Interprofessional Team Roles and Responsibilities in Providing Person-Centered Care

MODULE 9

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Outline

- Person-centered and collaborative care approaches
- Developing a collaborative interprofessional/interdisciplinary team

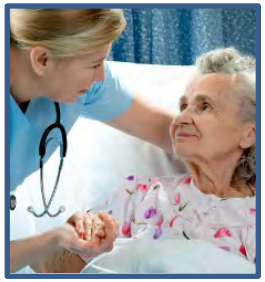
Learning Objectives

After completing this module, participants will be able to:

- Describe the benefits of having a person-centered interprofessional dementia care team.
- Describe the responsibilities of all members of the interprofessional dementia care team.
- Describe how responsibilities may evolve as the disease progresses.

Key Take-Home Messages

- Person-centered care (PCC) for persons living with dementia (PLwD) changes the focus from just treating medical symptoms due to dementia to addressing the medical and psychosocial needs of the whole person.
- PLwD and their care partners are the core of the interprofessional team.
- Care coordination among the full range of health care providers across all care settings is critical to providing continuity of care, quality of care, and PCC to PLwD.
- Dementia care teams need to be flexible and change with the needs of the PLwD.



Outline

- **Person-centered and collaborative care approaches**
- Developing a collaborative interprofessional/interdisciplinary team

Introduction

- Studies demonstrate the value of collaborative care models on quality of life issues (Edvardsson et al., 2010; Ervin & Koschel, 2012; Gladman et al., 2007).
  - Many challenges to integrating collaborative care approaches in primary care (Epp, 2003; Lloyd & Stirling, 2015; Venturato et al., 2011)
  - Importance of "person-centered" care
- Medical and psychosocial health care providers, along with nonmedical professionals as needed, are all crucial members of the collaborative care team.

Person-Centered Care (PCC) Approach

- PCC currently considered the gold standard for health care in the United States (AGS, 2016)
- Many different interpretations of PCC—all generally emphasize that "patients should be treated as persons" (Entwistle & Watt, 2013; Westphal et al., 2016)
- PCC for PLwD based on principles that emphasize quality of life, respect, and living a vital, engaged life (Love & Femia, 2015)

Applying Essential Elements of the AGS Person-Centered Care for PLwD

The AGS developed an approach for applying the 8 essential elements of PCC for PLwD (AGS, 2016).

1. Develop an individualized, goal-oriented care plan.
2. Perform an ongoing review of goals and care plan.
3. Develop an interprofessional/interdisciplinary team.
4. Assign one primary/lead point of contact.
5. Ensure active coordination among all providers.
6. Continually share information.
7. Provide education and training for all health care providers and PLwD.
8. Identify measurable outcomes for the care plans.

Developing a Person-Centered Plan

1. Begins by gathering information about the person's needs, values, and preferences.
2. Next, providers obtain input from family and care partners.
3. Information is then collected from the comprehensive health and functional assessment.
4. Finally, specific goals are defined on an individualized basis, based on current level of functioning instead of medically defined outcomes (Entwistle & Watt, 2013; Westphal et al., 2016).

Developing a Person-Centered Plan (continued)

- Consider likes, dislikes, strengths, weaknesses of PLwD (Entwistle & Watt, 2013; Westphal et al., 2016).
  - Consider how PLwD previously structured their days.
  - Consider when PLwD function best or worst.
  - Ensure sufficient time for activities, meals, bathing, and resting.
  - Schedule therapies accordingly (for example, when PLwD are rested).

Benefits and Challenges of Person-Centered Care Approaches

- Benefits: PCC approaches focus on improved quality of life for PLwD (Ervin & Kosche, 2012; Edvardsson et al., 2010) and their care partners (Gladman et al., 2007).
- Challenges: PCC approaches focus on the barriers to implementation (AGS, 2016; Apesoa-Varano et al., 2011; Epp, 2003; Lloyd & Stirling, 2015; Venturato et al., 2011) such as the need to spend additional time with each person, the need for more staff training, and the lack of recognition of cultural diversity (McMillan et al., 2010) and impact of lifelong disability (Watchman, 2014).

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- Person-centered and collaborative care approaches
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American Geriatrics Society Expert Panel Defines Person-Centered Care

In 2016, the American Geriatrics Society (AGS) Expert Panel on Person-Centered Care defined PCC for older adults living with chronic conditions and/or functional limitations.

- PCC involves two elements:
  - Eliciting the values and preferences of the older individual
  - Enabling these values and preferences to guide all aspects of the older individual's health care
- PCC is achieved through a dynamic relationship among all involved persons and professionals.

Collaborative Interprofessional/Interdisciplinary Team Approach

- Many PLwD continue to live at home as long as possible (Lloyd & Stirling, 2015).
- Use approaches that focus on managing chronic conditions as well as acute symptoms (Galvin et al., 2014).
- Interprofessional teams collaborate with one another; multidisciplinary teams provide parallel services with less interprofessional interactions.
- Collaborative care models use interprofessional teams to provide care across many settings (Galvin et al., 2014; Robinson et al., 2010).
- Enabling team leaders to delegate responsibilities throughout teams improves quality of care to PLwD (Lichtenstein et al., 2015).
- There are many system-level barriers to implementing a collaborative care program in primary care (Callahan et al., 2011).

Interprofessional/Interdisciplinary Team Member Roles and Responsibilities: Introduction

- Common components of best-practice models for dementia care (Galvin et al., 2014; Gaugler et al., 2016):
  - Fluidity of roles amongst team members (Galvin et al., 2014; Reuben et al., 2013)
  - Respect for diversity
  - Listen to all involved in care of PLwD
  - Recognize heterogeneity in recommendations across disciplines (Gaugler et al., 2016)
  - The PLwD are at the center of their healthcare teams.

Primary Care Providers (Physicians, Nurse Practitioners and Physician Assistants)

- The primary care provider:
  - Typically are responsible for assessment, management, and treatment of all conditions and diseases of the PLwD (Galvin et al., 2014).
  - Work with the PLwD and care partners to develop a care plan based on the person's diagnosis and stage of disease, needs, wishes, and goals and then work with all team members in executing and modifying it as needed.
  - Coordinate all other medical providers and services.
  - Seek consultations from various allied health professionals.
  - Refer to home and community-based services.
  - Are also responsible for educating the PLwD, care partners, and family on disease self-management.

Registered Nurses

- The registered nurse:
  - Evaluates the safety of the care plan.
  - Implements the orders of the primary care providers.
  - Continuously assesses the health status of the PLwD.
  - Works with the interprofessional team to develop and implement the best individualized, evidenced-based plan of care
  - Serves as the advocate of the PLwD.
  - Works with PLwD and the health care team to assist with disease self-management.

Physical Therapists, Occupational Therapists, Dieticians/Nutritionists

- Physical therapists and occupational therapists assess and work with PLwD and their care partners to optimize function and activities of daily living. (Galvin et al., 2014).
- Dieticians and nutritionists focus on benefits of diet, nutrition and exercise (Galvin et al., 2014; Hilliard, 2013).

Psychiatrists and Psychologists

- May be involved in evaluating persons with atypical presentations or in managing comorbid psychiatric disorders.
- Can administer and/or interpret neuropsychological testing and provide therapy and/or cognitive retraining (Galvin et al., 2014).

Clinical Social Workers

- Clinical social workers can provide counseling and referrals to the PLwD and their care partners (Cox, 2007; Galvin et al., 2014).
- Clinical social workers can conduct psychosocial assessments and identify resources in the community.

Other Medical Specialists and Community Partners

- The need for additional interprofessional team members will depend on the needs of the PLwD.
- The team can include adult day care providers, dentists, dental hygienists, neurologists, ophthalmologists, speech and language pathologists, allied health professionals, and other clinicians involved in the care of comorbid conditions (Galvin et al., 2014).
- Community team members include personal care workers, transportation providers, religious leaders, support group liaisons, and other providers.

Attorneys and Accountants/Financial Advisors

- Dementia can involve many legal and financial consequences necessitating advice from attorneys and accountants or financial advisors.
- The dementia care team can advise the PLwD and their care partner(s) to seek guidance from these specialists.

Creating Dementia Care Teams

- Two different types of dementia care teams:
  - Interprofessional teams: determined by medical need and availability of professionals
  - Interpersonal teams: family, friends, neighbors, religious leaders, and providers of community resources
  - PLwD and care partners are on both teams

Evolution of Roles as the Dementia Progresses

- Dementia care teams need to be fluid and evolve with the needs of the PLwD (Apesoa-Varano et al., 2011; Entwistle & Watt, 2013; Grand et al., 2011; Robinson et al., 2010).
- The PLwD are at the center of care, and the primary care partners are also an integral part of the shared decision making process of a team throughout the progression of the dementia.
- The members of the team also change with progression of the dementia and the changing needs and wishes of the persons living with dementia and their care partners.

Evaluation

1. What best describes the focus of person-centered care?

a. Using pharmacotherapy always to treat the acute condition or medical concern

b. Providing medical interventions to prolong life at all costs

c. Providing care that is responsive to and respectful of the needs and preferences of the person

d. Providing curative treatments based on the person's current medical needs

Evaluation (continued 1)

2. Which of the following best describes an interprofessional/interdisciplinary collaborative care team for a person living with dementia?

a. Delivery of team-based interventions across many settings

b. Integration of many types of health care providers who collaborate with one another and the person living with dementia in developing appropriate care strategies

c. Delivery of parallel services with minimal direct interaction between providers

d. Strategies that involve either a physician, physician assistant, or nurse practitioner along with other health care professionals all located within one primary care practice

Evaluation (continued 2)

3. How does the progression of dementia affect the composition or roles of the interprofessional/interdisciplinary collaborative care team?

a. As the needs of the person living with dementia evolve over the course of the disease, the roles and composition of the care team must evolve and adapt.

b. Only the primary care providers need to remain constant throughout the course of dementia.

c. The roles and composition of the care team do not change over the course of dementia.

d. There should always be a core team of primary care providers, psychological providers, and physical or occupational therapists; all others are on an “as-needed” basis.

Evaluation (continued 3)

4. **The center of the interprofessional care team for the person living with dementia is _____ and the team lead is _____.**

a. The physician, the social worker

b. The person living with dementia, the person chosen by the team

c. The person chosen by the team, the caregiver

d. The social worker, the physician

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