Information to informal caregivers.
Help in managing disruptions in work, activities, family life, and social network. Prepare for care transitions due to disease progression.	<ul style="list-style-type: none"> ▪ Family/caregiver education, counseling. ▪ Assistance with activities of daily living (ADLs), and instrumental activities/chores (IADLS). ▪ Information on legal protections and services. ▪ Ongoing social network development.
Financial advice and/or assistance. Managing and maintaining health insurance over time.	<ul style="list-style-type: none"> ▪ Assist with financial planning/counseling including management of activities such as bill paying. ▪ Insurance counseling/advocacy. ▪ Eligibility assessment for supplemental income benefits and assistance with major out of pocket expenses.

Adapted from a report by the Institute of Medicine titled *Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs*, 2007. Available at: <http://www.nap.edu/catalog/11993.html>.

Care Coordination as a Model of Health Services Delivery: The Evidence Base

What Is Care Coordination?

- ◆ Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services (McDonald et al., 2007).

This overarching construct includes programs of intervention that have been referred to by such terms as disease management, case/care management, multidisciplinary team management, and patient navigation. Social workers are increasingly called on to participate in the development and implementation of these programs because they often incorporate many social work functions and provide major opportunities to improve the quality and effectiveness of patients' health care, a core social work commitment.

The Need for Care Coordination

- ◆ The structure of the health care delivery system in the U.S. is marked by fragmentation, complexity, pervasive deficiencies, and remarkable variation in patient safety and healthcare quality (McDonald et al, 2007).
- ◆ Additionally, older patients are more vulnerable to the negative consequences of this fragmentation as they often have complex management regimens for their chronic conditions, strained or reduced family support, and lower health literacy (McDonald et al, 2007).
- ◆ The range of psychosocial services described earlier that are useful in improving the health and quality of life of elders are located in various delivery systems in the community, making it difficult for elders and families to access these services.
- ◆ The following summary statement characterizes the view of many health professionals about current challenges to the health care system.

Providers and decision makers at the health service delivery level are caring for patients with increasing needs for coordination services in a system that is progressively becoming more fragmented. Physicians report that time constraints are a major barrier to patient care. Coordinating care for patients takes time; time that is typically not reimbursed. As the population ages, as the number of people with multiple chronic medical problems increases, and as patients see more doctors and receive care at a greater number of healthcare settings, the need to coordinate care will continue to increase. This increase in need is occurring in an environment in which cost

containment efforts result in decreased access to social support services. While the need for coordination increases, healthcare providers frequently lack the infrastructure and resources to respond to their patient's needs.

(McDonald et al., 2007, p. 32)

These new challenges to the health care system have led to widespread interest in ways to improve the effectiveness and efficiency of medical care for chronic conditions. In the last decade, one intervention has received increasing attention in work with older adults with chronic illnesses: *coordination of care*.

In 2003, the IOM identified care coordination as among the key strategies to deal with escalating problems in the treatment of chronic conditions (IOM, 2003). In 2007, the Agency for Health Care Research and Quality (AHRQ) issued a review and synthesis of the evidence base for the effectiveness of these approaches to intervention (McDonald et al., 2007). It provided a working definition of care coordination programs, identified the range of components, provided a critique of their effectiveness, and made suggestions for future program development and research.

Models of Care Coordination Programs

- ◆ The need for care coordination is critical at several points in the health care delivery system and several models of care coordination programs have been developed to address specific needs.

Table 3 below outlines some of the major models of care coordination and, for each model, provides an example of an evidence-supported care coordination program and its specific outcomes. Many of these models of care coordination include social workers in the intervention. Readers are referred to the 2008 Institute of Medicine (IOM) report, the National Registry for Evidence-based Programs (NREPP), the Centers for Disease Control and Prevention (CDC), and Care Transitions.Org for more details on each program.

TABLE 3. Models of Care Coordination and Selected Evidence

<p>I. INTERDISCIPLINARY TEAM CARE</p> <p>Providers from different disciplines collaboratively manage the care of a patient.</p> <p><u>Example:</u> <i>Program for All-Inclusive Care for the Elderly (PACE).</i></p> <p><u>Specific Aim:</u> Within a managed-care program (for those eligible for Medicaid and Medicare), address the spectrum of needs for adults aged 55 and older whose disability level qualifies them for nursing-home care.</p> <p><u>Intervention:</u> PACE services are provided by an interdisciplinary team composed of at least the following members: a primary care physician, a registered nurse, a social worker, a physical therapist, a pharmacist, an occupational therapist, a recreational therapist, a dietician, a PACE center-manager, a home-care coordinator, personal care attendants, and drivers. PACE has an innovative team approach as it includes both professionals and direct-care workers as part of the care team. Each member of the team performs an initial assessment of each patient, and then the group works together to create a single care plan that takes the different assessments into account. The services, which are provided primarily at an adult day-care center, are also highly coordinated.</p> <p><u>Outcomes:</u> PACE enrollees showed higher patient satisfaction, improved health status and physical functioning, an increased number of days in the community, improved quality of life, and lower mortality. The benefits of PACE were even greater for the frailest older adults, who had lower rates of service utilization in hospitals and nursing homes and higher rates of ambulatory care services.</p> <p><u>Source:</u> Institute of Medicine, 2008. Retooling for an Aging America: Building the Health Care Workforce. http://www.iom.edu/?ID=53452</p>
<p>2. CARE MANAGEMENT</p> <p>In most forms, a nurse or social worker provides patients (and sometimes families) a combination of health assessment, planning, education, behavioral counseling, and coordination. Their communication with primary care providers varies depending on the care-management program.</p> <p><u>Example:</u> <i>Improving Mood: Promoting Access to Collaborative Treatment for Late Life Depression (IMPACT)</i></p> <p><u>Specific Aim:</u> To treat depression in primary care settings because depression is common among individuals with chronic illness.</p> <p><u>Intervention:</u> Patients participating in IMPACT receive educational materials about late-life depression and visit a depression-care manager at a primary care clinic. The care managers (typically nurses, psychologists, and social workers) are trained as depression clinical specialists and work with the patient's regular primary care provider to establish a treatment plan. Care managers are supervised by a team psychiatrist and a primary care physician. Results indicate that evidence-based care for major depression can be successfully delivered by specially trained nurses, psychologists, and social workers in primary care settings.</p> <p><u>Outcomes:</u> IMPACT participants had higher rates of depression treatment, greater reductions in depressive symptoms, more satisfaction with their care, less functional impairment, greater quality of life, and more depression-free days. Positive results were maintained over 1 year.</p> <p><u>Source:</u> Institute of Medicine, 2008. Retooling for an Aging America: Building the Health Care Workforce. http://www.iom.edu/?ID=53452</p>

3. CHRONIC DISEASE SELF-MANAGEMENT PROGRAMS

Self-management programs are structured, time-limited interventions designed to provide health information and to empower patients to assume an active role in managing their chronic conditions. Some are led by health professionals and focus on the management of specific conditions, such as stroke, while others are led by trained laypersons and address chronic conditions more generally.

Example: *Chronic Disease Self-Management Program (CDSMP)*

Specific Aim: To teach self-management skills useful for managing a variety of chronic diseases such as arthritis, diabetes, lung and heart disease.

Intervention: CDSMP workshops are held in community settings and meet 2 1/2 hours per week for 6 weeks. Workshops are facilitated by two trained leaders, one or both of whom are non-health professionals living with a chronic disease. This program covers topics such as techniques to deal with problems associated with chronic disease; appropriate exercise; appropriate use of medications; communicating effectively with family, friends, and health professionals; nutrition; and how to evaluate new treatments.

Outcomes: Participants in the CDSMP have shown significant improvements in exercise, communication with physicians, self-reported general health, health distress, fatigue, disability, and social/role activities limitations.

Source: CDC. <http://www.cdc.gov/arthritis/intervention/index.htm>

4. PREVENTIVE HOME VISITS

Home visits are provided to older persons by nurses or other visitors to monitor health and functional status and to encourage self-care and appropriate use of health care services. These visitors usually see their clients quarterly and communicate regularly with their clients' primary care providers.

Example: *Geriatric Resources for Assessment and Care of Elders (GRACE)*

Specific Aim: Providing health care for low-income older adults as they face several challenges, including high incidence of chronic illness, limited access to care, low health literacy, and socioeconomic stressors that lead to unmet need and greater burden of illness.

Intervention: A team consisting of a nurse practitioner and a social worker visits patients at their homes for an initial assessment and then follows up with the patients at least once a month, either by phone or face-to-face. Home visits are also conducted after any emergency-department or hospital visit. This two-person team is supported by an interdisciplinary team led by a geriatrician that includes a pharmacist, physical therapist, mental health social worker, and community-based services liaison. This group, using input from the patient's primary care physician, establishes a care plan for the patient that incorporates protocols for the treatment of 12 targeted geriatric conditions.

Outcome: A controlled clinical trial of the GRACE program indicates improved quality of care and reduced acute-care utilization. However, improvements in health-related quality of life were mixed, and physical functional outcomes did not differ from the control group.

Source: Institute of Medicine, 2008. Retooling for an Aging America: Building the Health Care Workforce. <http://www.iom.edu/?ID=53452>

5. CAREGIVER EDUCATION AND SUPPORT

These community-based programs are designed to help the informal caregivers of older persons with chronic conditions such as dementia and stroke. Led by psychologists, social workers, or rehabilitation therapists, these programs provide varying combinations of health information, training, access to professional and community resources, emotional support, counseling, and coping strategies.

Example: *Resources for Enhancing Alzheimer's Caregiver Health II (REACH II)*

Specific Aim: Support caregivers of persons with dementia.

Intervention: Provide educational information, skills to manage care recipient behaviors, social support, cognitive strategies for reframing negative emotional responses, and strategies for enhancing healthy behaviors and managing stress. Methods used in the intervention include didactic instruction, role-playing, problem-solving tasks, skills training, stress management techniques, and telephone support groups.

Outcome: Caregivers in the REACH II intervention group experienced greater improvement in quality of life and fewer cases of clinical depression.

Source: National Registry of Evidence-Based Programs and Practices, SAMHSA.
<http://www.nrepp.samhsa.gov/>

6. TRANSITIONAL CARE

Typically a nurse or an advance-practice nurse prepares and coaches the patient and informal caregiver for the transition from hospital discharge to home care.

Example: The Care Transitions Program

Specific Aim: To help patients with complex care needs learn self-management skills to ensure their needs are met during the transition from hospital to home.

Intervention: For 4 weeks after discharge the nurse visits the patient at home to ensure that all needed medication, equipment, and supplies are available, and that the patient and caregiver know how to use them, how to self-monitor, and whom to call if problems arise. The nurse continues to monitor the situation for several weeks until the patient has returned to pre-admission status, contacting the primary care physician as needed.

Outcome: Intervention patients had fewer hospital readmissions, reported high levels of confidence in obtaining essential information for managing their condition, communicating with members of the health-care team, and understanding their medication regimen (Coleman et al., 2004).

Source: The Care Transitions Program. www.CareTransitions.org

Features of Innovative Care Coordination Models

The IOM (2008) committee report did not attempt to rank the models described above or to recommend one model of care over another. In fact, little evidence exists that one might use to rate the relative effectiveness of these different approaches. Typically, evaluations focus on whether a single model proved to be successful rather than identifying which of several models produced the strongest results.

- ◆ The committee concluded that no single one of the models described above would be sufficient to meet the needs of all older adults. The health care needs of the older population are diverse, and addressing those needs requires varying models of care to meet their specific requirements.

For example, preventive home visits may be too costly to expand to all older persons, the majority of whom may not even require that level of care. Similarly, caregiver-support programs may not be sufficient for older adults with more intensive needs. The models described above have generally been successful in enrolling mainly those older adults who would best benefit from the particular expanded services.

- ◆ After reviewing the evidence on a number of different models of care, the IOM committee concluded that some of the models with the strongest evidence of success in improving care quality, health-related outcomes, or efficiency have common features that may contribute to their success.

Common components of care coordination programs include the following:

- 1) Essential care tasks (e.g., assess client and develop a care plan)
- 2) Associated coordination activities (e.g., service arranging, psycho-education)
- 3) Common features of interventions to support coordination activities (e.g., standardized protocols and manuals, multidisciplinary teams).

Key aspects of these care coordination interventions are thoroughly integrated in the social work profession's knowledge, skill, and value base:

- 1) Patient education
- 2) Self management
- 3) Provider education
- 4) Provider reminders to patients (e.g., regarding appointments, procedures)
- 5) Audit and feedback
- 6) Relay of clinical data
- 7) Organizational change (e.g., adding staff, changing or adding programs)
- 8) Financial and regulatory incentives (e.g., compensated time for patient education).

Evidence for the Relative Efficacy of Various Care Coordination Programs

- ◆ The evidence base for the effectiveness of various care coordination is substantial but not sufficient, and the comparative usefulness of various programs is unknown.

Although there is substantial evidence for the effectiveness of care coordination programs, it currently is not adequate to determine the relative effectiveness of any particular strategy compared to other strategies in improving patient outcomes. Because few intervention studies have clearly identified their component parts, the specific aspects of these interventions that are most effective also are unknown.

The AHRQ's examination of 75 systematic reviews provides an up-to-date evaluation of the evidence base for care coordination interventions (McDonald et al., 2007). From these reviews, 20 different interventions were identified that had been implemented in multiple settings and that covered 12 clinical populations spread across the settings. Specific components of care coordination were clarified to support the analysis. Overall, this synthesis found that care coordination interventions improved important patient outcomes in different diseases across a broad spectrum of clinical settings.

The AHRQ report (McDonald et al., 2007) included the following overall benefits of care coordination:

- Care coordination strategies for older adults have resulted in reduced numbers of hospital admissions.
- Interventions by multidisciplinary teams have improved continuity of service for severely mentally ill patients, reduced mortality and hospital admissions for heart failure patients, reduced symptoms for terminally ill patients, and reduced mortality and dependency for stroke patients.
- Disease management programs have reduced severity of depression and improved adherence to treatment in patients with mental illness, reduced mortality and hospital admissions in patients with heart failure, and improved glycemic control in patients with diabetes.
- Case management programs have shown reduced rates of rehospitalization among patients with mental health problems, and improved glycemic control among patients with diabetes.

Despite the above findings, unclear definitions and descriptions of the specific components used in most care coordination interventions make it difficult to determine which specific components were affecting the outcomes. Therefore, continued well-designed research in this area is needed.

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Curriculum Resources



Suggested Readings:

Comprehensive Text Books on Social Work in Health and Aging

- Berkman, B. (Ed.). (2006). *Handbook of social work in health and aging*. New York: Oxford University Press.
- Gelhert, S., & T. A. Browne (Eds.). (2006). *Handbook of health social work*, New York: Wiley.
- Kane, R. L., & Kane, R. A. (2000). *Assessing older persons: Measures, meaning, and practical applications*. New York: Oxford University Press.
- McInnis-Dittrich, K. (2005). *Social work with elders: A biopsychosocial approach to assessment and intervention*. Boston: Allyn and Bacon.



Class Assignment: Group Project for Health Care

In the context of an ever-changing health care environment, the ability to define social work roles and to be able to advocate for social work programs in the field of health is critical. This assignment is an opportunity to design and present a proposal for a new service or program in a setting of your choosing (i.e., hospital, outpatient, prevention agency, specialty clinic, advocacy). Working in a group of students, you are expected to identify a specific need and population and prepare a 30-minute presentation on this topic. This presentation will have several key components:

Statement of the problem and why services are needed:

- ◆ What is the scope of the problem areas
- ◆ What is known and how is it relevant to social work practice

Findings from literature review:

- ◆ How has the problem been studied or evaluated
- ◆ What literature exists about practice approaches and methods

Description of the program or service:

- ◆ Introduce your intervention strategy

Presentation of practice issues and plan for implementing the intervention:

- ◆ How will you begin

- ◆ How will individuals find out about/gain access to your program/service
- ◆ How do you anticipate that other health professionals will respond and/or interact with this intervention

Description of resources that would be needed to implement the intervention.

Definition of ways to evaluate the success of your program/service:

- ◆ Review of literature to identify ways to evaluate this program/service
- ◆ Identify evaluation instruments that you would use

Identify how this relates to other setting and community resources:

- ◆ Identify how this relates to other setting and community resources
- ◆ Identify relevant government/other agencies to this client population
- ◆ Discuss opportunities for partnerships or possible overlap with other programs that will need to be considered.

You are encouraged to interview professionals in the field to get ideas and strategies. This presentation should be targeted to an inter-professional decision-making audience as if you were presenting this to a committee in the setting that you have chosen.

The group is expected to provide the instructor with the following prior to the presentation:

- ◆ an outline of the presentation (this may be a print out of PowerPoint slides)
- ◆ a copy of all handouts
- ◆ a reference list of key literature used in your research of the presentation and any additional resources you found helpful.

All group members are expected to share delivering the presentation to the class. Ten minutes will be allotted following the presentation for questions and discussion. Peer feedback/evaluation will be included although the final grade for this assignment will be given by the instructor.

Note: This assignment was submitted for inclusion in this module by:

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Teaching Modules and Films and Media:

Resources for Screening and Biopsychosocial Assessment



John A. Hartford Institute for Geriatric Nursing Try This.

Try This: Best Practices in Nursing Care to Older Adults is a series of assessment tools to provide knowledge of best practices in the care of older adults. Includes:

- A general assessment tool (SPICES)
- The Katz Index of Independence in Activities of Daily Living
- The Lawton Instrumental Activities of Daily Living Scale
- Fall Risk Assessment
- Mental Status Assessment of Adults (Mini-Cog)
- The Geriatric Depression Scale (GDS) in English or Spanish
- Alcohol Use Screening and Assessment
- Modified Caregiver Strain Index
- Elder Mistreatment Assessment in English or Spanish

The *Try This* resources were developed for a nursing curriculum, but they are quite appropriate for social work students and practitioners.

The videos include a demonstration of the instrument, a discussion of the problem, debriefing, and the implications of the assessment for intervention/ treatment planning after the assessment. The assessments are conducted in a hospital setting, so instructors may need to discuss with their students the influence of context on the process of evaluation.

Overall, the quality of the videos is good as are the other *Try This* resources.

(See below for links to demonstration videos of the various instruments.)

<http://www.hartfordign.org/trythis>

[To show these in full screen, you will need to click the full screen icon in the lower right corner.]

Resources for Health Care Issues and Ethnic Diversity



Stanford Geriatric Education Center

<http://sgec.stanford.edu/>

The SGEC has many valuable resources that can help faculty who need health-related information about older adults. In particular, this center offers excellent on-line training resources on racial and ethnic diversity that include:

- Curriculum in Ethnogeriatrics
A comprehensive curriculum in the health care of elders from diverse ethnic populations for training in all health care disciplines. It includes five Core

Curriculum modules and eleven Ethnic Specific Modules to be used in conjunction with the Core Curriculum.

- **Diabetes and Mental Health**
Developed as a resource for teaching culturally appropriate care for depression and cognitive loss for elders at high risk for diabetes.
- **Improving Communication with Elders of Different Cultures**
Provides information on how to recognize barriers to communication with elders who are culturally or ethnically different from the health care provider, and some culturally sensitive approaches to elicit information and promote shared decision-making and mutual respect.
- **Diversity, Healing, and Healthcare**
Contains information about communication and healthcare beliefs related to 15 cultures, 11 religions, and 8 American immigrant cohorts.



Web Resources:

General Chronic Care Information

- ◆ **Healthy Aging:** <http://www.cdc.gov/aging>
Contains excellent overviews of issues related to chronic diseases, caregiving, and end-of-life, and provides examples of state programs.
- ◆ **National Chronic Care Consortium:** <http://www.nccconline.org/>
This organization is dedicated to transforming the delivery of chronic care services. It provides access to advanced knowledge for serving people with multiple, complex chronic conditions. It offers tools and methods for addressing numerous aspects of integration of care for people with serious chronic conditions.
- ◆ **National Registry of Evidence-Based Programs and Practices:**
<http://www.nrepp.samhsa.gov/>
NREPP is a searchable database of interventions for the prevention and treatment of mental and substance use disorders. SAMHSA has developed this resource to help people, agencies, and organizations implement programs and practices in their communities. Also contains information on health care and caregiver support programs.

Disease-Related Information

- ◆ **Alzheimer's Association:** <http://www.alzheimers.org/>
Comprised of a network of chapters, the Alzheimer's Association is one of the largest voluntary organizations studying the disease and providing support to caregivers.
- ◆ **American Cancer Society:** <http://www.cancer.org/>
Provides information for patients, families, health care providers. Also has materials in Spanish and some Asian languages.

- ◆ American Diabetes Association: <http://www.diabetes.org/main/application/commercewf>
News, recipes, tip of the day and resources to help users find local help.
- ◆ American Heart Association National Center:
<http://www.americanheart.org/presenter.jhtml?identifier=1200000>
Includes risk assessment for heart attack and stroke, resources for advocates and scientists, and a "Heart and Stroke A-Z" guide.
- ◆ American Stroke Association:
<http://www.strokeassociation.org/presenter.jhtml?identifier=1200037>
Sponsored by the American Heart Association, this group provides resources for doctors, and patients and their caregivers.
- ◆ The Arthritis Foundation: <http://www.arthritis.org/>
Connects users with events, treatments, research, advocacy, and goods related to arthritis. A zip code search provides information on the nearest Foundation chapter.
- ◆ Introduction to Diabetes: <http://diabetes.niddk.nih.gov/intro/index.htm>
From the NIH-sponsored National Institute of Diabetes and Digestive and Kidney Diseases, this page contains tips on how to take care of diabetes and how to prevent some of the serious problems that the disease can cause.
- ◆ Foundation for Osteoporosis Research and Education: <http://www.fore.org/>
A nonprofit resource center dedicated to preventing osteoporosis through research and education of the public and medical community. Includes links to an educational video available at the National Osteoporosis Foundation.
- ◆ National Stroke Association: <http://www.stroke.org/>
A group dedicated to education, services, and community-based activities in prevention, treatment, rehabilitation, and recovery from stroke.
- ◆ Parkinson's Disease Foundation: <http://www.pdf.org/index.cfm>
Features news, "ask the expert," and an email newsletter.