



Interprofessional Curriculum for Care of Older Adults (iCCOA)



UNIVERSITY OF
LOUISVILLE
INSTITUTE FOR SUSTAINABLE
HEALTH & OPTIMAL AGING

Welcome to the Interprofessional Case Management Experience

Please log in to the iCCOA Portal at <https://medapp.louisville.edu/iCCOA/iccoa.cgi> and make sure you have registered for ICME and completed the pre-test. Specific instructions are located on your table. Please verify your registration and pretest with your facilitator.

Wi-Fi Information

University of Louisville student,
staff, or faculty:

Network: ULSecure

Username: ULINK User ID

Password: ULINK Password.

If you are not affiliated with UofL
see host for Wi-Fi and login details.



Interprofessional Curriculum for Care of Older Adults (iCCOA)

ICME

Interprofessional Case Management Experience

The Joe and Thelma Hedgepath Case

Learners, go to this site and make sure you are registered for ICME and have taken the pretest.

<https://medapp.louisville.edu/iCCOA/iccoa.cgi>

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number 1 U1QHP28732-01-00, Geriatric Workforce Enhancement Program.



A Collaboration of Many



UNIVERSITY OF
LOUISVILLE®

Trager Institute

School of Medicine

School of Nursing

Kent School of Social Work

Brandeis School of Law

School of Dentistry

College of Education & Human Development

Activities for Today

- You will:
 - **Participate** in team discussions and activities representing a discipline as a team member involved in the care of the couple, Mr. and Mrs. Hedgepath.
 - **Observe** videotaped interactions between members of Mr. and Mrs. Hedgepath's healthcare team
 - **Critique and discuss** these interactions.
 - **Participate** in a family meeting.
 - Please **turn off** computers and phones
 - Have **FUN!!**

Team Introductions

In your teams introduce yourself by NAME & DISCIPLINE and answer the following questions:

- What do you want everyone to know about your discipline?
- What stereotype do you hate the most about your discipline?

Interprofessional Case Management Experience

ICME

In this session you will follow the care of a couple with complex health and family issues surrounding end of life care. You will learn about patient-centered, geriatric, integrated, primary, behavioral, and community care. You will conduct a goals of care/family meeting and “practice” working with an interprofessional team.

SAMHSA Core Competencies

(Substance Abuse and Mental Health Services Administration)

This ICME Session Highlights These Competencies
for Integrated Behavioral Health & Primary Care

- I. Interpersonal Communication
- II. Collaboration & Teamwork
- III. Screening & Assessment
- IV. Care Planning & Care Coordination
- V. Intervention
- VI. Cultural Competency & Adaptation
- VII. Systems Oriented Practice

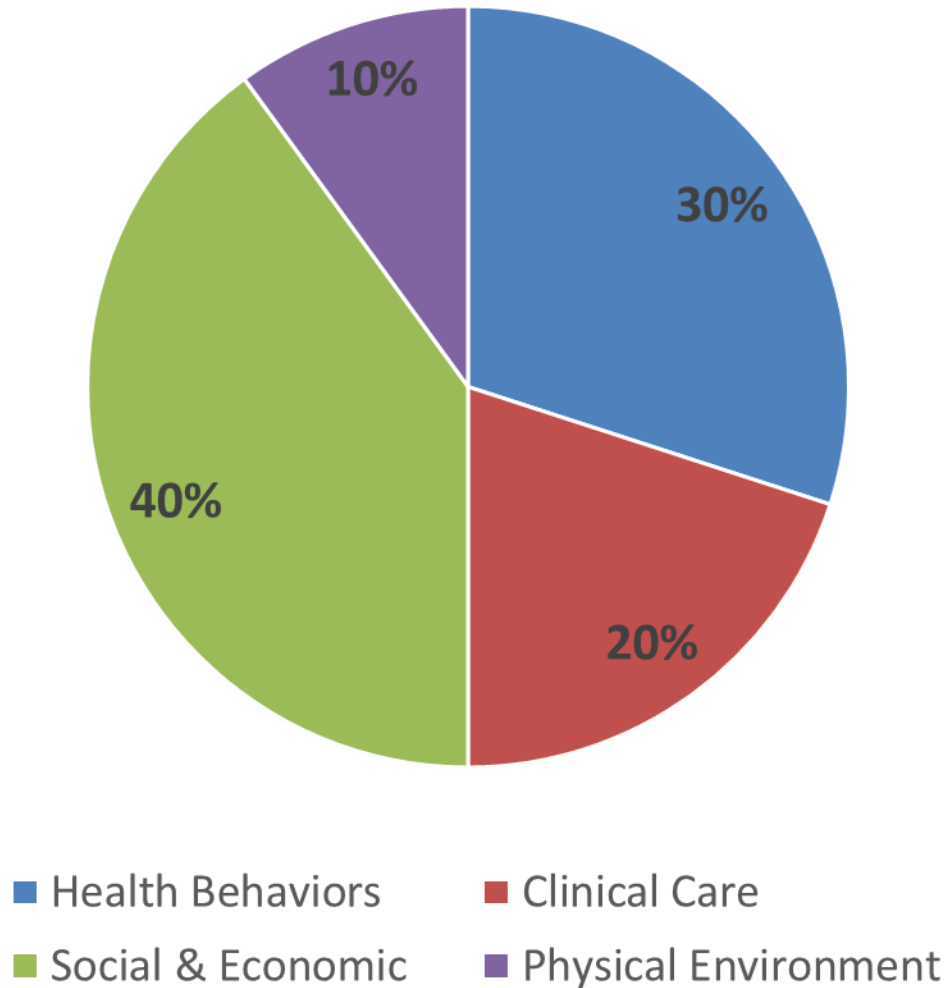
World Health Organization

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

Health Outcome Determinates

Health Factors

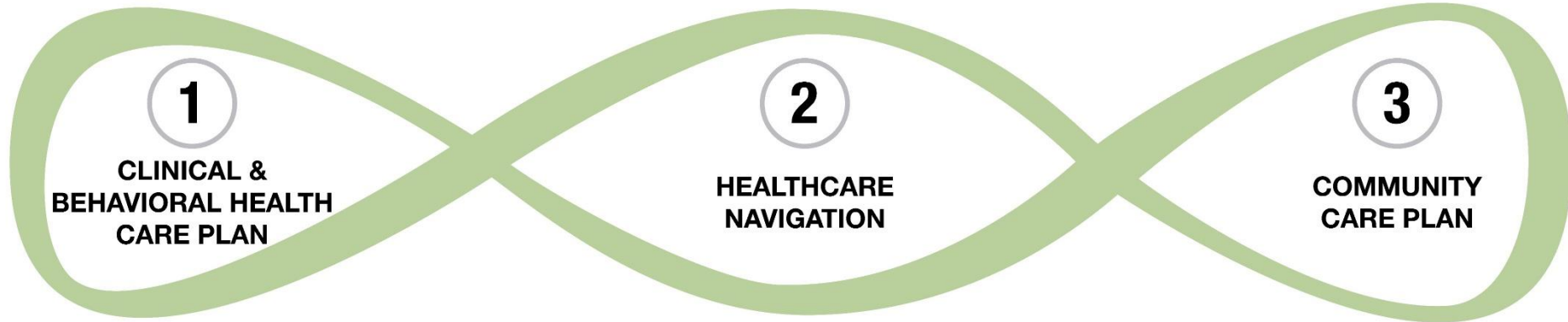


What does that mean for older adults?

- If we address only the physiological changes and treatment of the disease, we are missing 80% of the factors impacting patient outcomes
- Holistic patient/family-centered care is essential if we are to obtain desirable outcomes

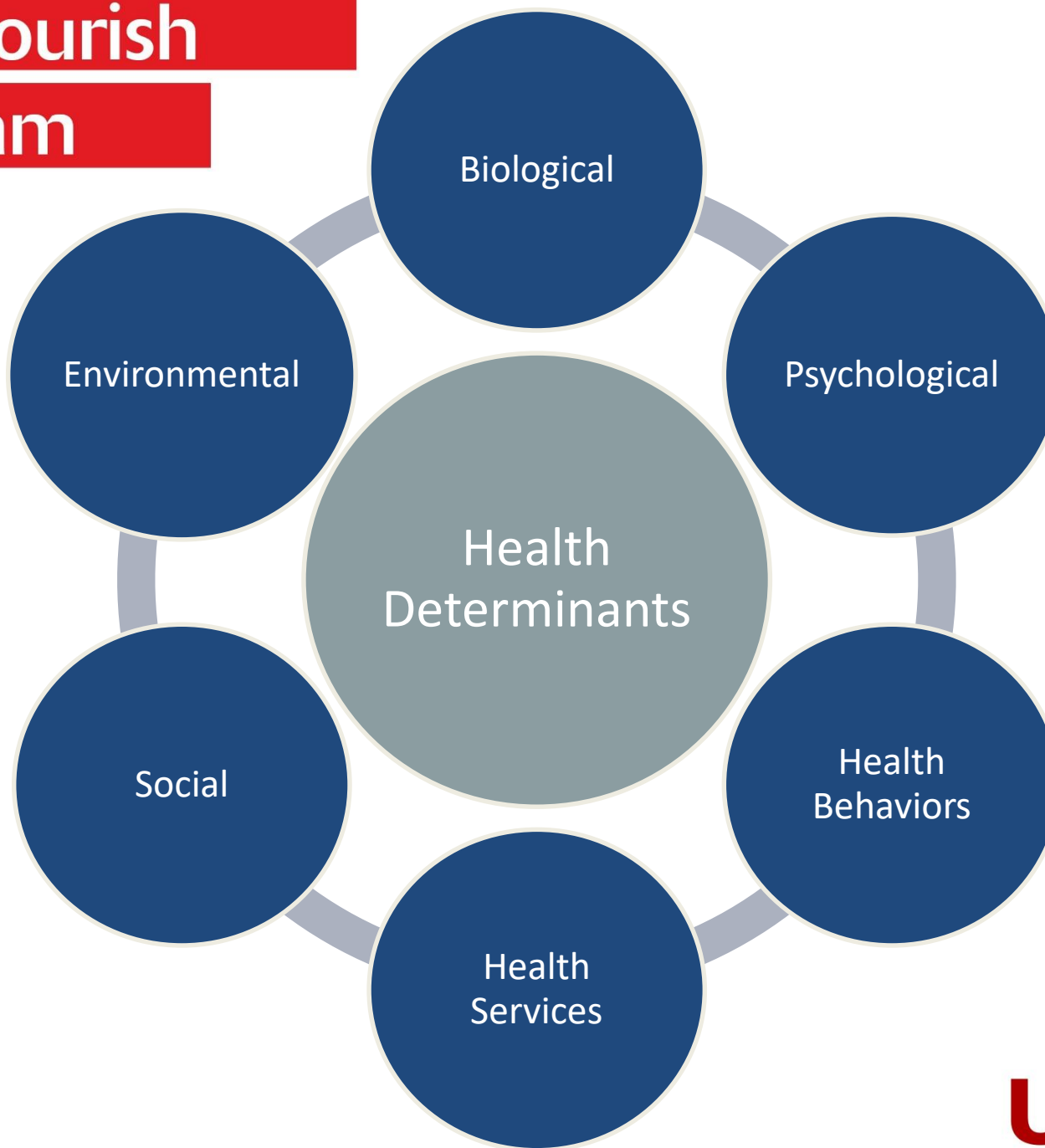
WHAT IS INTEGRATED PATIENT-CENTERED GERIATRIC PRIMARY CARE?

An Example of the Model



**The Flourish
Program**

The Flourish Program



Who should be the
members of the
Community Team?

Multidisciplinary Team

- Strong, focused leadership
- Individual accountability
- Individualized work products
- Efficient meetings
- Success = influence on others



Crawford, G. B., & Price, S. D. (2003). *Team working: Palliative care as a model of interdisciplinary practice*. Medical Journal of Australia, 179(6 Suppl), S32-34.

Kilgore, R. V., & Langford, R. W. (2009). Reducing the failure risk of interdisciplinary healthcare teams. *Critical Care Nursing Quarterly*, 32(2), 81-88.

Youngwerth, J., & Twaddle, M. (2011). Cultures of interdisciplinary teams: How to foster good dynamics. *Journal of Palliative Medicine*, 14(5), 650-654.

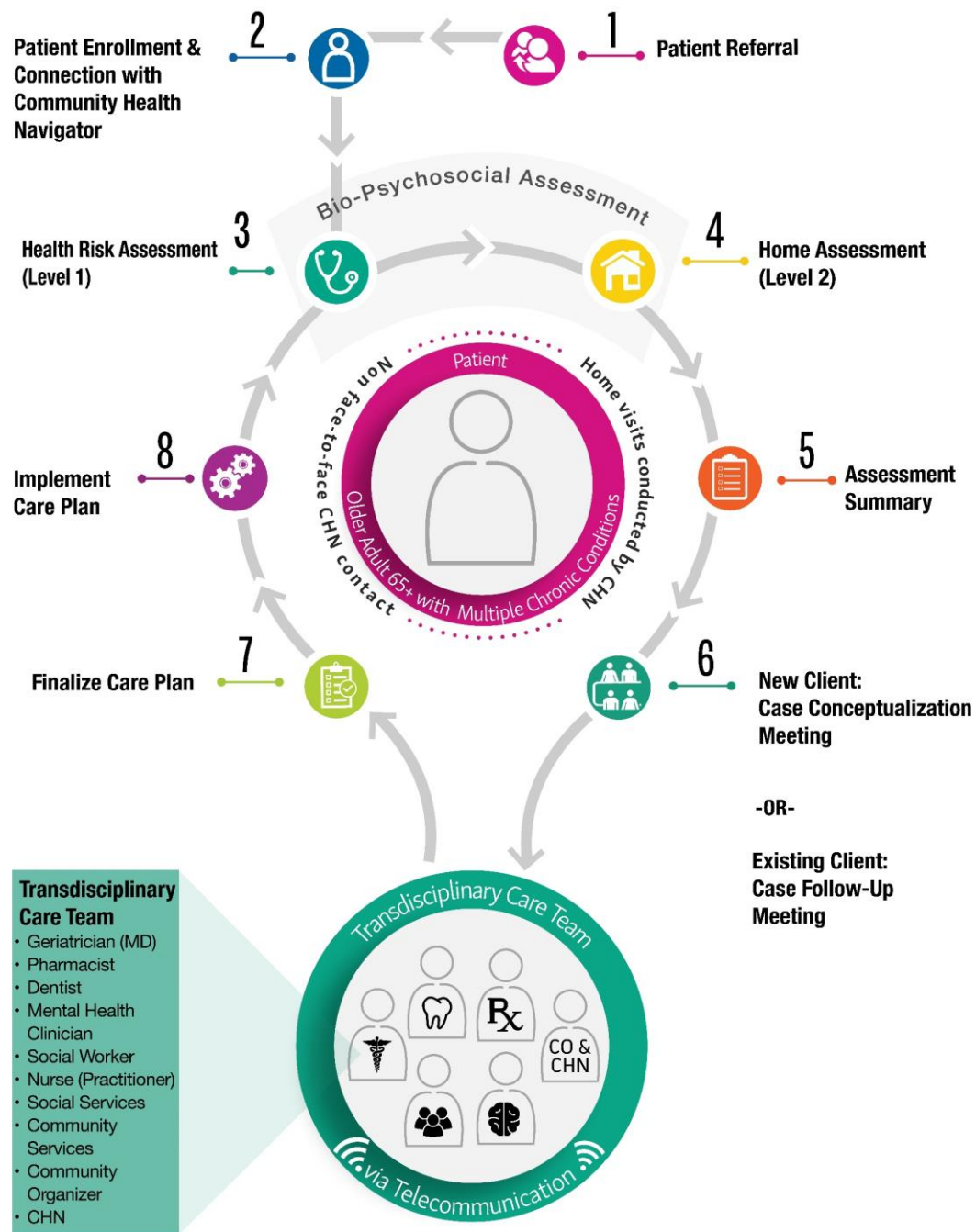
Interprofessional Team

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



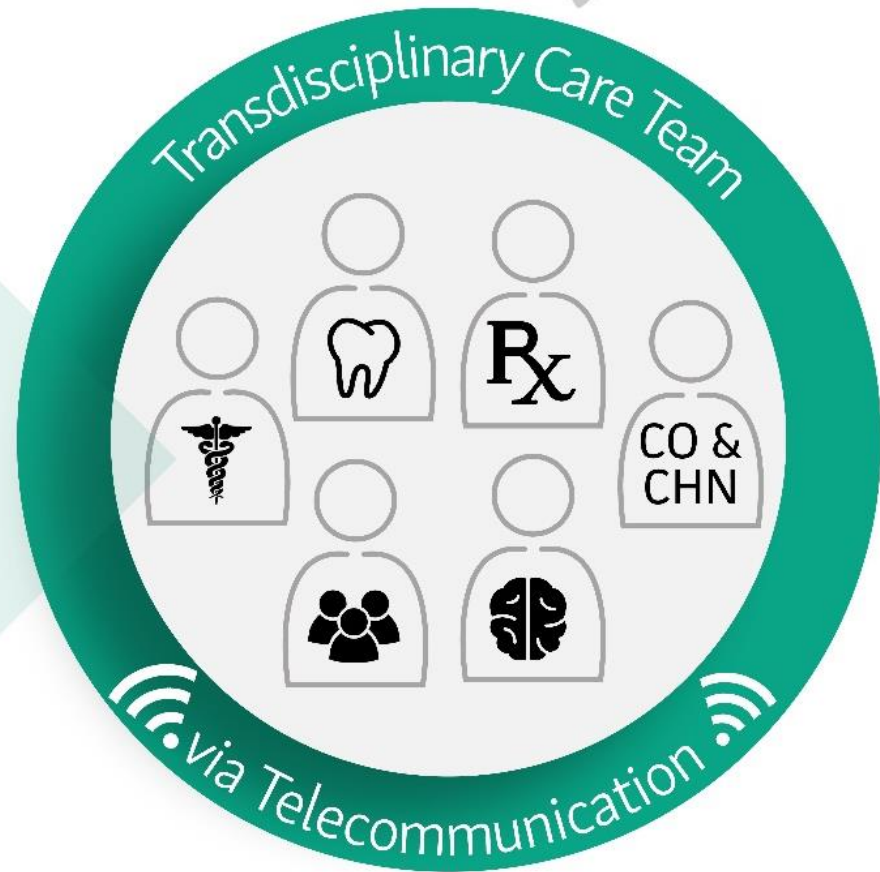
Crawford, G. B., & Price, S. D. (2003). *Team working: Palliative care as a model of interdisciplinary practice*. Medical Journal of Australia, 179(6 Suppl), S32-34.

Youngwerth, J., & Twaddle, M. (2011). Cultures of interdisciplinary teams: How to foster good dynamics. *Journal of Palliative Medicine*, 14(5), 650-654.



Transdisciplinary Care Team

- Geriatrician (MD)
- Pharmacist
- Dentist
- Mental Health Clinician
- Social Worker
- Nurse (Practitioner)
- Social Services
- Community Services
- Community Organizer
- CHN



Introducing:

Joe and Thelma Hedgepath



Learners read case summary

What determinants of health will impact Mr. and Mrs. Hedgepath's care?

Based upon the written summary, each team will explore different issues of Mr. and Mrs. Hedgepath's case.

- Identify Mr. and Mrs. Hedgepath's main issues as determinants in the area listed on your team's chart paper.
- List these on chart paper.
- Select a reporter to share your ideas with the full group.

Who should be on the **integrated community care team** for Mr. and Mrs. Hedgepath?



Mr. and Mrs. Hedgepath's In-Home Assessment by Community Team

The Elder Abuse Suspicion Index (EASI)

Questions 1 through 5 asked of the patient; question 6 answered by the physician.

Within the past 12 months:

1. Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	Yes	No	Did not get answer
2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids, or medical care, or from being with people you wanted to be with?	Yes	No	Did not get answer
3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	Yes	No	Did not get answer
4. Has anyone tried to force you to sign papers or to use your money against your will?	Yes	No	Did not get answer
5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	Yes	No	Did not get answer
6. Physician: Elder abuse may be associated with findings such as poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the past 12 months?	Yes	No	Not sure

NOTE: The EASI was developed to raise a physician's suspicion about elder abuse to a level at which it might be reasonable to propose a referral for further evaluation by social services, Adult Protective Services, or the equivalent. Although all six questions should be asked, a response of "yes" on one or more of questions 2 through 6 may establish concern. The EASI was validated for family physicians to administer to older persons with a Mini-Mental State Examination score of 24 or greater who are seen in ambulatory settings.

Figure 1. The Elder Abuse Suspicion Index (EASI).

Mr. and Mrs. Hedgepath's Flourish Case Conceptualization Meeting

Mr. and Mrs. Hedgepath's Care in the Community

*Flourish
Index Score*

BREAK

What's Next?



Preparing for the Family Meeting

- Community Health Navigator arranges meeting with Mrs. Hedgepath and her primary care provider to discuss her diagnosis and goals.
- Mrs. Hedgepath requests that her husband and children be present.
- Hospice and therapy have not yet been presented as an option for the Hedgepaths.

Team Assignment

- You will role play a family meeting.
- Your facilitator will assign you a role on this team.
- You will be given a description of that role and what that team or family member will contribute to the meeting.
- Based on your role, you will interact accordingly.
- Your meeting will last 15 minutes (unless you finish sooner).

The Flourish Program

1

CLINICAL &
BEHAVIORAL HEALTH
CARE PLAN

2

HEALTHCARE
NAVIGATION

3

COMMUNITY
CARE PLAN

Behavioral Health &
Primary Care Teams
for Mr. & Mrs.
Hedgepath

The Flourish
CHN & The
Hedgepaths

Community Care
Teams:
VA Home Team
Hospice
AAA

Mr. and Mrs. Hedgepath's Family Therapy Meeting with a Hospice Social Worker

- You will now debrief and evaluate how well this team did in assessing, planning and implementing care for this couple.
- How well did the team honor the patient and family members' values and perspectives?



Thank you

Before leaving complete the survey & consent

<https://medapp.louisville.edu/iCCOA/iccoa.cgi>