

Module # 22: Interdisciplinary Care  
Planning: Leading to Healthy  
Transitions

# **Geriatrics, Palliative Care and Interprofessional Teamwork Curriculum**

## **Module # 22: Interdisciplinary Care Planning: Leading to Healthy Transitions**

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**Module # 22: Interdisciplinary Care Planning:  
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## Geriatrics, Palliative Care & Interprofessional Teamwork Curriculum

### Module #22: Interdisciplinary Care Planning: Leading to Healthy Transitions

#### I. Overview

The interdisciplinary care plan is based on data gathered during patient assessment, identifies the patient's care needs, and develops strategies to meet those needs. The purpose of the Care Plan is to transition the patient through the continuum of care in a seamless, safe and effective way. In order to accomplish this goal, the plan of care documents treatment goals and objectives; states criteria for terminating specific interventions, and documents the patient's progress in meeting the goals and objectives. An interdisciplinary care plan requires that each discipline must collaborate in the assessment and reassessment of the patient, and then strive to integrate interdisciplinary documentation of needs, goals, strategies and interventions.

#### II. Learning Objectives

1. Describe the conceptual framework in which an interdisciplinary care plan is developed.
2. Identify care plan intervention strategies.
3. Explain the differences between interdisciplinary and multidisciplinary perspectives.
4. Discuss the care coordination process.
5. Develop a professionally sound care plan.

#### III. Definition

- A. The process of developing an agreement between client and case manager regarding client problems identified, outcomes to be achieved, and services to be pursued in support of goal achievement.”<sup>1</sup>
- B. A dynamic decision making process based on assessment.<sup>2</sup> The effectiveness and appropriateness of the care plan depends on the assessment process

#### IV. Conceptual Framework

- A. Care plans are patient centered and individualized.

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1. When developing a care plan for an older adult, the interdisciplinary team must take into consideration not only the bio-psycho-social aspects of the case, but also the patient and caregiver's desires.
  2. Especially with larger interdisciplinary teams, the size of the geriatrics team may make it increasingly difficult for patients and families to have their voices heard. The patient/client and his/her family should always be considered as integral members of the team. Patients must be asked what involvement they desire.
    - a. In one study, 40% of nursing home residents reported not being involved in their health care decisions. However, 79.3% of those patients reported that the level of their participation was sufficient.<sup>3</sup>
  3. Needs that threaten life, safety and security must be a priority. Core needs, those which if not dealt with will cause other problems, must be handled first. (i.e. hip pain vs. mobility issue)
- B. Perception of need
1. By patient
  2. By family
  3. By provider
- C. Problem assessment
1. What are this patient's/ family's needs, expectations, strengths and history
  2. What was tried before?
  3. What worked? What did not work?
  4. What are current relationships?
  5. Who is the leader – voluntary vs. involuntary?
- D. Achievable outcomes must be created
1. Accessible
  2. Acceptable
  3. Adaptable
  4. Appropriate
  5. Affordable
- E. Strength Based Care Plan<sup>4</sup>
1. State in positive terms
  2. Make it realistic and achievable
  3. Measurable and visible

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4. Specific and time limited
5. Relevant and understandable

## V. Intervention Strategy

### A. Engagement

1. Engage the client, not the diagnosis
2. Go slow
3. Don't make promises
4. Respect their right to disagree
5. Determine who the "other" significant players are and
6. Engage them as soon as possible

### B. Implementation

1. Prioritize
2. Start slow – Go slow
3. Choose your battles wisely
4. Healthy Alliances
5. Pick a "bad" guy
6. Get it right the first time!

### C. Specific strategies for assistance

1. Educating patient/ family on available resources
2. Fostering clearer communication among patient and family
3. Acceptance, reassurance
4. Keep all family members in the loop via designated point person

### D. Follow-up

1. Monitoring
2. Reassessment
3. Termination

## VI. Interdisciplinary Care Planning

A. Team members understand the roles and contributions of each discipline on the team and includes methods for communication, collaborative care planning and shared responsibility for patient outcomes.<sup>5</sup>

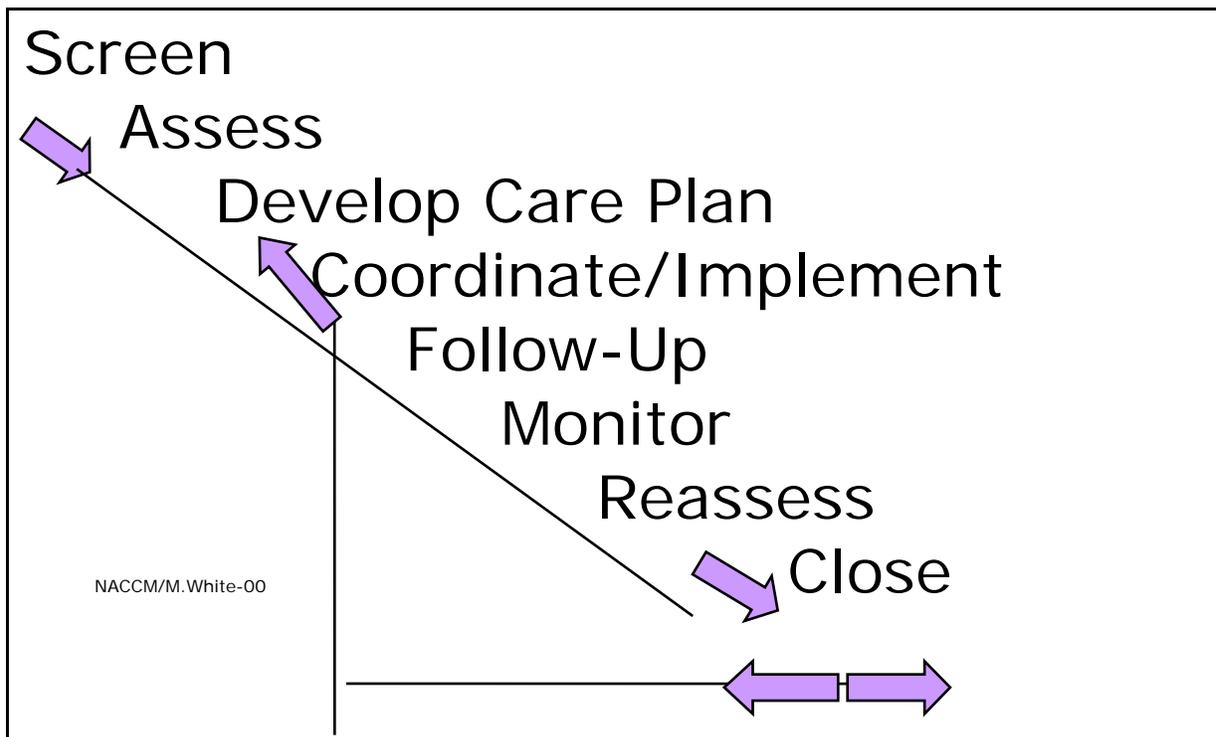
B. Team members integrate their assessments and recommendations for intervention, which creates a comprehensive care plan. (Multidisciplinary team members function independently with limited integration and collaboration.)

C. See Learning Resource:

“Interdisciplinary Practice and the Geriatric Care Manager,” by F. Ellen Netting, PhD.

## VII. Care Coordination Process

### A. Care Coordination Task Flow:



**B. Care planning is an important part of Care Coordination.** The following list describes the Sequential Tasks of Care Coordination of which care planning is an integral part.

1. *Case finding or screening* to identify people in the target population who may require services
2. *Comprehensive, multidimensional assessment* to determine any individualized unmet needs
- 3.. *Care planning*, which requires decisions about how the needs identified in the assessment can be met
- 4.. *Implementation of the plan*

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- 5.. *Follow Up* to determine progress of implementation
6. *Monitoring* both the progress of the patient and the adequacy of the services given under the plan
- 7 *Formal reassessment* at intervals to gauge continuing need
- 8.. *Care Plan re-development or Close* depending on reassessment findings

**C. See Learning Resource:**

**“Care Planning: The core of case management” by Barbara Schneider <sup>6</sup>**

**VIII. A Model Care Plan**

A. Model Interdisciplinary Care Plan and Its Development

The following case study provides a comprehensive assessment model. Developed by the University of South Florida GITT Program as a simulation with actors, it contains a patient script, caregiver script and physician script. The case also describes a care plan that looks at the needs of the patient, the necessary interventions as well as which discipline should address each problem. The purpose of this model is to illustrate the steps in geriatric assessment and treatment plan development.

B. Patient Script

Identifying Information:

I am an 81-year old, white widowed man, born on 6/15/1917. I have completed 7<sup>th</sup> grade education. I have lived in the area of 10 years. My sister June, who is 75 years old, brought me to the office. June has moved in with me 3 years ago to help with the management of my diabetes and also because I was starting to have problems with my memory. This is my fourth visit.

Chief Complaint or Concern:

I frequently fall and I loose my urine. June, my sister, wants me to have a prescription to control, my urine to make me sleep better at night.

Present Illness:

Within the past week, I have fallen twice while en route to the bathroom. For the past few months there, I have had urinary accidents once or twice weekly when I was unable to get to the bathroom on time. I understand and acknowledge the problem with my memory deficits and the poor control of my diabetes, but feel that there is nothing I can do. It is my sister’s role to help me with those problems.

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Medical History:

Medical conditions:

- Hypertension
- Edema of the lower extremities
- Diabetes
- Degenerative joint disease, commonly known as arthritis
- Decreased visual acuity secondary to cataract in my right eye
- Two transient ischemic attacks (TIA) in the distant past

Medications:

- Tylenol prn (as needed ) for pain caused by arthritis
- Lente insulin U-100, 30 U in am and 10 U in pm for diabetes
- Verapamil SR 240 mg daily for high blood pressure
- Temazepam 15 mg at bedtime to help me sleep
- Furosemide 40 mg daily prn (as needed) for the swelling in my legs
- Benadryl 25 mg prn (as needed) for anxiety

Past Psychiatric History:

I became depressed when my spouse died and was treated with medication for a few months.

Social Resources:

I have three children, Jan, April and Joe. They all live in other states and have children and grandchildren. They cannot give me any support with care giving. June and I live on our social security. The home belongs to me and I have a small retirement pension left by my spouse. During the day I look at the TV, read the paper, and watch the birds and the squirrels in the backyard. My friends have stopped visiting since my sister moved in .I wish my longtime friend Mary would come by and visit me. June complains that I am very demanding, that I don't sleep at night, and that I need constant attention. This, June says, leaves her with no free time.

Physician Examination:

Weight: 130 lbs., a loss of 30 lbs. over 7 months. B/P: 120/78

The patient appears disheveled and weak. The patient smells of urine and his clothes are soiled. This is a marked change from a usually neat demeanor. He needs assistance with transfers and with undressing. The patient reports being left alone for long periods of time. The patient reveals being put to bed before his sister goes out for the evening and restrained to prevent him from getting out of bed. The patient eats twice a day and frequently receives the insulin dose late at night.

- A cataract is visualized in the right eye. Visual acuity is minimal in right eye but there is no loss of visual acuity in the left eye.
- Mucous membranes appear dry, tongue is red and smooth.
- Pitting edema of ankles 1+ (minimal)

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- Knee joints are large, non-tender but with crepitation
- Patient is unsteady steady while standing
- Skin shows no bruising, except for purpuric lesions on the extensor surface of the hands.
- Skin turgor is poor.
- No other abnormalities are found.

Lab results: Hgb 9.9, Hct 27%, MCV 72, BS 84, albumin 2.8, cholesterol 160

Diagnoses: After review of systems and physical exam, the doctor/nurse practitioner list the following diagnoses:

- |                                  |                               |
|----------------------------------|-------------------------------|
| -Rule out neglect                | -Fall risk                    |
| -Diabetes poorly controlled      | -Dehydration                  |
| -Malnutrition                    | -Urinary incontinence         |
| -Rule out dementia               | -Cataract right eye           |
| -DJD                             | -Hypertension well controlled |
| -Mild edema of lower extremities |                               |

Mental status:

The patient's voice is a monotone. His facial expression is sad and he appears depressed. He expresses the feeling that he cannot do anything that is valuable anymore. He is tearful when talking about being left alone. He expresses fear of intruders especially when his sister is not home. He reports being afraid of placement in a nursing home. He is unhappy and hopeless about the future. He reports not sleeping until his sister comes back home at night. He states, "I had a good life and am ready to go join my deceased spouse."

His Mini Mental State Exam score is 20/30. He is disoriented to month, date and day. He does not know the name of the office although was able to recall it's name during previous visits.

When he is asked to begin at 100 and count backward by 7, he makes two mistakes. When he is asked to remember three items, he can only remember one. When asked to copy a design, he cannot do it correctly. He can read a sentence after squinting his eyes and makes two attempts.

Functional Assessment:

He requires some assistance with bathing and dressing because of his arthritis and unsteadiness. On the days when his arthritis is worse, he needs help with transfers from his chair to the bed, with going to the bathroom, and with walking around the house. He can walk with a cane and he is sometimes unsteady because of the arthritis in his knees.

His sister cooks lunch sometimes and prepares all the dinners. He states that he can prepare breakfast, and that he eats leftovers or frozen dinner when his sister does not prepare lunch.

He cannot prepare his insulin injection because he can't see the small numbers on the syringe. He doesn't like to give it to himself, and states, "that's what my sister is there for."

### C. Caregiver Script

#### Social Resources:

My brother has three children, Jan, April and Joe who live out of state and cannot give any support with care giving. My brother and I live on our social security. The house belongs to my brother. My brother has a small retirement pension left by his deceased spouse. I am not sure what my brother does during the day; I am busy with my work and with continuously answering the same questions. We have a TV that is on all the time. Some friends used to come by and visit, but they don't anymore. Who would want to visit when they hear the same questions and the same stories all the time?

There is always something my brother wants me to do. I never do enough. I cannot even have rest during the night, and I have no free time anymore.

#### Physical Health:

There is always something wrong. You have to do this, you have to do that. Take the blood pressure, check the sugar, give the injection. I don't know why he has to take an injection since they have pills now for diabetes. I know because my friend takes pills.

My brother is always tired and cannot see well. He needs to go to the bathroom all the time and cannot even make it to the bathroom. He does not complain of pain.

#### Mental Status:

My brother keeps repeating that he is ready to die and join his deceased spouse. He never knows what date it is and asks me every 5 minutes. He never knows what's going on.

#### Functional Assessment:

I have to help him with bathing and dressing because he is unsteady on his feet. Sometimes I have to help with transfers from the bed to the chair and from one room to another.

I have to help with getting him to the bathroom. I don't know why I have to do that, the cane is there to use. Also, I have to do all the cooking and cleaning.

### D. Interdisciplinary Care Plan

**Main Problem:** Impaired coping by caregiver with suspected neglect and safety issues.

**Main Goal:** Caregiver: mobilize support and decrease stress

**Patient:** Improve mood and health care management

**Team:** Restore a safe patient environment

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Date	Problems/Needs	Goals	Interventions	Discipline	Evaluation Date
6/21	Impaired coping by caregiver with suspected neglect as evidenced by malnutrition, dehydration, and use of restraining device.	<ol style="list-style-type: none"> <li>Caregiver will verbalize understanding of diabetes management and the relationship between insulin, diet, medication, and blood sugar</li> <li>Caregiver will verbalize decreased stress</li> <li>No evidence of patient's emotional and physical neglect</li> </ol>	<ol style="list-style-type: none"> <li>Provide caregiver with education in diabetes management; assess ability to administer insulin, observe her draw up and administer; assess ability to do home blood sugar monitoring. If unable, refer to home health for daily injections. Give instructions about diet and exercise.</li> <li>Refer caregiver to support group.</li> <li>Refer to protective service (P.S.) to help mobilize support such as respite care, adult day care, home health services and to follow-up on suspected neglect.</li> <li>Counseling to validate feelings and discuss concerns</li> </ol>	<ol style="list-style-type: none"> <li>MD/NP: order RN or HHA</li> <li>SW</li> <li>MD/NP, SW, RN</li> <li>PSY, SW</li> </ol>	<p>6/28</p> <p>6/28 6/21</p> <p>6/28</p>
6/21	At risk for fall secondary to poor vision, DJD, incontinence, and self-care deficits	<ol style="list-style-type: none"> <li>Potential home safety problems will be resolved</li> <li>Patient will use assistive devices</li> <li>Patient will follow an exercise regimen</li> <li>Occurrences of falls will be decreased</li> <li>Patient will show improvement in self-care ability</li> </ol>	<ol style="list-style-type: none"> <li>Home evaluation for potential safety problems</li> <li>Ophthalmologist consult for cataract evaluation</li> <li>Referral to OT/PT for evaluation and treatment of arthritis pain and limitations, gait training, exercise program, assistive devices (wheelchair, bedside commode, urinal, bathtub railings, handles, etc.)</li> <li>Refer to HHA for bathing assistance three times per week</li> </ol>	<ol style="list-style-type: none"> <li>MD/NP: order, SW, RN</li> <li>MD/NP</li> <li>MD/NP : order, OT, PT</li> <li>MD/NP : order, SW</li> </ol>	<p>6/28</p> <p>7/21</p> <p>6/21</p> <p>6/28</p>
6/21	Knowledge deficit in diabetes management leading to poor blood sugar control, memory impairment, and	<ol style="list-style-type: none"> <li>Diabetes control will be maintained average (160-200 BS and 8.0 to 9.0 HgbAc1)</li> <li>Dehydration</li> </ol>	<ol style="list-style-type: none"> <li>Visiting nurse daily for education on insulin, diet exercise</li> <li>Refer to dietitian for evaluation of food intake and to prepare dietary plan</li> <li>Obtain support for Meal-On-Wheels</li> </ol>	<ol style="list-style-type: none"> <li>MD/NP: order, HHA,</li> <li>MD/NP: order, SW,</li> </ol>	<p>6/28</p> <p>6/28</p> <p>6/28</p>

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	incontinence,, dehydration and malnutrition	symptoms will resolve 3. Malnutrition symptoms will be reduced (goal: albumin 3. , low normal Hgb and Hct) 4. Weight will stabilize 5. Patient will verbalize relationship between insulin, diet, exercise, and BS results	4. Refer insulin administration to home health if caregiver unable to do 5. Monitor weight weekly 6. Have patient and/or caregiver record fluid and food intake for period of 3 days and blood sugar for one week 7. Review one week of above monitoring and re-evaluate insulin and diuretic requirements 8. Re-evaluate HgbA1c, albumin, Hgb, Hct	RD  3. SW  4. MD/NP: order, RN  5. HHA 6. RN, SW, RD  7. MD/NP  8.MD/NP : order lab and review results	pending  7/1 6/22  6/30  6/30
6/21	Patient exhibits memory impairment secondary to pseudo- dementia; this is aggravated by poor diabetic control	1. Geriatric depression scale will show improvement in depressive status 2. Social interactions will be increased 3. Patient will verbalize less fearful ideas 4. Suicidal ideations will not materialize 5. Instances of insomnia will decrease	1. Daily counseling 2. Volunteer visitor twice weekly 3. Plan enjoyable actives twice weekly 4. Encourage former friends to visit 5. Encourage children’s telephone contacts 6. ST referral to teach cognitive skills 7. Initiate antidepressants if above does not improve depressive status or if suicidal ideations occur 8. Taper off Temazepam and start on melatonin or Ambien if medication still needed for sleep	1. NP, PSY, SW 2. SW 3. SW  4.SW  5.SW  6. MD/NP, PSY 7. MD/NP, PSY  8. MD/PSY	6/28  7/1 7/1  7/1  7/21  7/21 pending  6/21
6/21	Probable financial issues	1. Available financial resources will be used where feasible	1. Assess financial needs 2. Explore sources of financial aid such as food share program, pharmacy medical program, drug company patient assistance program	1. SW 2. SW	7/26 8/2

SOURCE: Boucher, LA, Hyer, K, Paveza, G, West, L. “Simulated Patient Teaching Module” from University of South Florida Geriatric Interdisciplinary Team Training Program. Florida. 1999.

## IX. References

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- <sup>1</sup> MacBride SM et al, 1977. *A Service Management Manual Working Draft*. Philadelphia, Pennsylvania: Philadelphia Geriatric Center. Mimeo.
- <sup>2</sup> Kane, RL & Kane, RA (2000). *Assesing older persons: Measures, meaning, and practical applications*. Oxford University Press. New York.
- <sup>3</sup> Wetle,T., Levkoff,S., Cwikel, J., & Rosen,A. (1998). Nursing home resident participation in medical decisions: Perceptions and preferences. *Gerontologist*, 28(Suppl), 32-38.
- <sup>4</sup> Fast, B. & Chapin, R. (2000). *Strengths-based care management*. Baltimore, MD: Health Professions Press.
- <sup>5</sup> Petrie, H.G. (1976). Do you see what I see? The epistemology of interdisciplinary inquiry. *Journal of Aesthetic Education*, 10, 7-17.
- <sup>6</sup> Schneider, B. (1988). Care Planning: The Core of Case Management. *Generations*, Fall 1988, 16-18.

## X. Learning Resources

- Dellefield ME. Interdisciplinary Care Planning and the Written Care Plan in Nursing Homes: A Critical Review; *The Gerontologist* 2006; 46:128-133.
- Netting, F. E. (1998). Interdisciplinary Practice and the Geriatric Care Manager. *GCM Journal*, Winter 1998, 20-24.
- Schneider, B. (1988). Care Planning: The Core of Case Management. *Generations*, Fall 1988, 16-18.