INTER-PROFESSIONAL TEAM COLLABORATIVE CARE OF OLDER ADULTS

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Objectives

1. Understand the need for improved care for medically complex older adults
2. Define collaboration in geriatric care
3. Describe types & stages of team development
4. Differentiate skills of different professionals
5. Define principles of successful teamwork
6. Discuss team conflict & management
Number of Americans Over 65 will Grow by 35 Million Between 2000 - 2030

65+: 100% increase from 2000 to 2030

85+: 98% increase from 2000 to 2030

Source: U.S. Census; Prepared by AAMC Center for Workforce Studies
A WAVE OF CHRONIC DISEASE

90 million Americans have 1 or MORE chronic conditions

80% of people over the age of 65 years have 1 or MORE chronic conditions

Chronic disease contributes to ¾ of the total healthcare budget

“Too often, caring for chronic illness features an uninformed passive patient interacting with an unprepared practice team, resulting in a frustrating, inadequate encounter.”
Bodenheimer, et al 2002

“Currently, we can assure our patients that their care is always provided by a team of experts, but we cannot assure our patients that their care is always provided by expert teams.”
Frankel 2006
WHY HEALTHCARE DELIVERY IS CHANGING.....

• Advancements in technology and growth of community-based care
• Move towards managing patients in their homes or nursing home where in the past patient would have remained hospitalized
• Advent of managed care with focus on efficiency and appropriate resource utilization
The Chronic Care Model

Community
- Resources and Policies
- Self-Management Support

Health Systems
- Organization of Health Care
  - Delivery System Design
  - Decision Support
  - Clinical Information Systems

Improved Outcomes
- Informed, Activated Patient
- Prepared, Proactive Practice Team
- Productive Interactions

Developed by The MacColl Institute
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Definition of Collaboration:

PROCESS OF SHARED

PLANNING

DECISION-MAKING

ACCOUNTABILITY

RESPONSIBILITY OF CARE FOR PATIENT
WHY USE COLLABORATIVE TEAM APPROACH?

- Psychological Issues
- Cognitive Issues
- Functional Impairments
- Older Adult with Complex Chronic and Acute Medical Problems
- Medication Misuse and Abuse
- Family/Caregiving Issues
WHY USE COLLABORATIVE TEAM APPROACH?

- Ability to develop a comprehensive and integrated care plan.
- Increase coordination of care and continuity between providers and systems.
- Improve efficiency in delivery of care.
DOES A COLLABORATIVE TEAM APPROACH WORK?

• A multidisciplinary intervention conducted by Rich et al 1995 on the prevention of readmission of elderly patients with heart failure
• The intervention: comprehensive education by nursing, diet instructions by dietician, post-d/c follow up by social worker, geriatric cardiologist review of medication, PCP involvement in home care, and telephone contact.
• Found a 56% reduction in hospital readmissions, improved quality of life, and decreased cost of care for patients at high risk for readmission.
• Study by McAllister et al 2004 reviewed 29 studies with several models of multidisciplinary management and found 25% reduction in all cause mortality in addition to 27% decrease in heart failure hospital admission rates
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INTER-PROFESSIONAL COLLABORATION: Team Development

Types of teams

– **Uni-disciplinary:**
  - same discipline working together

– **Multidisciplinary:**
  - Different disciplines develop treatment plans independently
  - Complete independent assessments of the patient
  - One person, usually MD, orders services
  - No joint planning or discussion of how one service effects other so services may overlap, duplicate or be fragmented
INTER-PROFESSIONAL COLLABORATION: Team Development

- Traditional care - Physician-directed multidisciplinary team
INTER-PROFESSIONAL COLLABORATION: Team Development

Types of teams

- **INTER-PROFESSIONAL:**
  - Different disciplines assess and plan care in a collaborative manner
  - Common goals are established and each discipline works to achieve those goals
  - Care is interdependent, complementary and coordinated
  - Joint decision making is the norm. Team members are empowered and assume leadership on the appropriate issues depending on the patient’s needs and the team members expertise.

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INTERPROFESSIONAL TEAM

PATIENT

SOCIAL WORK

PT/OT

DIETICIAN

FAMILY & CAREGIVERS

DOCTOR

NURSING
INTERPROFESSIONAL TEAM DEVELOPMENT

• Teams focus on common goals
  – Individual disciplines provide their unique perspectives to the common goals of the team.
  – Successful teams are distinguished by the decision-making processes used to achieve goals.
INTER-PROFESSIONAL COLLABORATION: Team Development

• Stages of team development
  – Forming – create stage for the “group”
  – Storming – Tasks and roles are worked out
  – Norming – Norms and patterns are worked out
  – Performing – Team working together for the care of the patient/ client
INTER-PROFESSIONAL COLLABORATION:
Team Development

• Membership of a team does NOT automatically mean the group functions well and efficiently
• Teams evolve and change over time
• Effective Teams require specific skills related to group dynamics and conflict management.
  – Members must recognize their role, group responsibility and how they personally affect the team dynamics.
  – Skill development of team “roles” is critical for well-functioning teams.
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INTER-PROFESSIONAL COLLABORATION: Skills

• The education and skills among different professionals on geriatric health-care teams is an asset
  – Unique and overlapping skills
  – Each profession has its own culture, common language, professional behaviors, values and beliefs.
  – Understanding the above contributes to respect and appropriate referral of elderly clients to other professionals

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INTER-PROFESSIONAL COLLABORATION: Skills

Potentially most important team members

Patient and family

They have full rights to information from medical professionals and participation in decision-making.

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Case Example

• Mr. S is an 89 year male who has been proudly living independently in the community
• He has hypertension, type 2 diabetes, osteoarthritis of lower back, and mild COPD
• Over past month, he has had 3 falls, non-injurious, in addition to decreased oral intake, impaired hygiene
• He has been slowly declining over past 6 months
• HE & HIS FAMILY ARE CONCERNED
Initial Intervention

- MD examination, medication review, diagnostic evaluation, optimization of chronic medical conditions, correct reversible etiologies
- PT evaluate and treat through exercise & rehab procedures to maximize functionality
- OT utilize therapeutic goal-directed activities to evaluate and correct physical, mental, or emotional dysfunction to maximize functionality
- Social work evaluation for DME and additional support in his home
- Dietician evaluate dietary requirements and set goals with patient and family
FOCUS OF TEAM: OLDER ADULT NEEDS & PROBLEMS

- MEDICAL ISSUES & INTERVENTIONS
- PSYCHOLOGICAL & EMOTIONAL ISSUES & INTERVENTIONS
- SOCIAL ISSUES & INTERVENTIONS
- ECONOMIC ISSUES & INTERVENTIONS
- LIVING CONDITIONS & INTERVENTIONS
- NURSING ISSUES AND INTERVENTIONS
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PRINCIPLES OF SUCCESSFUL TEAMWORK:
IT BEGINS WITH THE EFFECTIVENESS OF EACH INDIVIDUAL MEMBER

• Complex care plans require good communication skills
• Need to recognize when to alert other team members of change in status
• Understand the “need to know” information required to make decisions about treatment
• Knowledge of other providers’ skills facilitate appropriate referrals for desired outcomes

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INTER-PROFESSIONAL COLLABORATION: Teamwork

• Principles of Successful Teamwork: Collaboration
  • Coordination of services
  • Shared responsibility
  • Communication
  • Mutual accountability

• Effective teams must work across settings and have effective mechanisms for information sharing and access.
INTER-PROFESSIONAL COLLABORATION: Principles of successful teamwork

- Patient becomes the common focus
- Collaboration involves skills of each team member AND understanding what information each member needs to contribute to the overall care plan
- Organized meetings
- Neutral Facilitator-asks for everyone’s input, clarifies issues, and communicates effectively
- Team rules
INTER-PROFESSIONAL COLLABORATION: Teamwork

- Structure: refers to the organization of elements of a meeting
  - Agenda: What do we expect to accomplish?
  - Timeline: Estimate for each item on the agenda
  - Roles:
    - Facilitator-calls meeting to order and reviews agenda
    - Timekeeper-keeps group on task
    - Recorder-keeps track of decisions and changes to care plan made by the group
  - Summary of agreement for each item on the agenda
  - Evaluate and reflect: discuss the process and outcome of the meeting
INTER-PROFESSIONAL COLLABORATION: TEAM RULES

• Attendance and timeliness
• Preparation
• How “disruptions” will be handled
• Managing conflict
• Contribution and participation
• Acknowledgement of other professional roles
• Sharing information
• Confidentiality
• Agreement of team goals
INTER-PROFESSIONAL COLLABORATION: Teamwork

• Characteristics of Effective Teams:
  – Consensus on purpose and goals
  – Clear roles and responsibilities
  – Open, honest communication
  – Disagreement is respectful
  – Active listening
  – Professional disciplines offer effective and appropriate contributions
  – Leadership shifts when appropriate
  – Trust and support each other, “we’re in this together” approach
INTER-PROFESSIONAL COLLABORATION: Teamwork

Steps in care-planning:

• Reflects patient-specific goals
• Feasible
• Cost-effective
• Clearly understood and agreed upon by all!

*An Inter-professional team develops care plans and treatment goals that incorporate all relevant information and understands how that information relates.
INTER-PROFESSIONAL COLLABORATION: Teamwork

Content of Care Plan-Questions to Address

• What additional information is needed to adequately define the problem or its implications?
• What strengths and resources does the patient have?
• What is the Plan of Care?
  – What needs to be done?
  – Who will do it?
  – When will it happen?
INTER-PROFESSIONAL COLLABORATION: Teamwork

Content of Care Plan-Questions to Address

- What priority should be assigned to each problem?
  - How important is it to the overarching problem?
  - What other factors might influence its relative priority?

- What outcomes should be expected for each problem?
  - Measurable terms
  - Timeline
<table>
<thead>
<tr>
<th>Agenda</th>
<th>Facilitator</th>
<th>Timeline</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr. S-continues with poor intake</td>
<td>Mary C. (VNA)</td>
<td>10min</td>
<td>SW to screen for depression, MD treat if present</td>
</tr>
<tr>
<td>Mr. S-family concerned he is still driving</td>
<td></td>
<td>10min</td>
<td>OT to perform drivers safety evaluation, MD to speak with patient &amp; family</td>
</tr>
<tr>
<td>Mr. S-still having significant back pain</td>
<td></td>
<td>15min</td>
<td>PT to perform additional treatment (TENS), MD to eval meds</td>
</tr>
<tr>
<td>Mr.S-new urinary incontinence</td>
<td></td>
<td>10min</td>
<td>Nurse to check ua, teach time voiding if applicable</td>
</tr>
</tbody>
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INTER-PROFESSIONAL COLLABORATION

Team Conflict

• Conflict as a part of teamwork
  – Inevitable, differing views and open discussions are ultimately beneficial

• Conflict management
  – Active listening
  – Define problem
  – Open questions
  – Clarification
  – Reframe for consensus
**INTER-PROFESSIONAL COLLABORATION**

**Effective Team Skills**

<table>
<thead>
<tr>
<th>Establish goals</th>
<th>Be respectful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognize Roles</td>
<td>Negotiate</td>
</tr>
<tr>
<td>Solicit input</td>
<td>Delineate tasks/assign responsibility</td>
</tr>
<tr>
<td>Include client/family</td>
<td>Follow-up</td>
</tr>
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</table>

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