IntegraCare M3: Multidisciplinary integrated approach

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This module explains what a multidisciplinary integrated approach means in providing health and social care support to individuals.

It demonstrates how important and useful is working together of professionals and practitioners from across different health and social disciplines around the needs of dependent people and their families in the concept of person-centered care.

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Module summary

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Abstract

This module explains what a multidisciplinary integrated approach means in providing health and social care support to individuals.

We will demonstrate how important and useful is working together of professionals and practitioners from across different health and social disciplines around the needs of dependent people and their families in the concept of person-centered care.

Learning objectives

1. Understand and implement an integrated approach in healthcare and social care.
2. Identify the rationale and elements of a multidisciplinary approach in providing care for people with different conditions.
3. Develop an understanding of the principles involved in providing multidisciplinary care.
4. Learn to monitor and evaluate a multidisciplinary integrated approach in different services.
5. Learn about the value of a multidisciplinary integrated approach in improving quality of life of dependent people.

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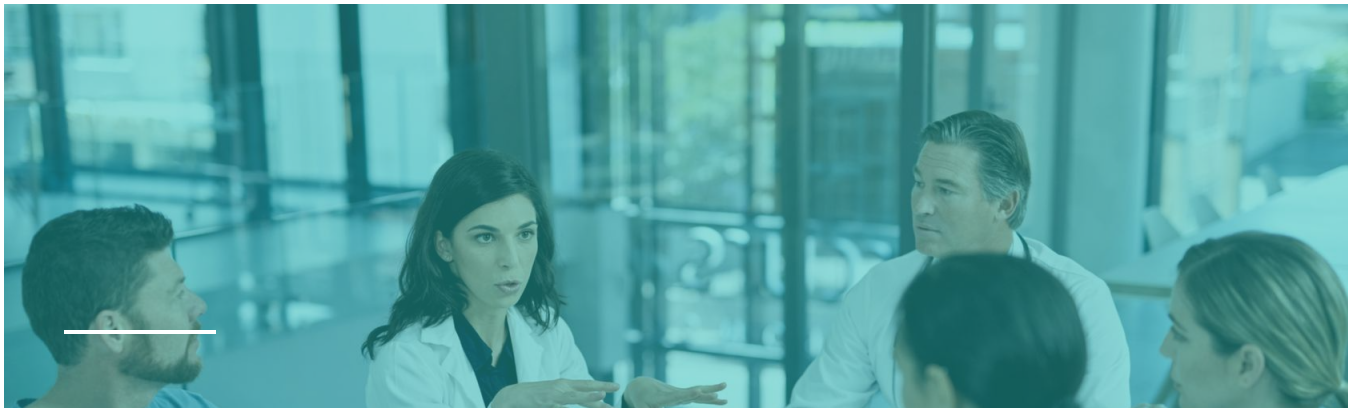
Duration 3 hours

START



Main concepts

INTEGRATED CARE | MULTIDISCIPLINARY TEAM | MULTIDISCIPLINARY CARE

Integrated care requires professionals and practitioners from across different health and social disciplines and sectors to work together around the needs of dependent people and their families, as well as and their communities.

A such collaborative approach can improve communication, save time, reduce duplication of effort, improve working relationships and provide a better experience for people who use health and social care services.

Integrated care concept is **designed to create connectivity and collaboration within and between the care sectors**. The aim of these collaborative approach is to provide high quality services, tailored to the multidimensional needs of the individuals and delivered by a coordinated Multidisciplinary Team of professionals and practitioners from across different health and social disciplines and even maybe sectors.

We are all aware that when someone has a great experience when using health or social care services this is often **the result of how different teams work together**. By integrating the efforts of diverse teams, you can often provide better care and a better experience for patients, careers as well as for staff.

Integrated care and support is the means to the end of achieving high quality, compassionate care resulting in better health and wellbeing and a better experience for patients and service users, their careers and families.

INTEGRATED CARE | MULTIDISCIPLINARY TEAM | MULTIDISCIPLINARY CARE

A **Multidisciplinary Team** (MDT) is a diverse group of professionals working together, that is aim to deliver person-centred and coordinated care and support for the person with care needs. They work together to provide holistic, coordinated and personalized care and support to dependent persons.

INTEGRATED CARE | MULTIDISCIPLINARY TEAM | MULTIDISCIPLINARY CARE

Multidisciplinary care is the care provided by a multidisciplinary team of professionals. These professionals work together to deliver comprehensive care that addresses as many of the person's needs as possible. This type of care can be delivered by a range of professionals functioning as a team under one umbrella organisation or by professionals from a range of organisations, including private practice. As each person's condition changes over time, the composition of the team may change to reflect the changing clinical and psychosocial needs of the person.

Let´s see an example!

Step 1

Michael´s case

Michael has asthma. In many cases, including Michael's, asthma is considered a complex condition. It affects his lungs, but it also causes inflammation, so it affects his immune system too. That means Michael will need to see an expert who specializes in the lungs, and another one who specializes in the immune system.

Step 2

Michael might also need to see a respiratory therapist to help with diagnostic testing and long-term management, an asthma counselor to help determine what's triggering the asthma, and, because asthma is often related to food allergies, maybe even a dietitian.

Step 3

These are five different specialists for one condition. It means that Michael's parents need to make five separate appointments to all those specialists.

Step 4

Multidisciplinary Integrated approach in care means that all the above-mentioned specialists, as well as other staff (nurses and many others) work as a team to address the individual needs of Michael's health treatment.

What’s more!

While these specialists are experts in their disciplines, they pay attention to what Michael and his parents say. In this approach, the person and their family have a central role in their care.

Benefits of a multidisciplinary approach

For dependent persons:

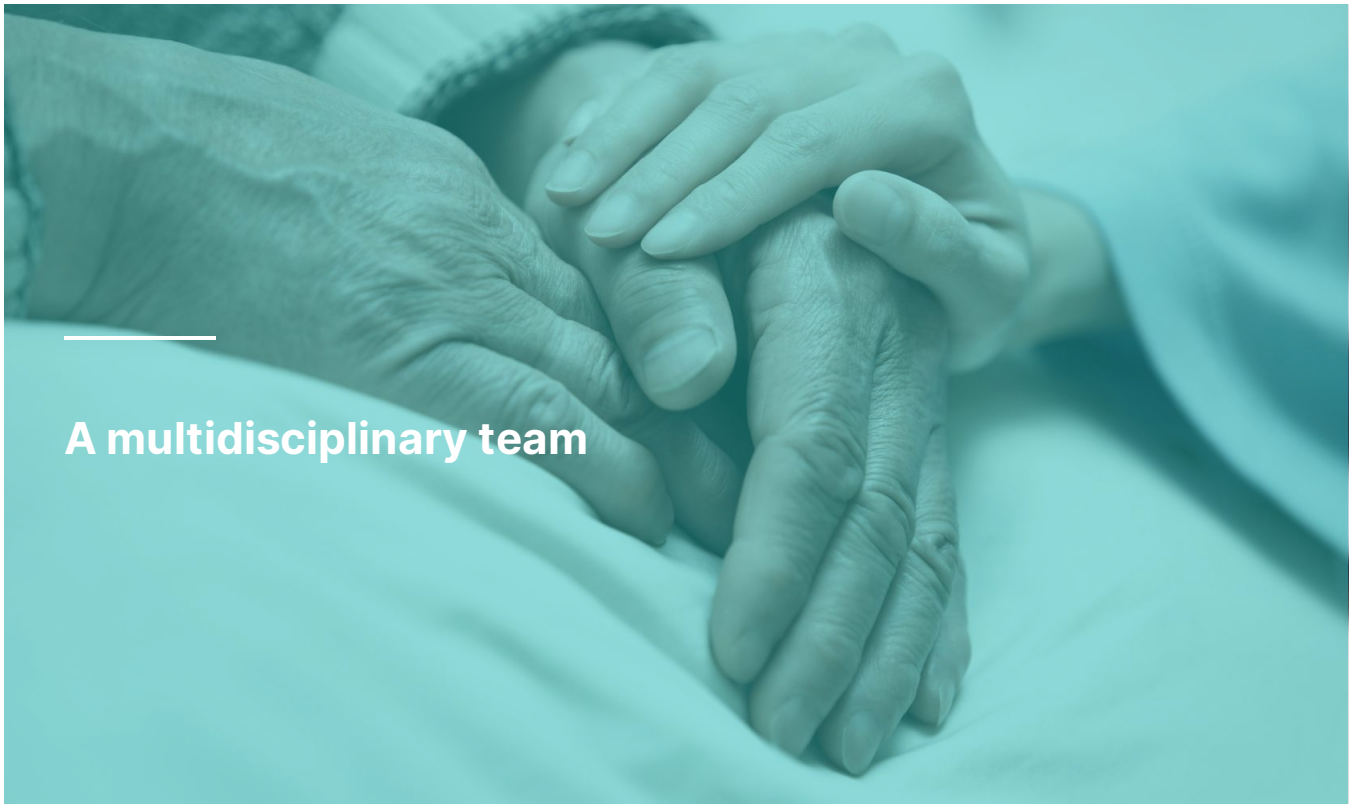
- Improved outcomes for individuals treated by the multidisciplinary care team
- Better access to health information
- Enhanced user satisfaction
- Improved treatment and care quality
- The shorter period from diagnosis to treatment
- Likelihood of receiving care according to standards/law, involving psychosocial support

For health professionals:

- Improved care coordination
- Better outcomes
- Streamlined treatment pathways and reduction in duplication of services
- More educational opportunities for health experts

The individual receives high-quality care because the services are well-coordinated, and there is a framework of uniformity provided to each person that improves their care path.

A multidisciplinary team



The multidisciplinary team

A multidisciplinary team is simply a diverse group of professionals working together.

The multidisciplinary team aims to deliver person-centred and coordinated care and support for the person with care needs.

This is usually a team of professionals, comprised of different disciplines and/or organisations in the health care and allied sectors that work together to provide holistic, coordinated and

personalized care and support to dependent persons.

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For example, a multidisciplinary team could include a doctor, a social worker, a physiotherapist, and/or even staff from local authority, as well as from a voluntary organisations. These professionals work together to deliver person centred and coordinated care and support for the person with care needs.

An effective Multidisciplinary Team can bridge professional and organisational specialisms and use the best of the knowledge and skills on hand to deliver great outcomes.

A multidisciplinary team in healthcare

- **In healthcare sector** a multidisciplinary care team is a team of professionals involving nurses, dietitians, primary doctors, and other staff who work together to give high-quality and coordinated care to dependent individuals.
- It often includes staff from all levels in the treatment pyramid, including aides, nurses, physician assistants, physical therapists, social workers, anesthesiologists, and attending doctors. These teams are more effective in managing care. Each member of the multidisciplinary care team is responsible for the provision of services or treatment in which they are experts.

- Doctors, nurses, and other health care professionals are ensuring the delivery of evidence-based care.
- Most multidisciplinary teams will have a key member assigned to the person, working as that person's primary contact point to the rest of the team.

Populations the multidisciplinary team works with

The simple answer is anyone who can benefit from comprehensive, continuous and seamless care. This includes adults, children, people with mental health problems and older people.

While suitable for people with single conditions, evidence indicates that integrated care is especially effective for people with complex needs. Improved outcomes include treatment planning, patient experience, and continuity of care.

CONTINUE

Multidisciplinary Integrated approach

Person-centered, collaborative and integrated care, provided by a multidisciplinary team.

This approach can deliver excellent results for a wide range of people with diverse needs and desired outcomes.

The ultimate goal is the provision of comprehensive, continuous and seamless care.

What are the most important principles of multidisciplinary care ?

Each Multidisciplinary Team is unique—it has its own purpose, size, setting, set of core members, and methods of communication. Regardless of the specific tasks, patients, and settings, effective teams throughout health care and social care are guided by basic principles. Four of them are the most important:

1. Person-defined goals of care
2. A team approach
3. Mutual trust and effective communication and
4. Standards of care.

Let´s take a look at them!

The principles of multidisciplinary care

Step 1

Person-defined goals of care

When the person and their nominated team members (including family members) where appropriate, are involved in decisions about their care.

The team, including the patient and, where appropriate, family members or other support persons—works to establish **shared goals** that reflect patient and family priorities, and can be clearly articulated, understood, and supported by all team members.

1. The patient, caregivers within the family, and the family itself must be viewed and respected as integral members of the team. High-functioning teams in health care strive to organize their mission, goals, and perfor-mance seamlessly around the needs and perspective of patients and families.

2. As part of integrating the patient into the team, high-functioning teams fully and actively embrace a shared commitment to the patient's key role in goal setting. E.g. the first meetings with the patient and family, or an initial interview is used to begin the process of developing shared goals of the care. Patients and families may not expect the full extent of services available. When such a comprehensive approach to patient needs is taken, though, patients and families are grateful to know that the team will collaborate with them to meet their needs to the extent possible.

3. Teams regularly eval-uate their progress toward the shared goals and work together with patient and family members to refine and move toward achieve-ment of these goals.

Step 2

A team approach

Recognised as a clear roles of each member's team and input from as many professions as required is achieved

There are clear expectations for each team member’s functions, responsibilities, and accountabilities, which optimize the team’s efficiency and often make it possible for the team to take advantage of division of labor, thereby accomplishing more than the sum of its parts.

Members of care teams often come from different backgrounds, with specific knowledge, skills and behaviors established by standards of practice within their respective disciplines. Additionally, the team and its members may be influenced by traditional, cultural, and organizational norms present in health care environments. For these reasons it is essential that team members develop a deep understanding of and respect for how discipline specific roles and responsibilities can be maximized to support achievement of the team’s shared goals. Attaining this level of understanding and respect depends upon successful cultivation of the personal values necessary for participating in team-based care, noted above.

Integrating patients and families fully into the team represents a particular challenge that requires careful planning. Patients and families are unique members of the team in several ways. First, patients and families often do not have formal training in health care. If patients and families are to be full members of the team, they must understand their fellow team members. Second, a number of different patients and families typically come in and out of the team many times per day. This requires continual adaptation by other team members.

Since roles on the team vary by both professional capability as well as function, patients and their caregivers must be fully informed about these roles. Each team member should communicate his or her role clearly and solicit input from others, especially the patient and family, so that all responsibilities are clearly defined and understood.

Step 3

Mutual trust and effective communication

Team members earn each others' trust, creating strong norms of reciprocity and greater opportunities for shared achievement. The team prioritizes and continuously refines its communication skills. It has consistent channels for candid and complete communication, which are accessed and used by all team members across all settings.

Trust is allowing team members to rely upon each other personally and professionally and enabling the most efficient provision of health and social care services. Achieving a team with norms of mutual trust requires establishing trust, maintaining trust, and having provisions in place to address questions about or breaches in trust. When a strong trust fabric is built, team members are able to work to their full potential through relying on the assessments and information they receive from other team members, as well as the knowledge that team members will follow through with responsibilities or will ask for help if needed.

Establishing and maintaining trust requires that each team member hold true to the personal values of honesty, discipline, creativity, humility, and curiosity, which together support the creation of an environment of mutual continuous learning.

If the team members are unable to provide information and understanding to each other actively, accurately, and quickly, subsequent actions may be ineffective or even harmful. In the digital age, team communication is not limited to in-person communication, such as in team meetings. It incorporates all information channels like e.g. progress notes and electronic health records, telephone conversations, e-mail, text messages. Many channels of communication may be employed by team members to achieve their purposes. The framing and content of that communication is the core of effective communication. Effective communication should be considered an attribute and guiding principle of the team, not solely an individual behavior.

Step 4

Standards of care

Provision of care is in accordance with agreed standards. There are measurable processes and outcomes settle down.

The team agrees on and implements reliable and timely feedback on successes and failures in both the functioning of the team and achievement of the team's goals. These are used to track and improve performance immediately and over time.

Key components of effective multidisciplinary care

The key attributes of an effective and efficient multidisciplinary team:

- Collaborative practice.

- Clear communication.
- Clear definition of tasks and responsibilities.
- Clear goals, objectives and strategies
- Recognition of and respect for the competence and contribution of each team member.
- Competent leadership.
- Clear procedures for evaluating the effectiveness of the team.
- Support for team members as required.
- Recognition of the contribution of team members' experience.

Interpersonal skills that may contribute to effective team communication are :

- Communication and negotiation.
- Self-awareness.
- An ability to self-reflect.
- An ability to apply principles of self-care.

CONTINUE

Tools for implementing multidisciplinary integrated care

Individual Care Plan

Shared electronic records

The individual care planning process

An individualized plan of care is developed through contributions from all relevant disciplines, It is based on a comprehensive assessment and understanding of the individual's needs and preferences with the contribution of their significant others.

The multidisciplinary team works both autonomously and together with individuals, families and careers to clarify the goals of care and develop a single, coordinated, needs-based care plan.

Each professional in the team follow an evidence-based approach when creating the care plan.

During the care planning process the following are taken into account:

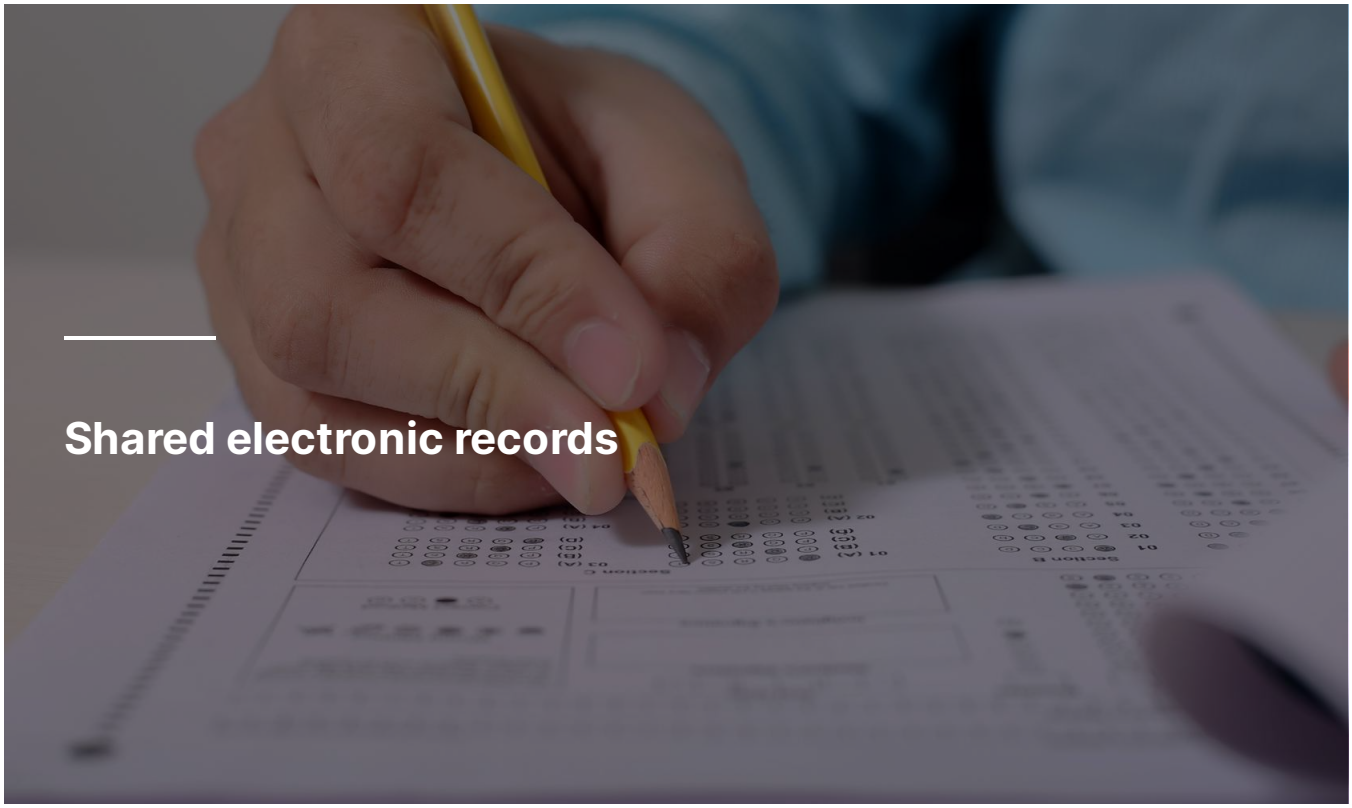
- Current health status and past medical history, including all comorbidities
- Physical and psychological symptoms

- Functional status
- Social, cultural, spiritual aspects
- Advanced care planning preferences.

The multidisciplinary team communicates regularly (the frequency of the meetings depends on the situation) to review and evaluate the care plan.

The care planning process involves the family of the person in care

Family meetings are conducted in order for the family members to be informed about the care process and to also assist with certain aspects of care planning and provision.



Shared electronic records

Shared electronic records

- Information sharing is a crucial aspect of providing multidisciplinary integrated care.
- The multidisciplinary team of professionals should be able to have access to the person's records in order to implement a holistic approach. It is common that, this information may need to be shared with other multidisciplinary teams and organisations.
- Keeping electronic medical and care records is a useful tool for multidisciplinary professionals to access information about the person that receives care.
- It is important that information is shared securely according to the law.

Monitoring and evaluating a multidisciplinary integrated approach

Monitoring and evaluation methods in healthcare need to take into consideration all aspects of care and more specifically how these benefit the service user and their caregivers.

Ways of monitoring and evaluating the multidiscliplinary integrated approach

Methods that are focused on the person

- Assessments of their health status before and during and after the implementation of the care plan
- Assessment of quality of life before during and after the care plan (eg. quality of life questionnaires)
- User satisfaction questionnaires
- User and family feedback

Methods that are focused on the system/team

- Duration of stay in an inpatient facility
- Frequency of hospitalization
- Systematic team meetings
- Team work and cooperation evaluation
- Care plan objective achievement
- Cost-effectiveness of the care plan

Successful examples

Example 1

Model of social support for the elderly in the living environment

Step 1

The model of social support for older people in the living environment was designed with the housing of these people in mind, as well as the local environment and the institutions and communities functioning in it.

Step 2

Activities that create the conditions for staying in your own apartment should be implemented on three levels:

- Material
- Organizational
- Social

Step 3

Material

Consisting in adapting the premises to the needs of their residents, removing all kinds of architectural barriers, introducing amenities in moving around the apartment and performing daily activities.

Step 4

Organizational

Consisting in a gradual increase, as needed, of the scope of services provided at home based on an integrated system of cooperation and cooperation between government and local government institutions and organizations, non-governmental and private.

Step 5

Social

Consisting in establishing and maintaining a local support network including informal carers, neighbours and volunteers.

Similar (comprehensive), related to the replenishment model is the concept of ageing in place. The key assumption of this concept is to support the individual in staying in their living environment through programs supporting their existence. The complement model, emphasizing the importance of the family due to its key role in supporting the elderly in ageing in their current environment, is an implementation of the ageing in place concept.

Example 2

Day care centre for older adults

Step 1

The Day Care Centre offers different types of services such as a memory clinic, psychosocial interventions, counselling, physical therapy and various activities for older adults. The professionals that work in the centre include, neurologists, neuropsychologists, psychologists, social workers, nurses, physical therapists and administrative personnel.

Step 2

When creating a care plan for each individual, the healthcare professionals of the day care centre take into consideration all the characteristics and needs of the person including their social and financial situation, their mobility needs, the type of assistance they have access to etc. The healthcare professionals working at the centre always show empathy towards the problems the users face, offering individualized care, cooperation with the people and looking at the person as a whole rather than focusing on the disability.

Step 3

During this process of making the care plan both the person and the caregiver/family members are involved in the process of evaluation, decision making and intervention. The healthcare professionals of the centre interview both the person of interest and the caregivers/family members in order to acquire enough information and be able to formulate a well-rounded view of the situation.

Step 4

The healthcare professionals composing the team focus a lot on the value of teamwork and cooperation in order to provide high quality services for the users, also for maintaining a good working environment. They value the role and contribution of each different discipline and professional and view their services as a collective effort where everyone is inseparable to the others. In order to keep the team bonded, they communicate often with each other, they have a viber group for personal communication, they try to spend time together and organize activities such as trips, meals and exercise groups. Finally, they highlight the importance of discussing the issues that arise both among them and with the supervisor and the importance of having clear boundaries between the different professional and fields.

Step 5

Once a week the team of healthcare professionals has a staff meeting. In this meeting they discuss the difficulties they faced during the week and make decisions on these matters. Specifically, they gather all the information that the professionals of the different principles have collected about each person; based on all the information they discuss and take collective decisions about the intervention plan they will suggest. Furthermore, there is room and time for everyone to express their thoughts and concerns and receive feedback from the team and the supervisor. In addition to the weekly staff meetings, there is external scientific supervision for the healthcare professionals which takes place once a month.

As for information sharing, the healthcare professionals keep detailed daily journals regarding what happens in the day centre in a common excel drive. They also use this drive as a means to communicate with each other, they write comments and messages for their colleagues. All staff members have access to the file and check it every time they are on a shift. The users' records are kept in an online database by all the healthcare professionals.

Think about an example from your own experience where a multidisciplinary integrated approach to care was provided. In thinking about this example, identify:

- who was involved?

- why this approach was used?

- what benefits were achieved by this approach?

- what challenges were associated with this approach?

Module summary

In this part of the course you have learnt about multidisciplinary care approach that are the mechanism for organising and coordinating health and care services to meet the high standards of the health and social care services for dependent people and their family. You have learnt about the core principles of multidisciplinary teams. You have got practical information about the tools that you can use the establishment and sustain effective team-based care of dependent people.

The implementation of effective multidisciplinary care and teams is possible using common touchstone principles and values that can be measured, compared, learned, and replicated.

The multidisciplinary approach bring together the expertise and skills of different professionals to the one purpose: to deliver high quality needs of individuals with care needs. This collaborative approach improve communication, save time, reduce duplication of effort, improve working relationships and provide a better experience for people who use health and social care services.

Key words

Multidisciplinary team

A multidisciplinary care team is a diverse group of professionals working together to give high-quality care and coordinated care to patients or person. The multidisciplinary team aim to deliver person-centred and coordinated care and support for the person with

Multidisciplinary Care

Multidisciplinary care occurs when professionals from a range of disciplines work together to deliver comprehensive care that addresses as many of the person's needs as possible.

Individual Care Plan

An individualized plan of care is developed through contributions from all relevant disciplines based on a comprehensive assessment and understanding of the individual's needs and preferences; involving their significant others.

Monitoring and evaluating the multidiscliplinary integrated approach

- Methods that are focused on the person
- Methods that are focused on the system/team