

FACULTY GUIDE

Core Module 9:

**Interprofessional Team Roles and Responsibilities in Providing
Person-Centered Care**

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Slide 1:

- This module—Module 9: Interprofessional Team Roles and Responsibilities in Providing Person-Centered Care—identifies and discusses the various members and professionals who may comprise a dementia care team.

Slide 4:

- In Module 9: Interprofessional Team Roles and Responsibilities in Providing Person-Centered Care we will discuss the roles and responsibilities of the various team members involved in providing care for persons living with dementia (PLWD) and how to develop an interprofessional, collaborative, person-centered approach to care.

Slide 5:

- Our goal, by the time we finish with this module, is for you to learn about the following three topics:
- Describe the benefits of having a person-centered interprofessional dementia care team.
- Identify and describe the roles and responsibilities of all members of the interprofessional dementia care team.
- Describe how roles and responsibilities may evolve as the disease progresses.

Slide 6:

- Person-centered care for persons living with dementia changes the focus from just treating medical symptoms due to dementia to addressing the medical and psychosocial needs of the whole person.
- Persons living with dementia and their care providers are active participants 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 that remains person-centered to persons living with dementia
- Dementia care teams need to be flexible and change with the needs of the persons living with dementia.

Slide 7:

- We begin by examining the concepts of person-centered care and collaborative care approaches.

Slide 8:

- Clinical trials have shown the effectiveness of collaborative care models (improved quality of care for persons living with dementia, fewer behavioral and psychological symptoms of dementia, improved quality of life for both persons living with dementia and their care providers, and significant improvements in distress and depression of care providers):
 - The complexities of the health care system and the resources available sometimes make the use of a flexible, adaptive collaborative system in primary care practices challenging.

- Care coordination among the full range of health care providers across all care settings is a critical element in providing continuity of care and quality coordinated and collaborative health care to persons living with dementia.
- The health care team must work together to ensure the best possible outcomes for individuals living with Alzheimer’s disease and related dementias (ADRD) and their care partners for a variety of stages and types of dementias.
- As we will be discussing next, care coordination should ensure that the agreed-upon plan of care is “person-centered,” guided by the goals, needs, and preferences of the persons living with dementia and that the care partner and persons living with dementia are active participants in the plan of care at all times.
- Medical and psychosocial health care providers are crucial members of the collaborative care team who provide and coordinate care based on the needs and wishes of the persons living with dementia and their care partners.
 - The care team also includes nonmedical professionals and persons and resources from the community—from friends who provide informal respite care to residential care communities.
 - In person-centered care, the persons living with dementia are also members of the team.
 - With the limited effectiveness of medications to slow disease progression, care team emphasis on diet, exercise, meaningful activities, support services, behavioral interventions, plus palliative care, and end-of-life care is essential.

Slide 9:

- “Person (or patient)-centered” care is now considered the gold standard for health care in the U.S. and abroad.
- There are many different interpretations of person-centered care, but all generally emphasize that “patients should be treated as persons” and that care should be oriented to the perspective of the individual, not from the perspective of the disease or condition. This approach is not limited to the care of persons living with dementia, but it may be particularly valuable to this population in light of their progressive cognitive deterioration. PCC changes the focus from treating acute symptoms to addressing the needs of the whole person.
- The 2001 Institute of Medicine (IOM) report identified person-centered care as one of six “pillars” of quality health care.
- Person-centered care (PCC) is defined as “providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.” The following person-centered principles are the foundation of dementia care
- Quality of life depends on care received as well as values that others put on their abilities and life.
 - Being meaningfully engaged and having purpose are vital to well-being.
 - Respect, dignity, and choice are foundational basic human rights.
 - The logo at the bottom of the slide is the Centers for Medicare & Medicaid Services identity mark for person-centered care.

Slide 10:

- The SCAN Foundation charged the American Geriatrics Society (AGS) Expert Panel on Person-Centered Care, in collaboration with the Keck School of Medicine at University of Southern California, to develop a definition of person-centered care and its essential elements for older adults with chronic conditions and/or functional limitations.
 - According to the expert panel, person-centered care (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 the older individuals, all care partners and persons of importance to individuals, and all relevant providers.

Slide 11:

The AGS's 8 "Essential Elements of PCC" for persons living with dementia are as follows:

- Develop an individualized, goal-oriented care plan based on the preferences of the persons living with dementia—complete thorough medical, psychosocial, and functional evaluation.
 - Perform an ongoing review of the person's goals and care plan as the dementia progresses to address evolving needs. In the next slide, we will address how to apply a person-centered approach for developing an individualized daily care plan.
 - Develop an interprofessional team in which the person living with dementia is an integral team member.
 - Assign one primary/lead point of contact on the health care team.
 - Ensure active coordination among all health care and supportive service providers.
 - Continually share information through integrated and open communication.
 - Provide education and training for all health care providers and, when appropriate, the persons living with dementia and those important to them.
 - Identify measurable outcomes for the care plans, and assess using feedback from the persons living with dementia and care partners.

Slide 13:

- Developing a daily care plan begins by gathering and integrating information from family and other care partners about the person's needs, values, and preferences.
- Information is then collected from the comprehensive health and functional assessments to define specific goals on an individualized basis, using the person's current level of functioning instead of medically defined outcomes. This plan must be continually reevaluated to accommodate the increasing impairments of persons living with dementia.

- The daily care plan considers the likes, dislikes, strengths, and weaknesses of the persons living with dementia. It is not important that the daily plan is fully scheduled, but it is important to allow increasing amounts of time for rest as the dementia progresses. To schedule therapies, a person-centered plan would consider how the persons living with dementia had previously

structured their day and when they function best or worst. The plan must also allow sufficient time for meals, bathing, and resting.

Slide 14:

Person-centered care approaches have several benefits:

- Reduce behavioral and psychological symptoms of dementia
- Promote sense of identity and normality
- Benefits to care partners including reduced stress because persons living with dementia accept and respond to dementia care services

A person-centered care approach can also have limitations:

- Implementing it may be challenging.
- Providers may need to spend additional time with each person in order to be able to “care for” the “whole person” instead of “curing” an acute symptom.
- It requires an organizational culture to provide support and training.
- There is a lack of consensus regarding terminology and what constitutes “person-centered care” (Epp, 2013). Providers have no general guidelines or stage-specific recommendations.
- Person-centered care requires good communication skills.
- Person-centered care has been criticized for lacking recognition of cultural diversity. Module 3 provides an in-depth discussion of issues related to cultural diversity in persons living with dementia.

Slide 15-16:

We now examine the many facets of a dementia care team, specifically looking at three questions:

- What is an interprofessional dementia care team, and how does that differ from other interprofessional care teams?
- How does the interprofessional team create and contribute to a dementia care plan?
- How do you create an interprofessional care team if one does not exist?

Slide 17:

- Many persons living with dementia continue to live at home—alone or with family or care partner(s)—as long as possible.
- Long-term systematic approaches are needed to manage chronic conditions (such as dementia) instead of focusing on treating acute symptoms.
- Interprofessional teams consist of many types of providers who collaborate with one another; a “multidisciplinary” approach, by contrast, refers to delivery of parallel services with less direct interaction between providers.

Collaborative care models are team-based interventions that provide strategies to deliver integrated health care across many settings:

- Interprofessional teams are needed to address concerns of persons living at home with dementia.

- These models focus on shared decision-making between providers and persons living at home with dementia (and their family/ care partners).
- They emphasize evidence-based practices (medical, psychological, social work, among others) person- and family-centered care, and open lines of communication.
- Current collaborative care approaches may involve either the physician, physician assistant, or nurse practitioner, along with a psychologist, social worker, case manager, physical and/or occupational therapist, and other allied health professionals and support staff within a primary care practice.
- Each member of the care team provides their own clinical, management, and/or administrative strengths, thus improving the provision of comprehensive care.
- Research suggests that enabling the team lead to delegate select tasks is associated with an enhanced quality of care for common geriatric conditions, including dementia.

There are many system-level barriers to implementing a collaborative care program in primary care:

- Need to identify and address system-level issues
- Need to identify and address other resource constraints: financial limitations, space limitations, availability of interdisciplinary practitioners:
- Need time for clinical practices to adapt to new processes and approaches
- Need for training of providers and consistency across disciplines
- Need for supportive leadership
- Need for tool(s) and time to periodically assess collaborative approach

Slide 19:

- Best-practice models for dementia care have common components, including:
 - Specific roles may change based on the composition of each unique team.
 - Roles might overlap across professions:
 - For example, nurse practitioners (NPs), physician assistants and physician roles or responsibilities overlap.
 - Co-management between physicians and NPs may improve quality of care for the persons living with dementia and their care partners.
- Recognize and acknowledge diversity with respect to the special needs of persons with dementia and their care partners.
- Carefully listen to and observe the care partners, family members, and PLWD.
- Recognize that there is substantial heterogeneity in recommendations for care partners across disciplines.
- We note that many of these specialties have Dementia Curriculum for Health Care Professionals modules devoted to their roles: Module 11: focuses on attorneys and financial advisors, Module 13 focuses on social workers and psychologists, Module 14 focuses on acute care staff in emergency rooms and hospitals, Module 15 focuses on pharmacists, and Module 16 focuses on dentists.

Slide 20:

Typically, the primary care provider is responsible for coordinating the overall care of the person living with dementia, including, but not limited to:

- Conducting comprehensive assessments, making formal diagnoses, and developing treatment plans for all conditions and diseases of the person living with dementia.
- Developing a care plan based on the person's diagnosis and stage of disease, needs, wishes, and goals and collaborating with all medical and community team members in executing and modifying that plan as needed.
- Connecting the persons living with dementia, care partners, and family members to community services and supports:
 - Counseling (individual or family)
 - Support group for person with dementia
 - Support group for care partners
- Assisting in providing referrals for outpatient services (physical and/or occupational therapies).
- Facilitating a pharmacist-led review of medications from all health care providers and regularly reassess the side effects of prescription and nonprescription medications.
- Managing any syndromes (e.g., delirium, pain, and psychosis) and all comorbid medical conditions of the persons living with dementia.
- Referring to specialists as needed, including outpatient services (physical and/or occupational therapies).
- Assessing and ensuring safety: driving, home, medications, and general safety.
- Asking about the care partner's health and emotional state at each visit and either treat or make a referral to that person's primary care provider.
- Educating the persons living with dementia and their family about the diagnosis and care options.
- Identifying the need for guidance regarding legal issues.
- Participating in explanations that early care planning, and financial and estate planning, will help ensure that the wishes of the person with dementia are known and will be followed.
- Helping determine care visit frequency and communication options for time between visits
- Depending on state regulations, referring to Medicare Part A services (such as home care or hospice care) in order to address the care plan to include new providers and services (e.g., when care is needed in a nursing home, assisted living facility, hospice facility, or hospital) as degenerative dementia progresses.
- Communicating with other care providers whenever a recommendation will involve changes in the setting and transitions (e.g., respite care, institutional care, palliative care, hospice).

Slide 22:

- The registered nurse will have many responsibilities, including:
- Evaluating the safety of the medical plan of care before implementing it.
- Ongoing assessment of the health status of the person living with dementia and his/her response to the plan of care.

- Implementing the primary care provider's orders and assessing the person's responses to the treatment plan.
- Focusing on helping persons living with dementias meet their needs, including physical, emotional, cognitive, social, and spiritual needs.
- Working with the health care team to develop and implement the best-individualized, evidenced-based plan of care for the person living with dementia.
- Serving as an advocate for the person living with dementia.
- Working with the person living with dementia and the health care team to assist with disease self-management.

Slide 24:

Physical and occupational therapists (PTs and OTs, respectively) help in many ways:

- Observe ongoing behavior, daily routines, and any sudden or gradual changes.
- Assess physical home environment and suggest modifications as appropriate.
- Evaluate activities of daily living (ADL).
- Assess for fall risk and assist with fall prevention.
- Recommend sensory and/or mobility aids.
- Discuss driving evaluation with the persons living with dementia, care partner, and health care team.

Dieticians or nutritionists describe the benefits of diet, exercise, and meaningful activities:

- Persons generally have decreased thirst and hunger perception with aging, which can lead them to forget to eat or drink.
- In addition to physiologic changes associated with aging, persons living with dementia may have difficulties eating or drinking on their own.
- Dieticians or nutritionists may be able to make suggestions that can help prevent weight loss and dehydration.
- They can also assess a person's ability to self-feed. They may identify risks and recommend cues for care partners to implement to minimize the risk of choking.
- Through observing the person's mealtime regimen, they can make recommendations regarding the dining environment to facilitate optimal eating experiences.

Slide 26:

A psychiatrist, geriatric psychiatrist, or neuropsychiatrist can perform several functions:

- May be called upon to evaluate persons with atypical or unusual presentation of dementia
- Performs neuropsychiatric testing
- Manages comorbid psychiatric disorders

A neuropsychologist or geriatric psychologist may provide several services:

- Administer and/or interpret neuropsychological testing
- Help with diagnosis and monitoring of persons living with dementia
- Provide counseling or therapy (in role of psychologist)

- Provide cognitive remediation and/or retraining programs

Slide 27:

Clinical social workers play several roles:

- They conduct a psychosocial assessment. This is an evaluation of the persons living with dementia and their families' mental, physical, and emotional health; how they are coping with the illness; the familial historical relationships; emotional, social and financial resources; and overall strengths and challenges including the families' capacity to reorganize themselves around the changes that the illness brings.
- They understand resources needed for the persons living with dementia and families such as education, counseling (individual, group, family), legal and financial decision-making, and other social services and support to help maintain health and well-being over the disease course.
- The role of the clinical social worker is discussed in detail in Module 13 of the Dementia Curriculum for Health Care Professionals.

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Depending on the individuals' needs, additional professional members of the care team might include:

- Adult day providers who provide respite for care partners and provide structured activities (music, exercise, social activities) for persons living with dementia
- Home care providers (in-home companion services)
- Dentists and dental hygienists
- Neurologist
- Ophthalmologist
- Speech and language pathologist
- Allied health professionals
- Miscellaneous: clinicians who are involved in the care of comorbid conditions

Community members of the care team might include:

- Church/synagogue leaders
- Liaisons with local or regional dementia support groups
- Parish or community nurses

Additional members might include:

- Researchers
- Clinical trial staff
- Hospital staff

Slide 29:

- The dementia care team can advise persons living with dementia and their care partner(s) to seek guidance from attorneys and financial specialists to provide accurate legal and financial advice.
- Elder care lawyers can play several roles:

- Draft legal documents based on the wishes of the person with dementia.
- Review documents and make suggestions about anything that is not in order.
- Clarify who will hold financial and health care powers of attorney and who will serve as alternates.
- Ensure that all needed documents are signed and properly stored.
- Arrange for documents be updated as needed.
- Provide advice regarding decision-making capacity.
- Financial advisers can play many roles:
 - Review the current financial situation.
 - Identify future financial needs.
 - Develop a financial plan to “spend down” for Medicaid applicability (if appropriate).
- The role of attorneys and accountants/financial advisors is discussed in detail in Module 11 of the Dementia Curriculum for Health Care Professionals.

Slide 30:

- There are two different types of dementia care teams actively involved with the care of a person living with dementia: interprofessional and interpersonal. The persons living with dementia is involved in identifying members on both teams but may rely on guidance from the primary care provider to develop the interprofessional team.
- Forming an interprofessional team involves identifying all the professionals who might be involved in caring for the persons living with dementia and inviting them to join when their expertise is needed. The core team members will likely be identified by the primary care provider and approved or rejected by the person living with dementia. Additional members may be identified over time. The interprofessional team’s composition is determined—and often limited—by the diagnosis as well as the availability of professionals.
- Forming an interpersonal team involves identifying persons who can provide social support and guidance to the persons living with dementia and any care partners. They include trusted friends, neighbors, family members, religious leaders, and community resources.

Slide 31:

- Dementia care teams need to be fluid and evolve with the needs of the PLwD.
- Recognize that good communication and sensitivity to the needs of the family will guide changes to the care plan.
- Include health care providers from care facilities (e.g., day care, nursing home, hospital, hospice) when updating the care plan.
- Add specialized services as the need arises (e.g., home health care, palliative care, hospice), and add those providers to the care team.
- Provide care partners with ways to access additional support (e.g., physical help, respite, meals, personal care of a person living with dementia) as the disease progresses.
- The PLwD and care partners are an integral part of the shared decision making process throughout the progression of the dementia.

Slide 32:

- These items are provided to allow faculty to evaluate what students have learned. The items can be used in several ways including given at the end of the lecture to assess knowledge or as a pretest and posttest to assess knowledge gain. These items have face validity. Psychometric testing was not conducted on these items.

Answer:

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

Slide 33:

Answer:

2. **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**

Slide 34:

Answer:

3. **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**

Slide 35:

Answer:

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