

## **Recommendations to the Services Expansion Workgroup Coordination of Health and Social Services Objective**

### **Goals**

1. To improve the quality of care for older people in Illinois, who receive long-term care services, by coordinating their health and the social service needs through a system of enhanced care coordination designed specifically to address the coordination function.
2. To improve the system's effectiveness and efficiency by reducing hospitalizations, nursing home placements, hospital emergency room visits and other familiar consequences of delays in addressing medical problems.

### **Rationale**

1. Older adults receiving long-term care services have health and social needs
2. Their medical conditions (physical and/or cognitive) result in the limitations in daily living activities such as eating and dressing and in instrumental activities for daily living such as driving, shopping, managing finances and using the telephone that create the need for social services.
3. Yet, at this time, the health and social service systems operate separately with little or no formal communication between them.
4. This separation results in declining quality of life, unnecessary systems costs, and additional burden on family members and other informal caregivers. It may also contribute to premature mortality.
5. Research in Illinois suggests the following key barriers to coordination:
  - i. No one 'owns' the problem of coordination.
  - ii. Communication between medical providers is inadequate and between medical and community care providers, it is almost non-existent.
  - iii. There is no effective system to transfer client information between sites and systems of care.
  - iv. The CCP has no mechanism for identifying, tracking, and monitoring high risk clients.

### **Objectives**

1. During Fiscal Year 2010, provide funding for three demonstration/pilot grants in targeted areas of the state (criteria to be established) to establish necessary services and communication mechanisms between the Comprehensive Care Coordination system and the medical/allied health systems. Demonstrations will:
  - a. Develop a system of care that bridges the silos between medical and social care through improved communication, information transfer, and coordination of services.



4. Develop a medical monitoring/management system that includes a medication audit whenever the client moves from one site of care to another (reconcile meds whenever a transition from one site of care to another is made).
5. Develop mechanisms designed to improve communication between social workers and physicians so that information is more easily exchanged.
6. Where operational, link with the federal demonstration Medical Home project that makes primary care the centerpiece of a coordinated system of care.
7. Strengthen linkages with Medicare home health.
8. Develop client education protocols so that client can monitor his/her own care (with help of family or other caregiver for clients who cannot do this on their own).
9. Identify high-risk clients (e.g., by certain conditions such as COPD or diabetes or CHF, by frequency of hospitalization and when transitioning between hospital and home) and create enhanced interventions for them.
  - a. Use nurses as care coordinators or consultants for targeted individuals. Responsibilities would include:
    - i. Health risk screening and care planning
    - ii. Monitoring individual status and care plan effectiveness
    - iii. Contacting monthly when in active status
    - iv. Providing support with such things as educational materials
    - v. Monitoring treatment adherence
    - vi. Monitoring nutrition and providing nutrition education.
  - b. Assign a home care aide who has been trained in what to notice and how to report changes in the client's condition.
    - i. "Upskilled" aide will also help to create a career ladder for aides as they develop specific competencies.
    - ii. Integrate aide into health care team.
  - c. For individuals who are going from hospital to home:
    - i. Increase the service max in the immediate post-hospitalization period and provide extra support to families at this time.
    - ii. Coach families about potential changes in the patient's condition and appropriate responses to these changes.
    - iii. Conduct home visit to assess potential problem areas and remedy as possible.
    - iv. Inform Case Coordination Unit and homemaker agency about discharge.
    - v. Check on meals, assistive devices, etc., 2-3 days after discharge.
    - vi. Do spot checks to see that patient and family are able to follow through on post-hospital care.
    - vii. Create a SWAT Team of trained advocates to assist patients and families with whatever comes up for the 3 months after discharge.

