iCCOA

Interprofessional
Curriculum for
Care of
Older
Adults

ICME

Interprofessional Case Management Experience M-3

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Interprofessional Case Management Experience

ICME

In this session you will learn about integrated patient-centered geriatric community care, conduct a goals of care/family meeting and "practice" working in an interprofessional team to plan the care of a patient with diabetes and multiple social issues.

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Activities for Today

- **You will:**
  - **Participate in team discussions and activities as a team member involved in the care of the patient, Mr. Thomas.**
  - **Observe videotaped interactions between members of Mr. Thomas' healthcare team.**
  - **Participate in a care planning meeting.**
  - **Critique the meeting.**

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World Health Organization Definitions of Health

- Health = "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"

- Social determinants of health = the conditions in which people are born, grow, live, work, and age

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What Determines Health/Well-Being?

- The quality of medical care received?
- Socioeconomic status?
- Race/ethnicity?
- Access to resources?
- Physical environment?
- Personality and coping variables?
- Quality of caregiving?
- Social support?

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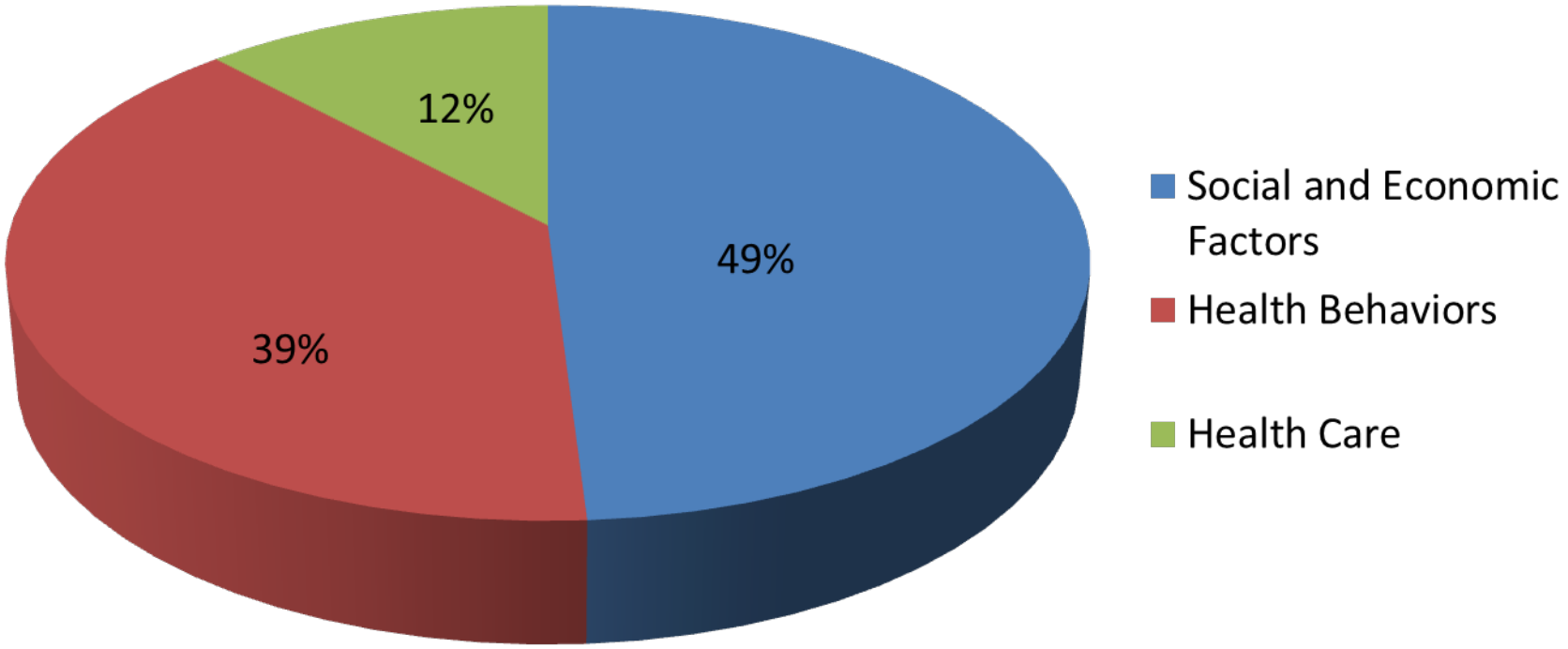
Health Outcome Determinants



Booske,BC, Athens,JK, Kindig,DA, Park,H, & Remington,PL. (2010). Different perspectives for assigning weights to determinants of health. University of Wisconsin Population Health Institute.

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How Should Social Determinants of Health Inform Care of the Older Adult?

- If we address only the physiological changes and treatment of the disease, we are missing 88% of the factors impacting patient outcomes
- Holistic patient/family-centered care is essential if we are to obtain desirable outcomes

- **It takes a team!**

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Who Should Be on the Team?

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Members of the Community Team

- Patient and Caregiver, Family Members
- Clinical Care Team - Physician or Nurse Practitioner, RN, Clinical Social Worker
- Community Health Navigator
- Community Organizer
- Care Managers
- Peer Mentor
- Other professionals depending on the patient's plan of care (home health, PT, OT, specialist MDs, dentists, pharmacists, etc.)

WHAT IS INTEGRATED PATIENT-CENTERED GERIATRIC PRIMARY CARE?

An Example of the Model

flourish

a shared-care approach to healthcare

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Interprofessional Team

- Shared leadership
- Individual and mutual accountability
- Open-ended discussions, active problem-solving
- Success = collective work-products

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Introducing Jim Thomas

Case summary

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What social determinants of health will impact Mr. Thomas’ care?

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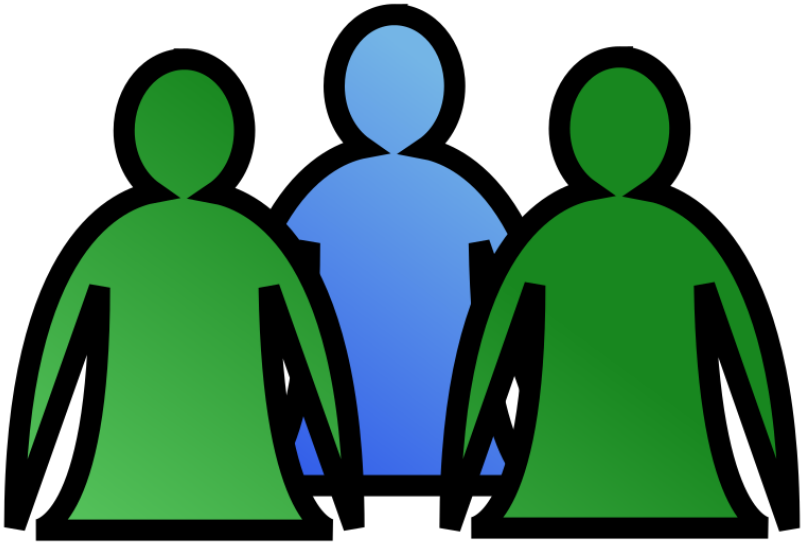
Who should be on Mr. Thomas' team?



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Next Steps

- Your team facilitator will assign you a role on the team caring for Mr. Thomas in the community
- Think about that role as you view video clips related to Mr. Thomas' care in the community
- Remember – the patient and family are essential members of the care planning team

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Let's look at Mr. Thomas' Care in the Community

- First visit with nurse practitioner
- Dental visit
- Health Navigator discussion with NP

https://youtu.be/xO-_0qMpXh0

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- What new information do we have about Mr. Thomas that will inform his care planning?

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Optimal interdisciplinary team care includes a Plan of Care that:

- is timely and patient-centered
- is based on comprehensive interdisciplinary assessment of patient and family
- respects patient/family preferences, values, goals and needs
- includes professional guidance and support for patient decision making
- ensures services provided in accordance with the plan of care
- includes all disciplines important to patient/family care
- allows for provision of care in the environment which best meets the preferences, needs and circumstances of the patient and family

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Team Assignment

- You will role play a care planning meeting between Mr. Thomas and his healthcare team.

- Based on your role, you will interact with the other members of the team, Mr. Thomas and his granddaughter to develop a plan of care.

- Your meeting will last 15 minutes

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- You will now debrief and evaluate how well your team did with care planning.

- Don't forget to get the patient and family members' perspectives

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Thank you

TEAM FACILITATORS:

- Collect one copy of the Interprofessional Plan of Care (learners may keep other forms)

LEARNERS:

- **Before leaving complete the post-test and give to your team facilitator.**
- Thank you for your participation.

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