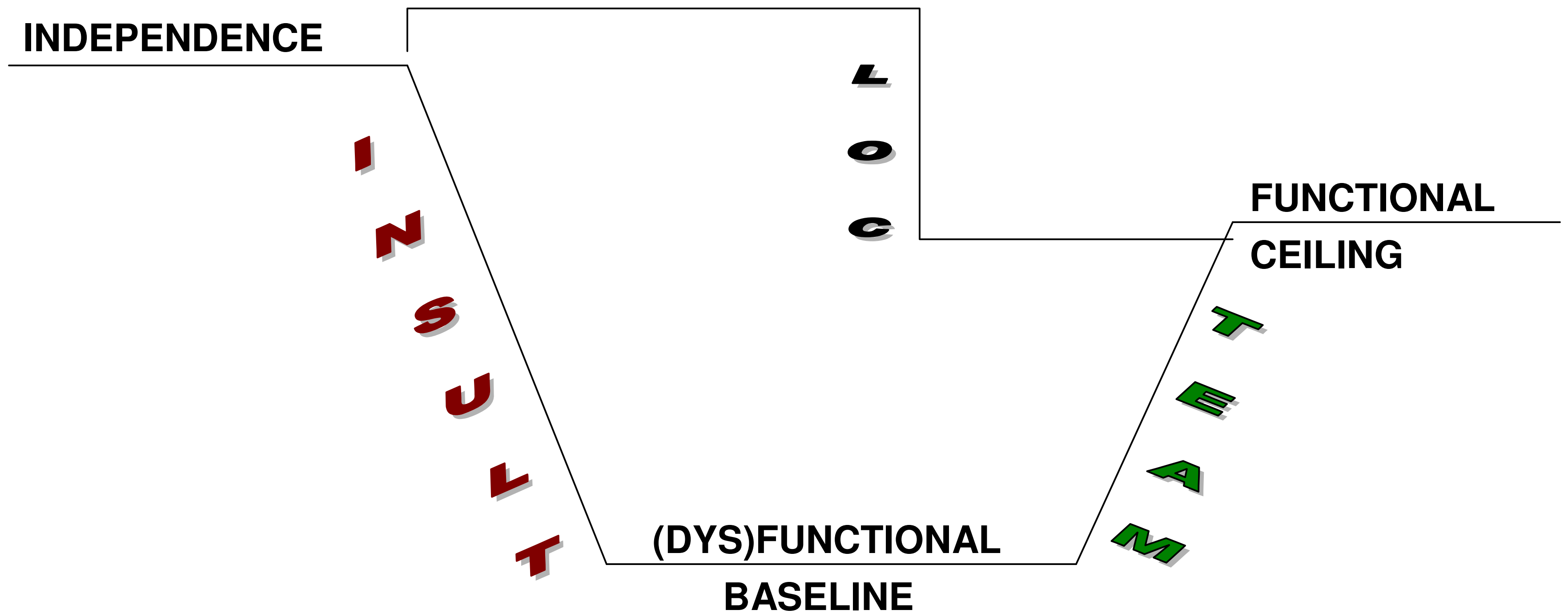
TEAM CARE TEACHING TOOL



Woodson, CE, “A Teaching Tool for Training Physicians in Coordination of Chronic Care”
Gerontology and Geriatrics Education, Vol 16(1), 29-37,1995

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SUMMARY AND EXPLANATION 2009 by the author.

Patients live at some level of **INDEPENDENCE** or BASELINE FUNCTION (which the healthcare team should try to understand . Often the information is not available).

An **INSULT** brings the patient into contact with health care professionals at a decreased level of function (**DYSFUNCTIONAL BASELINE)**. Physicians assess this baseline dysfunction and predict the **FUNCTIONAL CEILING** (how much can we expect the patient to recover based on the severity of illness, the natural history of the ailments and the effects of co-morbidity. The health care **TEAM** works to move patients toward the **FUNCTIONAL CEILING**. Team members can include family, community members, pharmacists, facility staff, primary care physicians, surgeons, subspecialists, nurses, therapists (mobility and behavioral health).

If there is a difference between the **FUNCTIONAL CEILING** and **INDEPENDENCE,** this difference is the **LEVEL OF CARE (LOC).**

FUNCTIONAL CEILING and **LEVEL OF CARE** are dynamic. If doctors assess that the condition they thought was dementia is actually delirium (reversible cognitive impairment caused by a remediable condition) , **FUNCTIONAL CEILING** goes up and **LOC** goes down. If doctors diagnose another stroke, heart attack or any other additional insult that worsens condition and prognosis, **FUNCTIONAL CEILING** goes down and **LOC** goes up. Collecting resources to support the patient's **LOC** may require the work of the initial **TEAM** members as well as, social service professionals, resources from community departments on aging, attorneys, financial consultants, realtors, adult protective services personnel, law enforcement officers and clergy.

This tool does not describe a patient's movement through any specific LOCUS of care (community→ hospital-→ rehab facility or SNF) although this is one possibility. The entire cycle could happen in the community, or in the nursing home. The tool is meant to follow the function of the patient regardless of the location in which the patient receives care.

This type of assessment and care planning leads to the LEVEL OF CARE Prescription (LOCRx) which patients and families SHOULD expect to get from eldercare professionals. My goal in presenting this tool is to help potential **TEAM** members and their trainees understand how important **TEAM** communication and function is to appropriate patient care planning and understand where each professional fits in to the process. Geriatrics is a team sport. We have to work together if we are to have any hope of protecting patients' function and quality of life. cw

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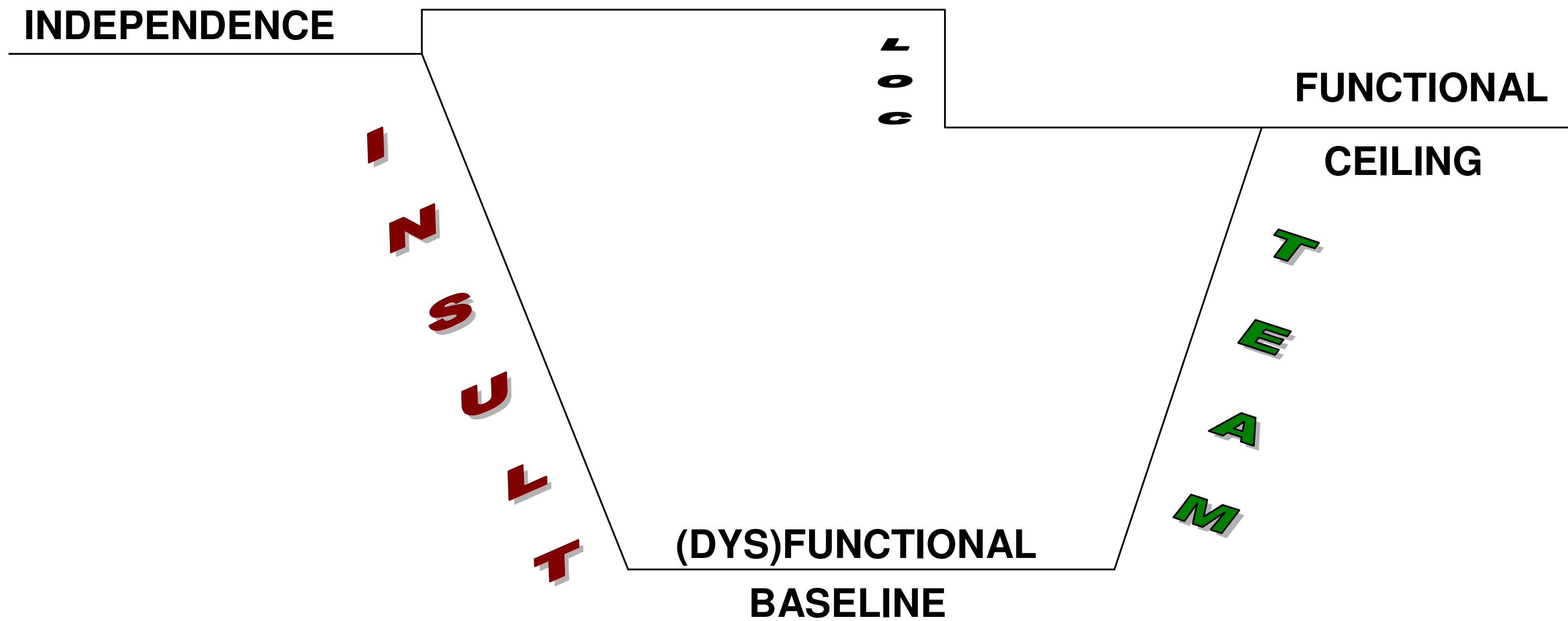

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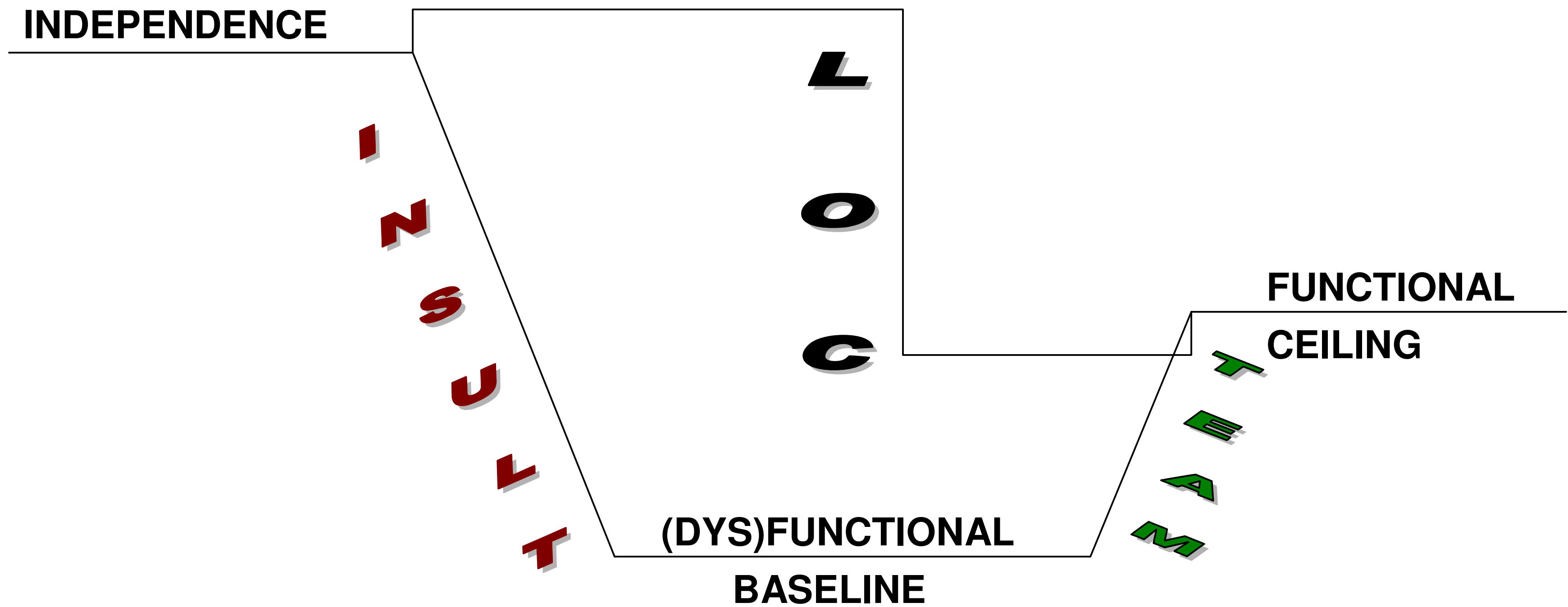

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