he number of elderly people will continue to rise significantly during the next 30 years, and it is anticipated that they will stay healthier and live longer. Maintaining independence and continuing to live at home are top priorities of older adults. With increasing numbers of older adults, our society must identify the most appropriate ways to use available resources to meet their health and social needs.

As people get older, they are more subject to chronic health problems, necessitating frequent use of both healthcare and social services. Access to these services in the community may be the referral, and gate keeping. Only minimal follow-up is available over a short period. The time-limited, problem-driven nature of the system is a particular limitation. A case manager arranges for services to alleviate a particular client problem; however, the totality of a client's needs and the ongoing nature of the needs often are beyond the scope of the system. Too often, fragmented care results. A further limitation is the single discipline approach, which restricts assessment, service arrangement, and follow-up. The case manager is usually a social worker or nurse. The more comprehensive perspective of a multidisciplinary team would be more effective for

Team-Managed Care
for Older Adults
A Clinical Demonstration
of a Community Model

By Claudia Leath, RN, MNSc, and Rozanne M. Thatcher, PhD, RN

key factor in determining whether a person can remain in the community. When older people use a number of services, they may need assistance not only in gaining access to them, but also in coordinating the services.

Assistance to older community residents in obtaining services is available in some areas through case management. Current case management systems are limited in that typical core services are problem-oriented assessment, resource

older clients who have multiple chronic needs.

Team-Managed Care
A team approach is particularly important for older clients because they have multiple problems with multiple causes. Problems and causes both cross traditional disciplinary lines. A team-managed care model that incorporates traditional case management and provides direct, comprehensive services in a coordinated, continuous manner was
developed by faculty members at the University of Arkansas for Medical Sciences College of Nursing to meet the health needs of older adults living in the community. This article describes that team-managed care model.

COMMUNITY MODEL

Individuals 65 years old and older usually experience such problems as medication compliance, psychosocial problems, and nutritional problems. They and their families face many decisions, with little or no knowledge of what to do. In the North Little Rock managed care approach, the team of health-care professionals is determined by the priority needs of the older adult. Consistently, those needs are for nursing, pharmacy, nutrition, social work, and medicine.

The major goals of the North Little Rock Community Seniors Health Services (NLRCSHS) project are to assist older adults to manage their own health care, maintain or improve their health, and continue living in their own homes. In this managed care model, the team obtains a comprehensive assessment of all health and social needs of the older adult, provides direct service delivery, focuses on health promotion and disease prevention, coordinates resource referrals, and monitors the client's health status as long as the client wishes.

Team Members

The multidisciplinary team consists of specialists in geriatrics and gerontology: a gerontological nurse practitioner, clinical pharmacist, clinical nutritionist, and social worker. The client's private physician is also considered a team member, but physicians often have limited time for team interaction; therefore, a geriatrician from the University Medical Center serves as a consultant with the team during client care planning. The clinical nurse specialist serves as team coordinator.

Project Clients

Project services are available to adults 65 years old and older who live in the community of North Little Rock. Although the target clients are relatively healthy community-living older adults, all older adults are eligible except those who are bedbound or on a waiting list for permanent nursing home placement. When clients enroll in the project, the team begins working with them wherever they are on the health continuum. Principles of self-care are used extensively as the team works with each client to develop an individualized care plan.

The multidisciplinary team sees clients either in their homes or in one of three clinics. All three clinic sites are at senior centers, which have noon meals and activity programs. One clinic is located in a community center that serves a primarily black, lower socioeconomic group of clients. Two clinics are in high-rise housing units for seniors: one serves a racially mixed clientele who fall within a lower to middle socioeconomic range; the other clinic serves primarily a white, middle socioeconomic clientele.

BECOMING A NLRCSHS CLIENT

Assessment

New clients to the NLRCSHS make an initial appointment for a 30-minute intake interview. The client is then scheduled for two appointments a week apart. These appointments, which last approximately 2½ hours each, can be done in the client’s home or in the clinic. A health assessment is conducted during these appointments, with each member of the team doing a discipline-specific part of it. For example, Mrs T will be assessed by the nurse and pharmacist during her first appointment, and by the social worker and nutritionist during her second appointment. The client’s private physician is contacted for additional medical and laboratory information needed to complete the database.

Care Planning

When the client’s assessment is complete, the team meets to develop the care plan. The consulting geriatrician provides medical input during the care planning. The team develops a problem list, prioritizes the problems, and decides on the appropriate interventions. Implementation of the plan is initiated by any of the team members, with the most urgent problems being dealt with first.

Mrs T’s priority problem was determined to be adherence to the medical regimen for her congestive heart failure. The outcome goal set during the care planning for Mrs T was the ability to perform self-care measures to maintain or improve her health status. For instance, the pharmacist would continue assessment of medication compliance and the need for medication education. The nutritionist would provide education related to a low sodium, high potassium or weight reduction diet, while the nurse may be engaged in monitoring blood pressure, dependent edema, and assessing lung sounds.

Once the plan has been initiated, the evaluation process begins. Clients’ progress toward their health goals is monitored on an ongoing basis, through follow-up visits and reassessments done yearly and as needed.

SERVICES

The NLRCSHS project operates from a health service delivery model designed to provide comprehensive, coordinated, and continuous services. With the focus on promoting and maintaining health, preventing disease, and regaining functional abilities, a full range of services is provided. The team-managed care model used by the project expands on the traditional case management model. The NLRCSHS team approach includes all health-related services that a client may require—medical, social, or other. Appropriate use of services is the goal; therefore, the team provides services that are not accessible or available elsewhere and makes referrals to community agencies for other services that clients may need. This may occur when a client exhibits a need for assistance in maintaining nutritional health. Based on the client’s assessment data, the team develops a plan to help the client improve her diet. The nutritionist would work with the client to support her abilities in meal planning, finding healthy recipes, and shopping. A referral to Meals-On-Wheels would be made to supplement the client’s diet until she is fully able to be independent in this area.

Team members maintain close communication with other agencies or individuals from which a client may obtain health-related services. For example, the social worker frequently assists clients to coordinate transportation or financial assistance services. The nurse and pharmacist often consult with the physician about a client’s treatment or medication regimen, and the nutrition-
A TYPICAL NLRCSHS CLIENT

Lila is fairly typical of people who benefit from this team-managed care mode. She is a 79-year-old black woman who enrolled in the NLRCSHS project by self-referral; she lives in her own home in North Little Rock. Lila had not received any type of health care for several years and did not have a medical doctor at the time that the team first saw her. She is approximately 5 ft 3 in tall and weighed about 213 lbs. Her major complaint when she entered the program was a stasis ulcer on her right leg about 4

\[ \times 3.5 \text{ in. diameter.} \]

Her blood pressure was significantly elevated at the first visit. Each team member completed Lila’s assessment over a 2-week period, which is the normal process. However, because of the problems with which she presented at her first appointment, an immediate referral was made to a geriatrician. The team promotes self-care behaviors, and all clients are encouraged to be responsible for their own health care. Therefore, with coaching from the team, Lila herself arranged the appointment with the physician and made her own transportation plans.

After Lila’s health assessment was completed, a comprehensive plan of care was developed and, through close coordination with the geriatrician, each team member initiated interventions. The nutritionist provided diet counseling and a 1,200 calorie diet for weight reduction. The nurse monitored Lila’s blood pressure weekly, assessed and dressed the stasis ulcer, and monitored her peripheral vascular circulation. The social worker educated Lila about assistance available to help her pay her overdue gas bill and information about Medicare assignment. New medications were prescribed for Lila; therefore, the clinical pharmacist provided specific education about those medications and the most effective method of taking them. Following a home visit, the team identified other needs. They helped Lila obtain medical aids, such as a raised toilet seat and bath bench, so that she could manage more efficiently at home.

Although Lila is typical of NLRCSHS clients, each person presents an individual combination of chronic care needs. Therefore, within the framework of self-care, the team provides care designed to match each individual’s specific health needs.

COMPUTERIZED DATABASE

An extensive database is generated on each client, continuing information on the discipline-specific assessments that are done. It is used by the entire team to determine clients’ problem lists, formulate care plans, and monitor clients’ progress toward their health goals. To assist them during the care planning, the team uses a computerized long-term care case management sys-

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Team-Managed Care

KEY POINTS


1. The multidisciplinary managed care approach is essential for older clients to meet the multiplicity of problems they experience.

2. Goals of the North Little Rock Community Seniors Health Services are to assist older adults to maintain or improve their health and remain living at home as long as possible.

3. The team-managed care focuses on health promotion/disease prevention, monitoring chronic health problems, and team-managed care.

4. Discipline specific assessments, care planning, and follow-up are generated on a computerized, long-term care case management system, COMPASS.

The multidisciplinary team of the NLRCSHS project has provided care to clients for nearly 2 years. As of January 1991, we have approximately 300 clients. Most are very active; for example, they schedule frequent follow-up visits to monitor their blood pressure, weight, or medication response. New clients continue to be enrolled weekly, as we have yet to achieve the potential total case-load.

Status of the Project

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Future of the Project

The true test of the NLRCSHS will be positive client outcomes. Indicators of positive outcomes for our clients include decreased or improved functional limitations, reduced health risk age, increased self-care abilities, appropriate mobilization of community resources, and client satisfaction.

Positive outcomes are evidenced in a number of ways. For instance, after analyzing regularly monitored clients, it was discovered that 35 clients had lost a total of 269 lbs, an average of 7.69 lbs per person. Of all active clients whose blood pressure is regularly monitored, 41 clients showed a substantially lower blood pressure, the most dramatic being 66 systolic and 42 diastolic points. Approximately 15% of the clients were found to be eligible for the Qualified Medicare Beneficiary. All of those eligible were assisted to enroll in the program. We are encouraged by these preliminary results.

Many health and social services programs currently available for older adults have been developed based on cross-sectional data. The NLRCSHS system of care requires data that can be evaluated by means other than comparison to "similar" projects. The NLRCSHS project is a unique model in that it provides multidisciplinary, community-based, long-term care. A longitudinal database showing changes in client outcomes over time is being developed. Longitudinal databases such as the one in this project will provide much needed information about how older adults respond to a system of team-managed care in the community.

REFERENCES


About the Authors

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