Frail Older Patient Care by Interdisciplinary Teams: A Primer for Generalists

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ABSTRACT. Frail older patients–unlike younger persons in the health care system or even well elders–require complex care. Most frail older pa-

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tients have multiple chronic illnesses. Optimum care cannot be achieved by following the paradigm of ongoing traditional health care, which emphasizes disease and cure. Because no one health care professional can possibly have all of the specialized skills required to implement such a model of health care delivery, interdisciplinary team care has evolved. This paper describes the roles of the participating team members in the context of interdisciplinary care for frail older adults. In addition, the challenges that occur when Geriatric Interdisciplinary (ID) Teams involved in providing care to frail older patients are identified and discussed. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2003 by The Haworth Press, Inc. All rights reserved.]*

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Until the 1940s, health care team members usually numbered two–a physician and the patient. Then, Montefiore Hospital in the Bronx doubled the size of the basic team–a social worker and a nurse were added (Baldwin & Rowley, 1976). In the 1970s, the University of Washington further expanded the team to include nutritionists, psychologists, and dental professionals. In the 1980s, interdisciplinary (ID) team care for geriatric patients was introduced–that included team members such as visiting nurses, therapists, social workers, and paraprofessional aides (Hyer, 1998).

However, while many geriatricians believe an ID team to be an effective and efficient model for delivering care to the frail elderly, the complexity of care required makes it a difficult approach to study, resulting in scanty coverage of ID team care in the literature. Even though they receive little information about the academic preparation, skills, and responsibilities of other members of the ID team, residents in training are expected to work competently and harmoniously with other providers as soon as they begin to practice (Qualls & Czirr, 1998). For example, as part of a hospital discharge plan, physicians are expected to supervise home care plans that specify the tasks of ID team members, yet they may know little about how each individual team member can best contribute to the patient's care.

As part of the John A. Hartford Foundation Geriatric Interdisciplinary Team Training (GITT) Program, three interest groups have devel-

oped concept papers detailing the specific team tasks of physicians, nurse practitioners, and social workers (GITTa, 1998; GITTb, 1998; GITTc, 1998; Hyer, 1998; Mellor & Lindeman, 1998), as well as the required educational preparation, the expected scope of practice, and the knowledge and skills needed to best contribute to the team. Faculty participating in development of the GITT Project believe that the care of frail older patients can be significantly improved by using the team approach. Only by uniting the experiences of professionals trained in different specialties can medical comorbidities, psychological and cognitive deficits, and social functioning be adequately addressed.

ROLES OF MEMBERS OF GERIATRIC ID TEAM

Medicine, nursing, and social work are considered to be the three core disciplines of Geriatric ID Teams (Aaronson, 1991; Christianson, Taylor & Knutson, 1998; Ouslander, Osterweil, & Morley, 1997; Qualls & Czirr, 1998; Taylor-Seehafer, 1998). Depending upon the needs of each individual patient, additional team members may also provide knowledge and skills from the disciplines of pharmacology, physical therapy, nutrition, occupational therapy, speech therapy, and psychology. Each team member will contribute his or her expertise at regularly held Geriatric ID team meetings (see Table 1). At these meetings, the work done by the individual team members is delineated. Much of the team process occurs outside of these meetings; daily telephone calls, interactions with specialists, and one-on-one encounters are crucial for providing optimum care to the frail older patient.

Physician's Role

The physician can serve as a team leader, a facilitator, a timekeeper, or simply a team member; often, this individual is the initial point of contact for patients and their families. When serving as case manager, the physician is responsible for completing and carefully reviewing the patient's history and physical examination. The most pertinent information–the differential medical diagnosis, the prognosis, and the impact that diagnostic tests and treatments may have on the patient's function, social situation, and quality of life, as well as specific aspects of all diseases identified, is shared and discussed among the team members. This information sharing ensures that the interventions selected take into consideration all aspects of the needs of the patient. The result is a com-

TABLE 1. Extended Team Members

DISCIPLINE	DUTIES	VALUE TO TEAM
Pharmacy	Medication review Patient education	• Spend more time with patients. • Detect problems with drug administration. • Advise team members about drug-drug interactions.
Dietary	Nutritional assessment Diet therapy Counseling and education	• Perform detailed nutritional histories. • Fashion customized diets for patients with complex nutritional issues.
Therapy Physical Occupational Speech Respiratory	Physical assessment Assessment of home environment	• Modify environment, daily habits. • Teach specific exercises to improve strength and function. • Order appropriate assistive devices and instruct patients regarding their use.
Psycho-spiritual Chaplain Clergy	Take spiritual histories Make mental and emotional assessments	• Provide extended counseling when necessary. • Extend comfort to patient and family regarding end-of-life issues.
Health administration	Ascertain funding status for patients Be repository for regulatory information	• Inform team members about services available to patients. • Advise team members of state and federal regulations.

prehensive assessment and care plan involving a broader range of health care resources than the physician alone could provide. While the physician must ensure that medical issues are given the proper weight in decision-making, at times the patient's medical condition is merely a peripheral issue and functional or social issues should be given primary emphasis.

Meetings are often conducted with several Geriatric ID Team members, the patient, and the family, with or without any caregiver. Any team member can lead these meetings, but when the major concerns are the medical problems of the patient, it is most appropriate for the physician to be the leader. Sometimes the family should not be included in the first meetings. By holding team meetings prior to family meetings, the team can present a unified care plan, and this inspires confidence and trust in the care being recommended and provided.

A continuing responsibility of the physician is to serve as a mentor and an educator. Physicians-in-training learn appropriate team behaviors from the physician, their model. Involvement with the Geriatric ID Team may be the first time that a trainee has worked closely with a physician; this initial interaction can greatly influence his or her perceptions about professionals practicing other disciplines and also about the interdisciplinary process of providing patient care.

Nurse Practitioner's Role

Geriatric nurse practitioners (GNPs) are vital to meet the demand for specialized primary care in geriatrics. The estimated 3,500 GNPs in this country account for approximately five percent of all nurse practitioners and practice in a variety of settings, including long-term care, home care, and acute-care hospitals. The roles of nurse practitioners vary and are influenced by factors that include the setting, the geographic location, and regulatory issues. A geriatric nurse practitioner is an expert in providing health care to older adults both independently and collaboratively with other health care professionals. The focus of the GNP role is to maximize functional abilities; promote, manage and restore health; prevent or minimize disabilities; and promote death with dignity. GNPs obtain comprehensive health histories; perform physical assessments; diagnose, manage, and evaluate common acute and chronic health problems; and promote disease prevention through health education (GITTb, 1998; Siegler & Whitney, 1994). Nurse practitioners confer with families, caregivers, home health and nursing home nurses, and other team members as needed to carry out the interdisciplinary care plan.

Most GNPs enter into collaborative practice agreements with physicians, but practice under their own licensure and certification, and have been granted prescriptive privileges in all but one of the fifty states. This contract between a physician and a GNP serves to define expectations. When agreements are clearly stated, acrimony over such issues as job responsibilities, charting requirements, peer review, and mechanisms for resolving disputes is less likely. Collaborative practice agreements are also mandatory in some states for prescriptive privileges. As geriatric experts, nurse practitioners often serve as a nursing resource and provide both formal and informal bedside nursing education. Some GNPs function in consultative roles conducting patient care rounds related to skin care, incontinence, and behavioral issues associated with dementia. As nurses often have the responsibility for coordination of

continuity of care throughout the health care system, often the GNP has strong preparation to serve as the case manager.

Social Worker's Role

As a member of the Geriatric ID Team, the social worker often serves as convener, facilitator, and patient advocate. Skills in listening, problem resolution, and negotiation foster collaboration as the team assists the patient and the family in setting priorities, establishing care goals, and balancing patient needs with the demands of an often overwhelming bureaucratic system.

Not only can the social worker assist others on the Geriatric ID Team in the management of an acute or chronic illness, but he or she can also help to determine whether the presenting medical problem is compounded by mental health problems. The social worker conducts holistic geriatric assessments, which determine how well the patient, as well as the family or the caregiver, is functioning within six separate but interconnected domains: physical, psychological, social, cultural, environmental, and spiritual (Mellor & Lindeman, 1998). Because the social worker identifies problems through diagnosis and assessment, establishes linkages to, and coordinates with community resources to facilitate the highest practical level of functioning for the patient and the family, he or she is often referred to as the case manager.

A patient's adaptation to illness exerts a profound impact on his or her quality of life, as well as on his or her willingness and ability to comply with the prescribed treatment plan, both of which are paramount to healing and recovery (Mellor & Lindeman, 1998). The social worker can identify and help to avoid barriers to medical compliance and service utilization and monitor the appropriateness and effectiveness of the services provided. This team member is also skilled in crisis intervention and in working within family systems (Boland & Leib, 1999; Mellor & Lindeman, 1998). Social workers counsel or treat mental health problems, such as anxiety and depression, to empower the patient and utilize a variety of techniques to assist the patient and the family to adjust to major life stressors and transitions. These techniques include group and family therapy, relaxation and stress management training, and supportive group counseling for both the patient and the caregiver.

It is the social worker's training in ethics, confidentiality, advance directives, cultural and ethnic factors, and patient and family rights that enables him or her to serve as patient advocate and liaison for the patient and the family with the professional community (Taylor-Seehafer, 1998).

THE TEAM APPROACH

The collaborative involvement of physicians, nurse practitioners, and social workers provides superior care to frail older patients. Because of the interplay of chronic medical problems with difficult psychosocial problems, sharing decision-making and the responsibility for care maximizes the contribution that each trained professional can make. This is particularly critical now that advanced technology enables treatments that previously required hospitalization to be provided in nursing homes or even in the patient's home. Treatments must be monitored in a variety of settings, and caregivers must be educated regarding new therapies or medication changes.

Recognizing that no individual practitioner possesses all of the knowledge and skills needed for managing the complex care of frail older patients, the American Geriatrics Society recently published curriculum guidelines for geriatric fellowship training for physicians and for geriatric team care training for residents (AGS Education Committee, 1998). For residents, the guidelines encourage formal training with Geriatric ID Teams to introduce them to meaningful patient-ID team interactions and coordination. For physicians, the guidelines specify an increase in the understanding of the skills and roles of other professional team members.

Most medical professionals are not taught the skills necessary to work on a team. Nevertheless, members of interdisciplinary teams caring for frail older patients as well as members of Geriatric ID teams must learn key interdisciplinary team skills: communication; collaboration; conflict resolution; coordination; brainstorming, joint decision-making; and team leadership.

Communication

Effective communication among team members is critical, and it is perhaps the most difficult skill to master. For example, physicians are taught to rule out diagnoses and use objective data to support their decisions; social workers are taught to broaden their assessments and search for psychosocial factors which might be influencing the patient; and nurse practitioners are taught to combine both models. Effective and efficient team members work to overcome these conceptual disciplinary differences and also to prevent overlap in role activities (Aaronson, 1991; Baldwin & Rowley, 1976; Christianson et al., 1998; GITTa,

1998; GITTc, 1998; Hyer, 1998; Ouslander et al., 1997; Qualls & Czirr, 1998; Siegler & Whitney, 1994).

Collaboration

Care for frail older patients requires understanding and trust among the providers and the caregivers. Each team member contributes his or her own special skills, as well as similar yet different strengths, and weaknesses to the team effort. Thus, collaboration among all of the team members is mandatory (Baldwin & Rowley, 1976; GITTa, 1998; GITTb, 1998; GITTc, 1998; Hyer, 1998; Mellor & Lindeman, 1998; Qualls & Czirr, 1998). This capability is what makes teams so effective in that they can be flexible and timely in response to the changing needs of the patient.

Conflict Resolution

Team members must be allowed to disagree; conflict is not only expected, but is encouraged and then managed. By questioning each other's opinions and then reaching an acceptable consensus, they ensure proper prioritizing of the different aspects of patient care during the creation of a care plan.

Coordination

Central to team care are the goals of the patient and the family. Goals must be stated clearly and explicitly in the care plan developed by the team for the patient. Goals should delineate tailored medical interventions and treatments, link specific providers to the treatments, and identify the priority of each of the needed care services. Then participation in implementing the care plan can be delegated, with mutual accountability (Baldwin & Rowley, 1976; GITTa, 1998; GITTc, 1998; Hyer, 1998; Qualls & Czirr, 1998). This is best achieved by freely sharing information and updating each other regarding changes in the care plan.

Joint Decision-Making

By sharing information and discussing the specifics of a patient's case, the expertise of each professional will help to advance the ability of the team to modify its activities as needed to achieve the established goals (Aaronson, 1991; Boland & Leib, 1999; Christianson et al., 1998;

Ouslander et al., 1997; Qualls & Czirr, 1998; Siegler & Whitney, 1994; Taylor-Seehafer, 1998).

Leading a Team

A team leader must be able to facilitate discussions, set agendas and goals, and use conflict to achieve the best possible recommendations for the patient. When teams function well, there is a comprehensive care plan and shared responsibility for good patient outcomes.

ESTABLISHING A NEW TEAM

Participants at the seven sites of the John A. Hartford Geriatric Interdisciplinary Team Training program have been convinced of the worth of team care as a management strategy. Before this approach becomes universally accepted, however, several problems must be addressed.

The first is the quantification of actions of the team. Not only are several team members immediately at work on each case, but also, when required for a particular case, specialized input is provided by additional professionals. Moreover, many of the recommendations for interventions and treatments and services are based on local availability and on the social support system of the individual patient. How can the effectiveness and efficiency of team actions be measured? How the team manages the creation of a care plan is one option; the degree to which the care plan actually meets all of the needs of the frail older patient is a second. No matter what measure is used, collection of valid and reliable data on each of the significant factors is difficult at best, which could explain the lack of relevant publications.

A second problem that must be addressed is the measurement of outcomes of multifaceted cases. Because of the extremely diverse case mix of frail older patients, conducting outcome studies is very difficult. The only geriatric team outcome study was reported in 1987 by Kerski and colleagues, who compared in-patient team care with the usual style of care (Kerski, Drinka, Carnes, Golob & Craig, 1987). Following 12 months of care, there were no differences in cognitive, affective, or functional status between the two groups. With regard to patient satisfaction, team care was rated higher than conventional methods of care. The sample size in this study was small, however, and the patients were well elders, so the results merely suggest what might be found in a comparable study of frail elders.

The third problem to address is the cost effectiveness of specialized services of a Geriatric ID Team. In 1997, Toseland and colleagues reported their comparison of the cost of care by a geriatric evaluation clinic staffed by a geriatric physician, a nurse practitioner, and a social worker with a general medicine clinic in a Veterans Affairs Medical Center. During the first eight months of the study, costs incurred by patients at the geriatric evaluation clinic were 34.8% higher than those incurred by patients at the VA medicine clinic; during the second eight-month period, the geriatric evaluation clinic patient costs were 37.8% lower, and this trend continued during the third eight-month period. However, in a recent randomized study by Cohen and colleagues, geriatric interdisciplinary care resulted in increased patient function and well-being at no increased costs (Cohen et al., 2002).

CONCLUSION

The complexity and interplay of chronic medical and difficult psychosocial problems of older adults necessitates the ID team approach. Advanced technology has brought the capacity to provide treatments at home or in the nursing home that were previously restricted to the hospital setting. Monitoring older adults in these community settings requires new skills, including the careful articulation of care plans among providers and support and education of caregivers. Care for fragile older adults requires a level of trust and understanding among providers and caregivers. An awareness that each team member brings complementary yet different strengths to the care of older adults is essential to good team dynamics and important to the efficient delivery of care.

Those who believe that geriatrics ID team care should be more widespread face many challenges. There is a need to document the approach, outcomes, and cost-effectiveness of this model to other medical professionals and health care administrators.

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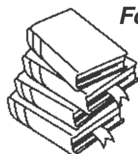
APPENDIX

Resources: The John A. Hartford Foundation, Inc., has funded a Geriatric Interdisciplinary Team Training (GITT) Resource Center located at New York University Division of Nursing (website: *www.gitt.org*). The website directs you to various educational products such as a pocket card developed for physicians and residents by the GITT Medicine Interest Group as well as curricula that can be adapted to fit several types of settings.

Two books on this topic have been written. The first is *Geriatric Interdisciplinary Team Training*, edited by E. L. Siegler, K. Hyer, T. T. Fulmer, and M. D. Mezey and published in New York by Springer Publishing in 1988. The second book, *Ethical Patient Care: A Casebook for Geriatric Health Care Teams*, edited by M. D. Mezey, C. K. Cassell, M. M. Bottrell, K. Hyer, J. L. Howe, and T. T. Fulmer, which provides examples of actual cases, was published by Johns Hopkins University Press in 2002.



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