It is estimated that 82% of adults age 65+ have at least one chronic disease, with hypertension, arthritis and heart disease as the most common illnesses.

5.1 million people aged 65 and older and 200,000 individuals under age 65 Alzheimer’s disease.

One in eight people aged 65 and older (13 percent) have Alzheimer’s disease.
Selected Chronic Health Conditions Causing Limitation of Activity Among Adults by Age: 1998 to 2000

- Arthritis/Musculoskeletal
- Heart/Circulatory
- Vision/Hearing
- Fractures/Joint Injury
- Mental Illness
- Diabetes

Source: National Center for Health Statistics, 2002
A Fragmented, Complex Health and LTC System

- The health care system is currently focused on acute care, which increases fragmentation and prevents communication between and among providers for any individual patient.

- Integration between health and long-term care systems is exception rather than the rule.

- Care delivery for older adults often includes healthcare providers, social service professionals, direct care workers, and family/informal caregivers.

- Providers must work together across disciplines and across settings to reduce fragmentation and promote quality care.
A Fragmented, Complex Health and LTC System

Carol Raphael, “Duncan Clark” Lecture at The New York Academy of Medicine, 01/28/08
Long-term Care and the Consumer

- Frustration with fragmentation and increased demand for home and community based services rather than institutional care
- Current generation educated and aware but need assistance with identifying resources and navigating system
- Family caregivers are backbone of long-term care system and experience high levels of stress
Care Coordination Can and Does Help

- Care coordination works to overcome fragmentation and inefficiency:
  - Ensures collaboration among providers and systems
  - Helps client and caregivers assess needs, develop and implement a care plan, gain access to needed services
  - Provides services to older adults in a home and community based setting and integrate medical and social services

- Effective care coordination models take an interdisciplinary approach:
  - Integrate medical and social services
  - Are patient centered
  - Include all caregivers
Care Coordination in the Delivery of Integrated Care

- Home and Community Based Services
- Formal Care
- Informal Caregiving
- Medicare/Medicaid/Private Insurance
- Housing/Nutrition/Transportation
- Mental Health
- Health Services
White Papers

- Towards the Development of Care Coordination Standards: An Analysis of Care Coordination in Programs for Older Adults.
- Who Is Qualified to Coordinate Care: Recommendations to the New York State Department of Health and the New York State Office for the Aging.
- Structuring, Financing, and Paying for Effective Chronic Care Coordination.
- The Promise of Care Coordination: Models that decrease hospitalizations and improve outcomes for Medicare beneficiaries with chronic illness.
- Strengthening Services for Older Adults through Changes to the Older American Act

http://www.socialworkleadership.org/nsw/care/carecoordination.php