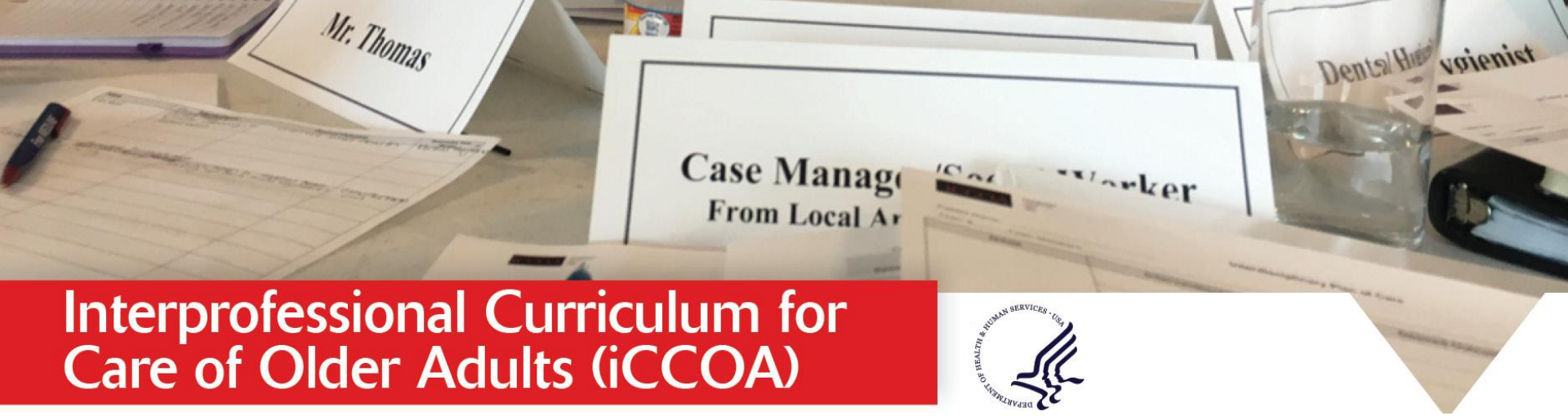

Interprofessional Curriculum for Care of Older Adults (iCCOA)

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.

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Interprofessional Curriculum for Care of Older Adults (iCCOA)

ICME

Interprofessional Case Management Experience

The Jim Thomas 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.

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A Collaboration of Many

KIPDA
Kentuckiana Regional Planning and Development Agency

BARREN RIVER
BRADD
AREA DEVELOPMENT DISTRICT

KCHC
Kentucky Coalition for Healthy Communities

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

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 Jim Thomas.**
  - **Observe videotaped interactions between members of Mr. Thomas' healthcare team**
  - **Critique and discuss these interactions.**
  - **Participate in a family meeting.**
  - **Please turn off computers and phones**
  - **Have FUN!!**

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

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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

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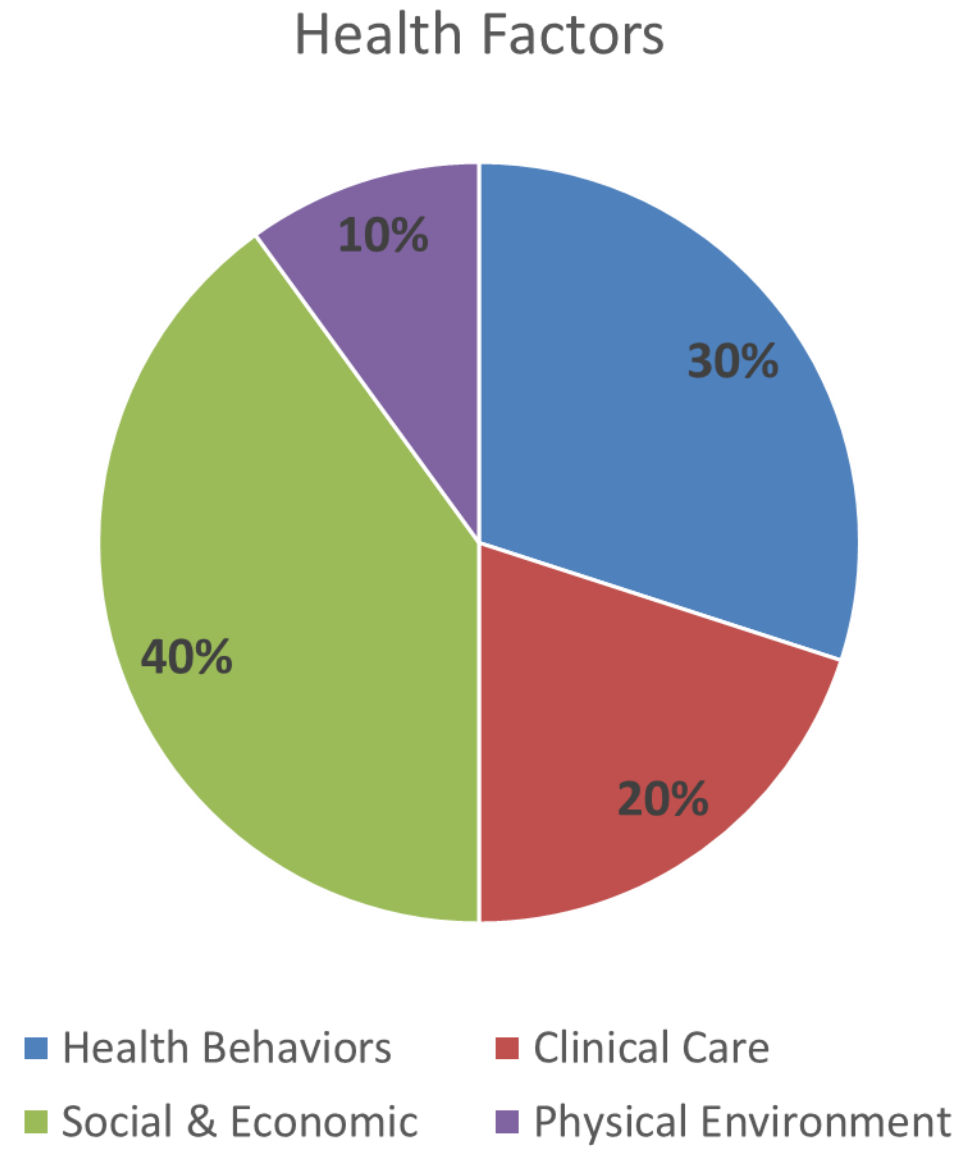
World Health Organization Definitions of Health

- 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

Health Outcome Determinates



(2014) University of Wisconsin Population Health Institute

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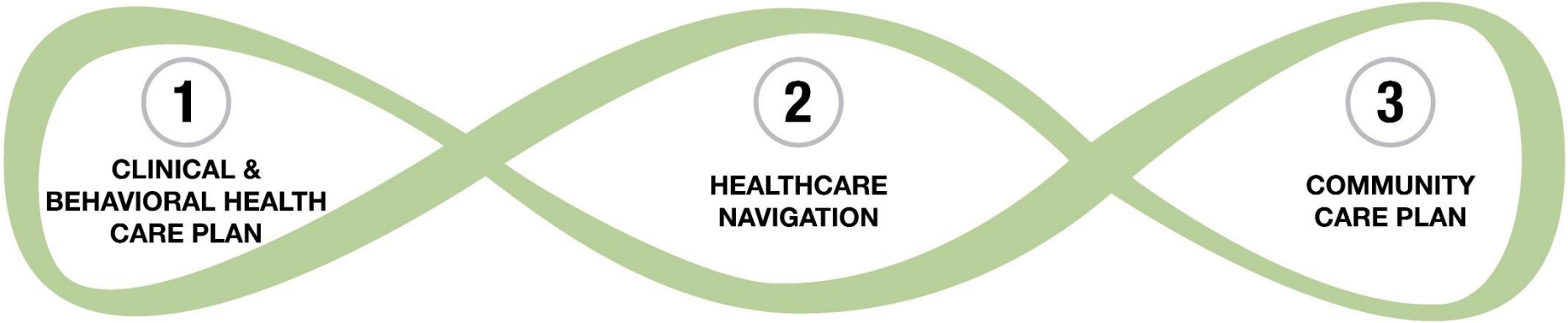
What does that mean for older adults?

- 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

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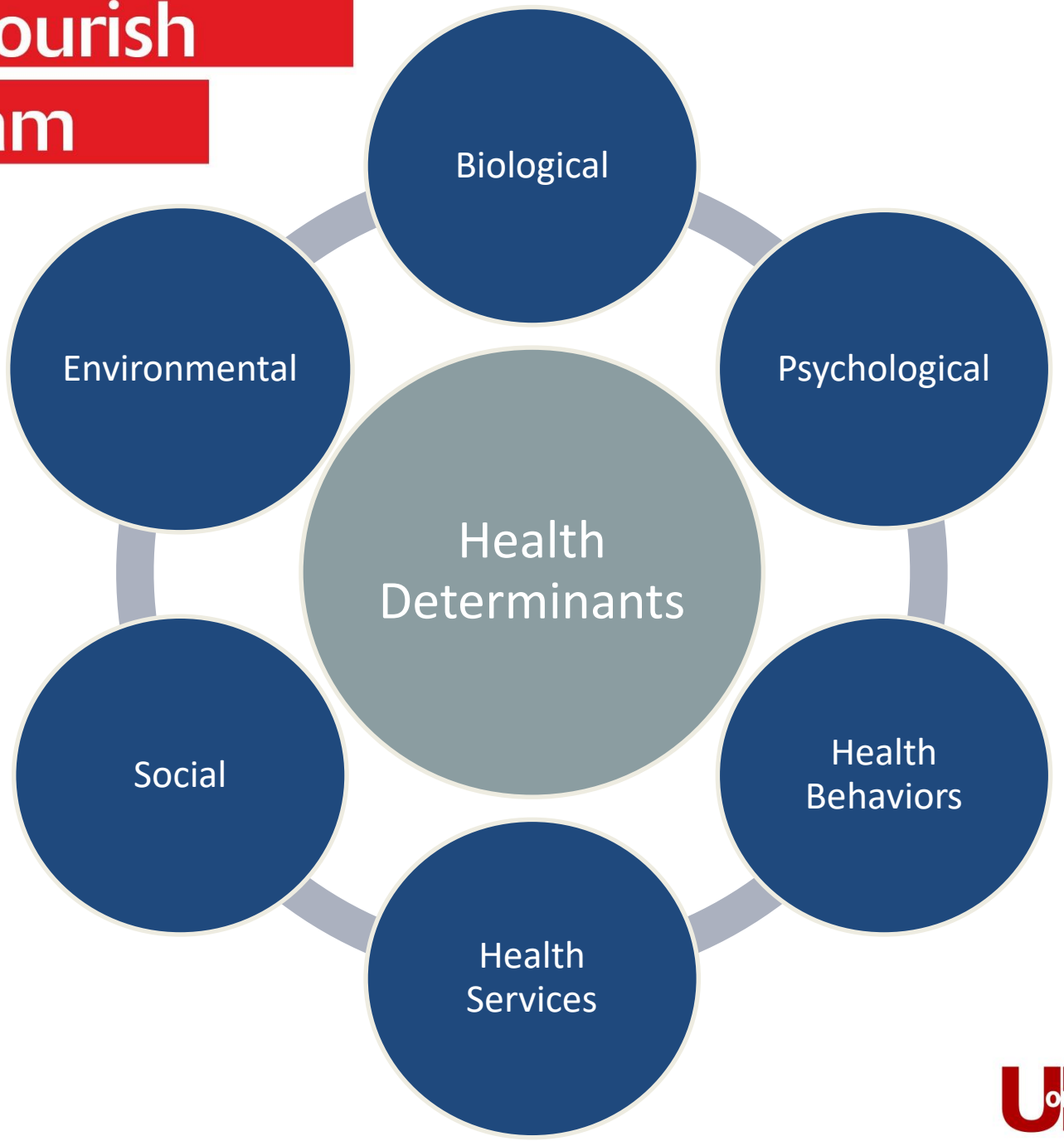
The Flourish Program



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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.

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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.

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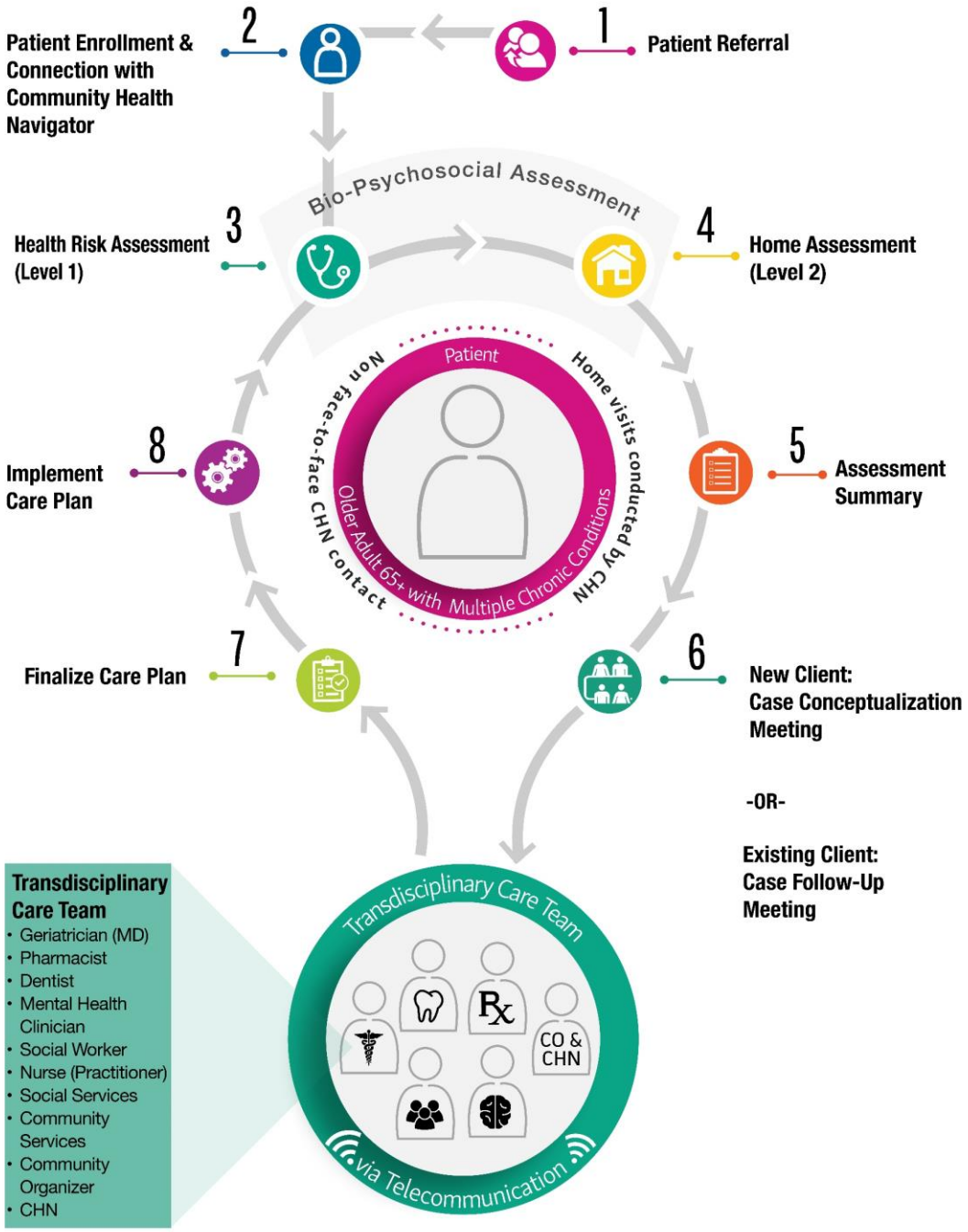

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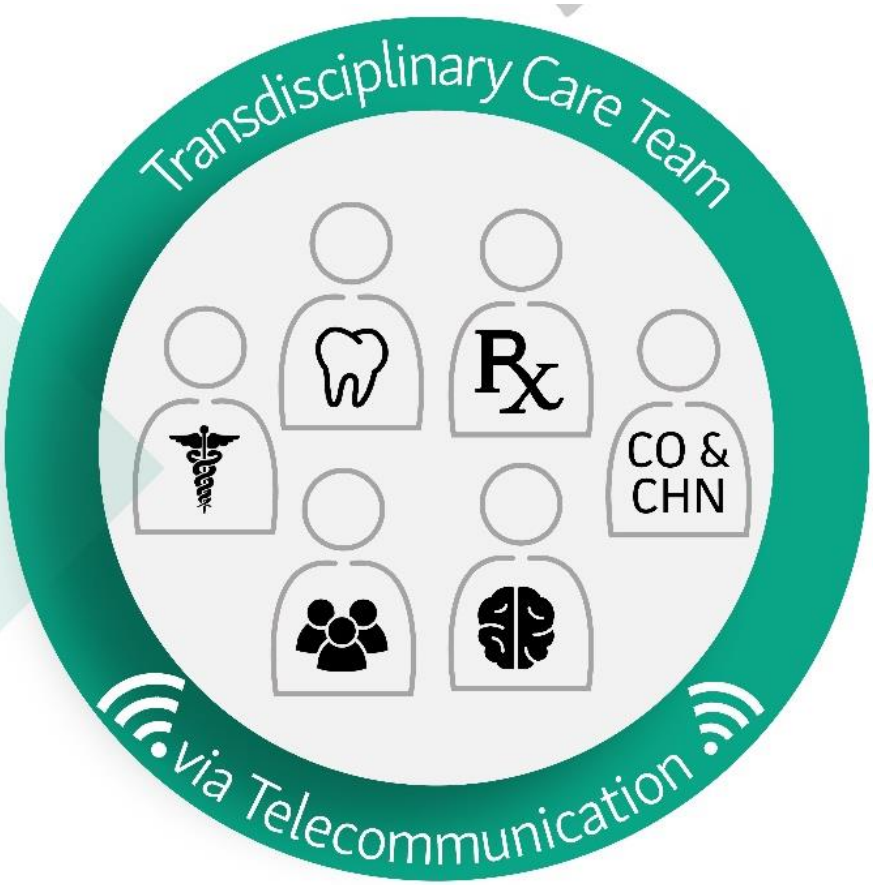
Transdisciplinary Care Team

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



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Introducing:

Jim Thomas

Learners read case summary

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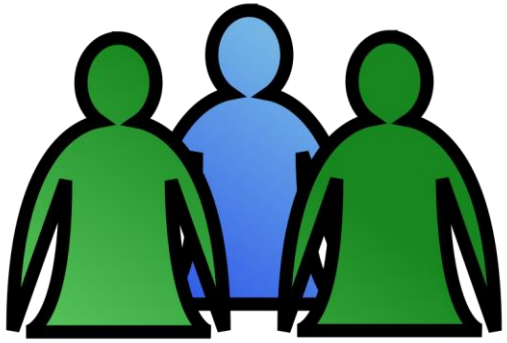
What social determinants of health will impact Mr. Thomas's care?

Based upon the written summary, each team will explore different issues of Mr. Thomas' case.

- Identify Mr. Thomas' 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. Thomas?



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

Mr. Thomas' Care in the Community-Video

There are 4 scenes:

- First visit with Primary Care Provider
- Dental visit
- Health Navigator discussion with NP
- Follow-up with NP

Learners should especially observe their assigned role.

Discuss in Your Teams

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

BREAK

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

Team Assignment

- You will role play a care planning meeting between Mr. Thomas and his healthcare team.
- 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 with the other members of the team, Mr. Thomas and his granddaughter to develop a plan of care.
- Your meeting will last 20 minutes (unless you finish sooner

Your Next Assignment

- Based on what you now know as a result of the care planning meeting, you are to develop a written interprofessional plan for care for Mr. Thomas.

- Each team will select a scribe to complete the form and develop one plan of care.

- Your facilitator will observe your work and provide feedback when you have completed the assignment.

- 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)
- Thank the learners for their participation.

LEARNERS:

Before leaving complete the survey & consent

- https://medapp.louisville.edu:8081/

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