CSWE Gero-Ed Center

# Health Resource Review - Section 2.2

Table 1. 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 | ▪ 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).<br>▪ 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).<br>▪ 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 | ▪ 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.<br>▪ 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).<br>▪ 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 | ▪ 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.<br>▪ 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 | ▪ 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.<br>▪ 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.<br>▪ 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. |

| Major Domains of Assessment | Specific Areas of Assessment Within Each Domain |
|---|---|
| Social functioning | ▪ 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).<br>▪ Health also affects social functioning because people who are confined to bed or have severely impaired mobility are likely to disengage from social activities.<br>▪ 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 | ▪ 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).<br>▪ 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.<br>▪ 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 | ▪ 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).<br>▪ 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.<br>▪ Thus, assessing both objective and subjective components of caregivers' strain is important for gaining a better understanding of their needs.<br>▪ 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).

# Health Resource Review - Section 2.2

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. | ▪ Continuous access to information and education about illness, treatments, and their effects, costs, health maintenance, and psychosocial and financial services.<br>▪ Decision-making support for patients and family who are considering options for treatment and care arrangements.<br>▪ 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. | ▪ Care coordination interventions to facilitate more appropriate delivery of services and assist with transitions in care.<br>▪ Comprehensive disease management/self-care programs.<br>▪ 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. | ▪ Community and peer support programs.<br>▪ Coaching/supportive counseling for patient and family.<br>▪ Pharmacological treatment for depression/anxiety coupled with psychotherapy.<br>▪ Pain and coping skills training for pain and discomfort. |
| Assistance in changing behaviors to minimize impact of disease and treatment and manage their effects. | ▪ Health promotion interventions such as:<br>• Assessment/monitoring of key health behaviors such as diet, smoking, exercise.<br>• Medication counseling/brief physician counseling. |
| Material and logistical resources such as transportation, home care. | ▪ Community and financial resources.<br>▪ Access to home care and environmental alterations.<br>▪ Information to informal caregivers. |
| Help in managing disruptions in work, activities, family life, and social network.<br>Prepare for care transitions due to disease progression. | ▪ Family/caregiver education, counseling.<br>▪ Assistance with activities of daily living (ADLs), and instrumental activities/chores (IADLS).<br>▪ Information on legal protections and services.<br>▪ Ongoing social network development. |
| Financial advice and/or assistance. Managing and maintaining health insurance over time. | ▪ Assist with financial planning/counseling including management of activities such as bill paying.<br>▪ Insurance counseling/advocacy.<br>▪ 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

## TABLE 3. Models of Care Coordination and Selected Evidence

### 1. INTERDISCIPLINARY TEAM CARE

Providers from different disciplines collaboratively manage the care of a patient.

Example: *Program for All-Inclusive Care for the Elderly (PACE).*

Specific Aim: 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.

Intervention: 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.

Outcomes: 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.

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

### 2. CARE MANAGEMENT

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.

Example: *Improving Mood: Promoting Access to Collaborative Treatment for Late Life Depression (IMPACT)*

Specific Aim: To treat depression in primary care settings because depression is common among individuals with chronic illness.

Intervention: 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.

Outcomes: 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.

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

### 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 topic 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

# Health Resource Review - Section 2.2

## 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