Interprofessional Care Planning[1]

Teams are generally organized to achieve specific programmatic goals. Primary health care teams may work with patients/clients, families, communities, stakeholders and others to achieve patient and/or population health goals. In order for an interprofessional primary health care team to function effectively, the team's purpose and goals should be clearly understood and agreed upon by all members. These goals – whether short or long-term – also need to be feasible, because the interprofessional team may function in a variety of settings and the team membership, types and intensity of services provided, and overall goals may vary.

Once the team has identified programmatic goals, team members will need to identify what this may mean in reality. For example, if "improve patient outcome" is a goal used by a team, successful outcomes will need to be defined case by case. If health promotion or disease prevention activities are a goal for the team, then the team will need to identify the health needs of the specific population they wish to address, the interventions to address these needs, and the strategies for evaluating the effectiveness of the intervention and impact on health needs. The process of interprofessional team care planning is the means of achieving consensus on desired patient and/or population health outcomes.

An interprofessional team developing care plans for patients/clients must be able to approach care in a holistic manner, considering the needs of the patient/client in a broad manner, and considering how different, yet pertinent information fits together.

The ability of each discipline to contribute to the care plan will depend on each team member's understanding of the connections between problems. The team may agree that "optimal health" is the goal for the patient/client. However, the means for achieving or arriving at the goal may differ between professions. These differences are in part a result of each discipline's background training, expertise and approaches to problem-solving and patient care. These differences are a significant element of interprofessional collaboration as different perspectives enable team members to view and approach problems in new ways. Different perspectives must be embraced by the team and integrated as part of the interprofessional approach to patient/client care. Team members need to respect the different kinds of expertise each profession brings to the group.

An interprofessional care plan, whether it is developed for an individual patient/client or a community, will not work unless the team has a system for recording and monitoring who will be responsible for what and by when. This record-keeping should be completed before the end of the meeting and available to all team members to remind them of their responsibilities. In addition, the team must have in place a system (formal and informal) for communicating on the steps of the plan between team meetings. This type of communication is often informal with different professions talking with each other as needed.

Steps in Assessing Patients Needs[2]

Handling a complex case requires team members to consider the patient/client's medical, emotional, social, environmental, and economic needs. Using the grid and the questions provided below, team members can consider the holistic (biopsychosocial) needs of the patient and their situation. In developing an interprofessional care plan, the team needs to identify the

expected activities and the responsibility of each team member (e.g. initiation, follow-up, and reporting results).

Considering the patient/client's medical, emotional, social, environmental and economic needs, answer each of the following questions:

1. What is the overarching goal? At least three perspectives need to be considered and reconciled:
    - patient/client
    - his/her family
    - team

2. What are the patient/client's problems? (e.g. medical, emotional, social, environmental and economic).

3. What is the impact of each problem on the patient/client's health?

4. What strengths and resources does the patient/client have or can be mobilized to deal with each problem?

5. What additional information is needed to adequately define the problem or its implications?

6. What is the plan of care? (What needs to be done; who will do it; when will it happen?)

7. What priority should be assigned to each problem? How important is its effect on the overarching problem?

8. What outcomes should be expected for each problem? (e.g. expressed in measurable terms, appropriate time to look for the outcome

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[1] Hyer, K., Flaherty, E., Fairchild, S., Bottrell, M., Mezey, M., Fulmer, T., et al. (Eds.). (2003). *Geriatric Interdisciplinary Team Training: The GITT Kit* (2nd ed.). New York: John A. Hartford Foundation, Inc.

[2] Hyer et al. (2003)