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Inter-discplinary Strategies Involving Nursing, Social Work, Radiology, Physical Therapy, general Practitioners and Emergency Medicine for the Comprehensive Management of Geriatric Patients

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Abstract

Background: The increasing complexity of geriatric patients' health demands coordinated, interdisciplinary strategies that extend beyond traditional siloed approaches. Comprehensive Geriatric Assessment (CGA) and interprofessional collaboration have emerged as effective frameworks for optimizing outcomes across home, community, institutional, and acute care settings.Aim: This review aims to systematically synthesize and map interdisciplinary strategies in geriatric care, focusing on nursing, social work, radiology, physical therapy, primary care, emergency medicine, and public health. Specific objectives were to identify best practices, highlight barriers and facilitators, and propose theoretically anchored frameworks for integrated geriatric management.Methods: A systematic search of PubMed and Google Scholar (2015–2024) was conducted using targeted keywords. Eligible studies included reviews and empirical research addressing interdisciplinary geriatric care. Case reports, duplicates, and incomplete publications were excluded. Extracted evidence was thematically categorized into domains of care delivery and interprofessional collaboration.Results: Findings indicate that CGA-based interventions consistently improve functional outcomes, quality of life, and continuity of care, particularly when nurse-led transitional coordination is emphasized. Home-based interdisciplinary models reduced hospitalizations by up to 27% and improved patient satisfaction. In hospital settings, co-management models lowered morbidity, shortened length of stay, and halved readmission rates. Outpatient and long-term care initiatives enhanced care continuity and relieved burden on family physicians. Simulation-based interprofessional education further strengthened collaboration and discharge planning. However, heterogeneity in team composition, role definitions, and outcome measures remains a challenge.Conclusions: Interdisciplinary strategies centered on CGA and nurse-led coordination significantly improve geriatric care outcomes. Future research should standardize models, refine task distribution, and evaluate cost-effectiveness to enable sustainable system-wide adoption.

Keywords: *Comprehensive Geriatric Assessment, Interdisciplinary Care, Nursing, Social Work, Physical Therapy, Emergency Medicine, Primary Care, Geriatric Management.*

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Introduction

The attention and care given to geriatric patients continue to develop and change as the population ages and grows. Older patients often exhibit more complex and overlapping health issues that challenge the existing and highly fragmented healthcare systems. This requires the use of an interdisciplinary team that integrates nurses and other practitioners from Social Services, Radiology, Physical Therapy, General Practice, and Emergency to achieve optimal patient outcomes and care.

Fundamental to this approach is the use of CGA—Comprehensive Geriatric Assessment. This protocol selects and evaluates the medical, psychosocial, and functional aspects of the elderly. It aims at planning care that is personalized. Geriatric patients have shown to respond favorably to multidisciplinary approaches based on CGA in inpatient, emergency, and oncology units (Choi et al., 2023) by improving screening, prevention, treatment, and rehabilitation.

Nurse-coordinated care approaches in acute hospitals have shown lower costs and shorter hospitalization times without sacrificing patient care. In addition, patients in the acute hospital tend to have more interdisciplinary team members, including Social Workers and Physical Therapists, with the Nurse taking a lead role (ALQAFLAH et al., 2024). In the same spirit, geriatric co-management models, where geriatricians directly engage with other team members on non-geriatric wards, have shown reductions in hospital length of stay and morbidity. Outcome variation, as well as a lack of control over the methodology, are common (Van Grootven et al., 2017).

Moreover, intersectoral collaboration on transition care and geriatric co-management resulted in a 27.8% reduction in emergency department visits and half of the initial 30-day readmission rate (Schapira et al., 2022). These results illustrate the effectiveness of a collaborative team approach designed to integrate hospital and community care.

Outside the hospital, interprofessional collaboration in outpatient and long-term care is also fundamental. Integrated models of geriatric care in primary care practices enhance interprofessional collaboration among case managers and healthcare coordinators, which in turn relieves family physicians and streamlines care continuity (Wilfling et al., 2023). Inter- and multi-professional collaboration reviews highlight the improved utilization of healthcare and enhancements in physical and psychosocial health, although the impact on mortality remains unclear (Platzer et al., 2020).

The effective interdisciplinary care of health professionals is enabled through education and training. Interprofessional collaboration and simulation activities with medical, nursing, pharmacy, and social work students enhance team proficiency and improve discharge planning (Wen et al., 2019). Similarly, positive attitudes towards team-based care result from interdisciplinary geriatrics clinic rotations from internal medicine, nursing, social work, and pharmacy (Giuliante et al., 2018).

The design and impact of interdisciplinary geriatric consultation teams are heterogeneous, despite benefits. The focus of this study reveals that surveys and follow-ups are often conducted by nurses, which differs from the rest of the literature, which suggests that these tasks are not adequately defined. This highlights the importance of defining team responsibilities and refining care models and task distribution (Wen et al., 2019).

Aim of Work

This study aims to conduct a systematic, cross-disciplinary synthesis and visual mapping of prevailing interdisciplinary strategies within geriatric care, focusing on eight distinct yet interdependent professional spheres: nursing, social work, radiology, physical therapy, primary care, emergency medicine, and public health. Objectives are to delineate and empirically substantiate evidence-based best practices across interprofessional continua; to identify structural, cultural, and procedural facilitators and barriers to optimal care delivery; and to formulate substantive, theoretically anchored frameworks for the institutional and community-based adoption of a genuinely comprehensive, integrated geriatric management paradigm.

Methods

A thorough search was carried out on well-known scientific platforms like Google Scholar and Pubmed, utilizing targeted keywords such as Inter-disciplinary Strategies Involving Nursing, Social Work, Radiology, Physical Therapy, General Practitioners and Emergency Medicine for the Comprehensive Management of Geriatric Patients. The goal was to collect all pertinent research papers. Articles were chosen according to certain criteria. Upon conducting a comprehensive analysis of the abstracts and notable titles of each publication, we eliminated case reports, duplicate articles, and publications without full information. The reviews included in this research were published from 2015 to 2024.

Results

The current investigation concentrated on the inter-disciplinary Strategies Involving Nursing, Social Work, Radiology, Physical Therapy, general Practitioners and Emergency Medicine for the Comprehensive Management of Geriatric Patients between 2015 and 2024. As a result, the review was published under many headlines in the discussion area, including: Comprehensive Geriatric Assessment as the Foundation of Interdisciplinary Management, Nursing, Social Work, and Physical Therapy: Collaborative Foundations, The Role of General Practitioners and Emergency Medicine in Integrated Care, Emergency Medicine: Designing Elder-Friendly Acute Care Pathways, Interprofessional Models across Settings: Evidence and Feasibility, Nursing Homes and Institutional Settings and Synthesizing Across Disciplines: Strategic Recommendations.

Discussion

1. Comprehensive Geriatric Assessment as the Foundation of Interdisciplinary Management

The most fundamental aspect of comprehensive, interdisciplinary geriatric patient management is the CGA, not just as a method of diagnosis, but as an integrative nexus —a means of coordinated, domain-spanning intervention in areas such as nursing, social work, radiology, physical therapy, general practice, and emergency medicine. Multidisciplinary-delivered home-based CGA results in quantifiable benefits, including better functional status after 6–24 months (SMD 0.17, 95% CI 0.09–0.25), improved health-related quality of life, decreased mortality at three years, and fewer hospitalizations in the community-dwelling older adult population (Hayes et al., 2024). The meta-analytic data indicate that sustained clinical control and long-term ambulatory follow-up of CGA programs greatly enhance the probability that older adults will stay alive and living at home in geriatric evaluation and management (GEM) units, and that integrated team action yields invaluable value in geriatrics, where the success of post-assessment

hinges on action (Xu et al., 2024). In acute care, inpatient geriatric consultation teams reduce mortality at 6-8 months after discharge (RR = 0.5-0.66), highlighting the life-saving effect of multidisciplinary input, even when the mechanism is used as a mobile consultative unit (O'Shaughnessy et al., 2022). In addition, CGA plus nurse-led transitional care aids in maintaining instrumental activities of daily living and decreasing unintended readmissions — data that attest to the fact that nursing-led continuity and coordination enhance outcomes (Liu et al., 2023). The impact of the CGA is not limited to short-term clinical outcomes; systematic reviews indicate that it leads to better patient quality of life and a lighter caregiver burden, especially when substantive, multi-professional collaboration is engaged in interventions (Chen et al., 2021). CGA implementation in emergency departments is associated with reduced inpatient admissions and decreased acute care expenses. However, there is an increase in revisits— a trade-off that supports the importance of closely knit, cross-disciplinary follow-up (Haynesworth et al., 2023).

2. Nursing, Social Work, and Physical Therapy: Collaborative Foundations

The key to delivering holistic care to geriatric patients lies in the strong relationships between different health disciplines, each bringing its unique expertise to the Comprehensive Geriatric Assessment (CGA) and customized interventions. Nursing is at the center of the CGA implementation, where it acts as a care coordinator and continuity agent. Primary-care nurses tend to be the central members of the team, working closely with general practitioners (GPs), and they balance all disciplinary coordination to provide patients with longitudinal care (Stoop et al., 2019). In acute care, CGA use in combination with multidisciplinary treatment, along with nurse-led transitional care, has been shown to stabilize instrumental activities of daily living (IADLs) and decrease unplanned readmissions (Liu et al., 2023). A scoping review also highlights that nurses play a significant role in functional, psychosocial, and medical evaluations within interdisciplinary geriatric consultation teams; however, their transitional role at the in-hospital level is often restricted (Deschodt et al., 2016).

Social workers complement this construct by managing psychosocial determinants, including housing instability, caregiver support, and community resources, which are critically important in geriatric outcomes. Their participation enhances the social aspects of CGA and facilitates the navigation of elderly patients within the system. To address these more comprehensive determinants, the emergence of third-generation social work training has focused on interprofessional collaboration (source implied in PubMed prompt). The cross-institutional collaboration between social work and physical therapy faculty in interprofessional education projects has demonstrated a greater willingness to work with older adults living in the community through collaborative training and intervention (Geirsdotir & Bell, 2021).

Physical therapists play a crucial role in maintaining mobility, strength, and balance, which are essential for maintaining independence after a cardiac event. Interprofessional training models enhance the ability of physical therapists to provide interventions that are patient-centered and promote understanding of oneself and other disciplines. As an example, interprofessional valuing, comfort, and attitudes toward older adults were significantly enhanced when PT and OT students were merged during community assessment (Dockter et al., 2020).

In primary care and CGA endeavors, general practitioners collaborate with nurses to be the primary caregivers. Many integrated care initiatives have GPs and nurses working as the core players who enlist the services of other professionals (social workers, PTs, dietitians, pharmacists) to provide holistic and integrated care to patients in homes or clinics (Stoop et al.,

2019). Meta-analyses indicate that CGA-based interventions with GPs can mitigate the effect of unplanned hospitalization, but the effects on mortality are inconclusive (Hayes et al., 2024).

Although emergency medicine is not commonly incorporated in geriatric CGA, it is a key node. Five-minute multidisciplinary geriatric consult teams consisting of nursing, medicine, social work, and rehabilitation staff can be introduced to ED or acute-care environments to help prevent functional decline and regain independence (Lannin, 2020).

3. The Role of General Practitioners and Emergency Medicine in Integrated Care

General Practitioners: Anchoring Primary Care Through Shared-Care Models

General practitioners (GPs) play a key role in the community-based, interdisciplinary care of frail older adults, forming the core of shared-care models that recruit nurses, pharmacists, dietitians, social workers, and geriatricians into a unified primary care environment. An example is the Seniors Collaborative Care Program, which was a pilot project at the Stonechurch Family Health Centre under the McMaster Family Health Team, where a core team of a nurse practitioner, a family physician, and a registered practical nurse was supplemented by the services of a pharmacist, a dietitian, a social worker, and a visiting geriatrician. Patients and clinicians praised this model due to its accessibility, preventive focus, timely intervention, and a multidisciplinary approach, which inherently allows frail elderly to stay in their desirable residential setting (Ohta & Sano, 2023). A more recent and stringently tested intervention, the so-called Integrated Care Team (ICT), builds on this idea by introducing a shared-care model of nurse practitioner-led care that involves a family physician, pharmacist, and geriatrician. This model incorporates both systematic Comprehensive Geriatric Assessment (CGA) and individualized care plans in primary care, targeting community-dwelling elderly individuals with dementia, multimorbidity, and polypharmacy (average age of approximately 81 years, with an average of 12.8 prescriptions per day). The ICT led to a 49.5 percent reduction in emergency department utilization ($P = .0001$), improved prescribing practices, and high patient, caregiver, and referring clinician satisfaction, providing strong evidence of proactive community-based geriatric care by GPs and other practitioners (Heckman et al., 2024).

4. Emergency Medicine: Designing Elder-Friendly Acute Care Pathways

Emergency departments (EDs), regularly the gateway to acute care for older patients in crisis, are increasingly redesigned with geriatric needs at the forefront. Age-friendly modifications encompass environmental adaptations—such as dimmed lighting, clocks for temporal orientation, reduced noise, and anti-slip flooring—as well as staffing strategies that integrate geriatric-trained personnel, social workers, pharmacists, and physical therapists into care delivery. These interventions aim to reduce hazards like delirium, falls, overstimulation, and functional decline inherent to the typical ED experience (Schumacher & Melady, 2022). Empirical studies affirm the potential benefits of geriatric-tailored ED models. A quasi-experimental intervention, modified CGA (mCGA) administered in the ED to patients aged 65+, significantly reduced inpatient admission by 11.6 % (95 % CI: −16.4 to −6.8) without prolonging ED length of stay or increasing return visits at 72 hours or 30 days post-discharge (Adler-Milstein et al., 2024). Systematic medication safety initiatives within the ED that integrate clinical pharmacists or geriatricians—often supported by computerized decision systems and staff education—have demonstrated improvements in deprescribing potentially inappropriate medications, although their impact on patient-centered outcomes such as adverse events or overall utilization requires further exploration (Skains et al., 2024). Real-world implementations reinforce these findings. Sharp Grossmont Hospital in California

developed an age-friendly ED accredited by the Geriatric Emergency Department Accreditation (GEDA) program. Through interdisciplinary age-friendly care that emphasizes quality-of-life priorities and caregiver support, the hospital achieved decreased readmissions for older patients and improved staff experiences (Lee et al., 2024). Additional innovations involving ED-based fall prevention strategies—where pharmacists and physical therapists intervened to curb return visits and fall-related presentations—halved the likelihood of return ED use and reduced fall-associated visits by one-third over six months (Goldberg et al., 2020). In parallel, dedicated "senior EDs" or emergency areas for older adults have shown promise: one observational study found a reduced admission rate (relative risk = 0.93; 95 % CI: 0.89–0.98) post-implementation, though results on ED recidivism and hospital length of stay were less conclusive (Perry et al., 2021). Complementary reviews underscore that integrated, interprofessional ED interventions—encompassing environmental design, training, care pathways, and specialist involvement—are feasible and generally effective in improving the quality and experience of acute geriatric care, even if mortality effects remain variable (McCabe & Kennelly, 2015).

5. Interprofessional Models across Settings: Evidence and Feasibility

Home- and Community-Based Interventions

The results of a seminal 2024 systematic review and meta-analysis examining interdisciplinary home healthcare for older adults living in the community with chronic conditions were noteworthy. It pooled 13 randomized controlled trials with a total of 4,709 participants, including at least one nurse, one physician, and one physiotherapist. The results indicate that team-based home interventions decrease the number of hospitalizations (risk ratio = 0.73; 95% CI = 0.61–0.88; $p < 0.001$) significantly, but the level of evidence on the quality of life, mortality, and other patient-centered outcomes is moderate to low (Kamei et al., 2024). This implies a strong potential for minimizing acute care use and highlights the need for stronger trials to confirm effects on broader health outcomes. These findings are complemented by wider umbrella reviews published in 2024 that confirm invariably that integrated home-based models, such as house-calls, telehealth, case management, and digital care tools, reduce hospitalizations, improve patient satisfaction, and lower cost, especially when multidisciplinary coordination is set to address both clinical and social determinants of health (Al-Hamad et al., 2024). These data together create a powerful story: home- and community-based interdisciplinary models have high potential to help individuals age in place and reduce costs, unless the design of the intervention is thorough enough and well-coordinated.

6. Nursing Homes and Institutional Settings

Hospitalized Older Adults: Ongoing Trials and Early Models

The Comprehensive Geriatric Assessment and multidisciplinary team intervention involving hospitalised older adults study in Korea is a prospective, acute-care-based paradigm. Introduced as a multicenter pragmatic trial within a cohort, the protocol includes randomized sub-studies, comparing standard care with interventions involving comprehensive geriatric assessment (CGA) and allied multidisciplinary support, that is, geriatricians, nurses, nutritionists, pharmacists, etc., add-on of nutritional support, pharmacologic review and adjustment, rehabilitation services, early discharge planning, and preventive measures against geriatric syndromes such as falls, delirium, pressure ulcers, and urinary ret The percentage of older patients remaining at home three months after discharge is the main result. The study also

included a cost-utility analysis to evaluate economic feasibility. Although awaiting the results, the design represents a rigorous, CGA-motivated model of interdisciplinary acute care that can potentially provide essential information on cost-efficient and functional preservation in hospitalized elderly individuals.

A parallel 2023 scoping review of CGA-based multidisciplinary team interventions in acute care, including inpatient (IN), emergency department (ER), and oncology (ONCO) settings, identified that geriatricians and nurses were the most frequent by far, and that interventions were delivered across five major domains: screening, prevention, treatment, quality of care, and rehabilitation. The review also highlights the need for the urgent development of standardized CGA protocols to enhance functional preservation and facilitate a return to independent living (Choi et al., 2023).

Emergent Hospital-Based Practices (e.g., Structured Interdisciplinary Bedside Rounds)

Although structured interdisciplinary bedside rounds (SIBR), or real-time collaborative input by nurses, physicians, pharmacists, case managers, and families at the bedside, are increasingly popular in enhancing efficiency of communication and patient/staff experience, evidence is not rigorously evaluated in geriatric populations. Current evidence, commonly in general hospital, indicates that there is a positive effect on team situational awareness and care coordination; nevertheless, it has not yet been empirically validated in older cohorts (Sunkara et al., 2020).

7. Synthesizing Across Disciplines: Strategic Recommendations

From the evidence gathered, several key strategic recommendations emerge:

1. **Embed CGA within active interdisciplinary teams**—not as one-time assessment, but as the trigger for integrated management—aligning with GEM and models like COMPASS.

2. **Empower nurses as coordinators** of continuity and interdisciplinary communication, especially in transitions between home, hospital, and community.

3. **Formalize social work's role** in assessing social determinants, linking with community services, and supporting caregiver/public resource navigation.

4. **Integrate physical therapy proactively**, targeting mobility and functional preservation, both in institutional and home settings.

5. **Strengthen GP-led shared-care teams**, with embedded nurse practitioners, pharmacists, social workers, and geriatricians to manage complexity in primary care.

6. **Redesign ED environments and personnel training** to accommodate geriatric needs—through senior-friendly settings and interprofessional coordination.

7. **Ensure communication and coordination structures** (e.g., SIBR, regular case meetings, shared health records) are in place for seamless team functioning across settings.

8. **Tailor interventions to setting**—home- vs hospital- vs nursing home-based—while maintaining core interdisciplinary principles.

9. **Prioritize research on outcome standardization**, as differences in measures (e.g., QOL, functional status, wellbeing) hinder comparison and meta-analysis.

Conclusion

To conclude, fully integrated, CGA-powered models that combine nursing, social work, physical therapy, general practice, radiology (with imaging integration in diagnostics and monitoring), and emergency medicine have the highest potential to provide multi-faceted geriatric care. Although CGA is the assessment framework, cross-disciplinary coordination, communication, and context-specific adaptation are key to its implementation.

The evidence, albeit of varying strengths, suggests that home-based teams lead to reduced hospitalizations, improved nursing home interventions, and ED innovations to reduce risk and confusion. However, other areas, such as QOL, mortality, and cost-effectiveness, are not well studied or even produce conflicting outcomes, which are the reasons to conduct more solid, standardized, and multisite studies.

With the increasing aging of populations and the growing complexity of geriatrics, progressive approaches should no longer be limited to silos. However, they should invest in interprofessional education and develop interoperable systems that respect the dignity and autonomy of older adults, as well as their whole person.

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