Achieving Holistic Dementia Care via Interdisciplinary Collaboration

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Goals of the Program

• Describe changes that occur in individuals with dementia across varying stages of the disease process
• Define characteristics of effective interdisciplinary collaboration
• Identify key components of innovative practices that illustrate effective interdisciplinary collaboration in dementia care
What is Dementia?

A progressive decline in cognitive function due to damage or disease of the brain and affecting two or more areas of cognitive function and interfering with day to day function.
# Most Common Causes of Dementia

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Most obvious deficit</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Alzheimer’s disease</td>
<td>• Memory loss, language losses and executive function are the first noted changes</td>
</tr>
<tr>
<td>• Vascular dementia</td>
<td>• Loss of attention most obvious, with changes in other cognition and motor function occurring based on location of lesions</td>
</tr>
<tr>
<td>• Mixed etiology*</td>
<td>• Likely the most common cause of dementia. Memory impairment common, but with greater variability in other losses</td>
</tr>
<tr>
<td>• Lewy Body Dementia</td>
<td>• Psychiatric changes and motor loss. Fluctuations in mental status common.</td>
</tr>
<tr>
<td>• Frontotemporal Degenerations</td>
<td>• Behavioral disinhibition and fluctuating mental status. Early onset typical.</td>
</tr>
</tbody>
</table>
## Age and Cognitive Impairment

<table>
<thead>
<tr>
<th>Age Group</th>
<th>None or Mild BIMS 13-15</th>
<th>Moderate BIMS 8-12</th>
<th>Severe BIMS 0-7</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Average</td>
<td>35%</td>
<td>26%</td>
<td>38%</td>
</tr>
<tr>
<td>Age 75-84 in PA</td>
<td>34%</td>
<td>27%</td>
<td>39%</td>
</tr>
<tr>
<td>Age 85-94 in PA</td>
<td>26%</td>
<td>28%</td>
<td>47%</td>
</tr>
<tr>
<td>Age 95+ in PA</td>
<td>18%</td>
<td>28%</td>
<td>53%</td>
</tr>
</tbody>
</table>

Alzheimer’s Demographics 2015

Quick Facts

- It’s the only cause of death in the top 10 in America that cannot be prevented, cured or slowed.

- Almost two thirds of Americans with Alzheimer’s disease are women.

- 1 in 3 seniors dies with Alzheimer’s or another dementia.

- Alzheimer’s disease is the 6th leading cause of death in the United States.

- Only 45% of people with Alzheimer’s disease or their caregivers report being told of their diagnosis.

- More than 90% of people with the four most common types of cancer have been told of their diagnosis.

- By 2050, these costs could rise as high as $1.1 trillion.

- In 2015, Alzheimer’s and other dementias will cost the nation $226 billion.

What Changes in the Brain?

• **Cellular**
  - senile plaques
  - neurofibrillary tangles

• **Chemical**
  - Decreased acetylcholine
  - Dementia medications inhibit reuptake of acetylcholine

• **Electrical**
  - EEG evidence of slowed brain wave activity
  - Loss of connection between cells

• **Neuroanatomical**
  - Hippocampus
  - Amygdala
  - Temporal, parietal and prefrontal lobe disconnect

• **Structural**
  - Atrophy
  - Enlarged ventricles
A Summary of Disease Progression

What is Alzheimer's disease?
New Perspectives on Alzheimer’s

• Prompted by ability to detect pathophysiological processes
• Expanded conceptualization of the disease spectrum and progression
• Recognition that underlying disease and clinically observable syndromes are not in complete correspondence
• Proposes a disease progression that moves from pre-clinical to late stage dementia
• Utilizes biomarkers within clinical criteria
• Increased focus on role of biomarkers in AD research
Hypothetical model of AD pathophysiology

Age Genetics ➔ Cerebrovascular risk factors Other age-related brain diseases

Amyloid-β Accumulation ➔ Synaptic Dysfunction Glial Activation Tangle Formation Neuronal Death

Continuum of Diagnosis and Care
Implications…

• Dementia is a moving target which varies by:
  – Etiology
  – Stage of progression
  – Quality of interaction between caregiving and capacity

• Treatment and cure are not likely to be available in the near future

• Quality of care becomes the primary mechanism to improve quality of life and reduce suffering.
More Importantly…

• People with dementia retain many strengths, skills and gifts, even as the disease advances.
• Holistic care recognizes and supports wellbeing across a range of dimensions.
• To effectively support holistic care grounded in best practice, a team approach is needed.
Personhood

...a standing bestowed upon one human being by others in the context of relationship and social being...Implying recognition, respect and trust

Foundations of Best Practice Dementia Care

• Strength based focus
• Primacy of relationship
• Meaningful engagement
• Recognition of individual purpose and value
• Focus on wellness and brain health – in spite of disease
Wellness: Modifiable Risk Factors

Top 7

• Exercise
• Depression
• Smoking
• Hypertension
• Obesity
• Diabetes
• Education (proxy for cognitive stimulation)

Also: Stimulation, Connection and Inflammation

• Stress reduction
• Avoid head injury
• Social support
• Meaningful engagement
• Diet

Determinants of Well Being

Person Centered Care

“Overall, dementia care in this country is impersonal and fragmented, and this paper is a call to action to change to what is considered the gold standard — a person-centered approach.”

Interdisciplinary Collaboration

“Geriatric care can be complex and time intensive, and many medical, psychosocial, and functional issues must be addressed simultaneously. For treatment to be effective, it must be carefully coordinated. The use of an interdisciplinary team (IDT) is an accepted and well-developed model for care coordination. IDTs have been successfully implemented in a variety of settings and have been shown to improve healthcare outcomes.”

American Geriatrics Society, 2011

Complex and Interrelated Needs

- Medical Issues
- Function
- Medications
- Financial resources
- Social supports
- Cognition
- Person-environment fit
- Emotional status

Identified Needs
Wrap Around Care

- Caregivers
- Healthcare providers
- Informal Supports
- Community Supports
- Social Service Providers

Older Adult
Let’s Define Our Terms…

**Unidisciplinary**
- One profession
- One level of expertise

**Intradisciplinary**
- One profession
- Different levels of expertise
- One level supervises another level

**Multidisciplinary**
- Multiple disciplines
- Varied levels of expertise
- Each discipline operates independent of others
- Communication is inconsistent and care is not coordinated

**Interdisciplinary**
- Multiple disciplines
- Multiple levels of expertise
- Care is coordinated across disciplines
- Each discipline contributes to assessment, care plan and treatment

**Intraprofessional**
- Term preferred in Europe
- Similar to interdisciplinary
- Enhanced respect for and understanding of the contributions of each discipline

Basics of Interdisciplinary Teams

- Grounded in appreciation for Biopsychosocial and spiritual model of care
- Respect for contributions of each discipline and level of expertise
- Active collaboration in all phases of care, i.e. assessment, care planning, intervention and assessment of outcomes
- Consistent communication and coordination of activities
- Patient and family considered team members and integrated into decision making
Principles of Effective Teamwork

1. Positive leadership
2. Communication structures
3. Personal rewards of participation
4. Training and team development
5. Resources and procedures to support team
6. Appropriate skill mix
7. Support team climate
8. Individual characteristics that support teamwork
9. Clarity of vision
10. Respecting and understanding roles of each member

Necessary for Effective IDT

• Training in Interdisciplinary Collaboration*
  – Positive attitudes toward team collaboration
  – Knowledge of group dynamics and teamwork
  – Knowledge of broad geriatric issues and appreciation for varied roles and responsibilities of each discipline
  – Expertise in communication, conflict resolution, cooperative decision making and analysis of personal and team performance

• Knowledgeable guidance of the team process
• Dedicated time for team meetings
• Structure and processes for meetings and follow up
• Administrative and institutional support

Opportunities for Interprofessional Collaboration

It Takes a Village

• In light of multiple losses and co-morbidities, geriatric care is complex
• Moreover, CARE (defined broadly) is our primary objective in the context of dementia
• A holistic “wrap around” approach is necessary to support well being and personhood
• Effective interdisciplinary collaboration is a primary vehicle for this kind of care
References


References


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References


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[http://www.alz.org/national/documents/brochure_DCPRphases1n2.pdf](http://www.alz.org/national/documents/brochure_DCPRphases1n2.pdf)

Brain Health As You Age: [http://www.acl.gov/Get_Help/BrainHealth/Index.aspx](http://www.acl.gov/Get_Help/BrainHealth/Index.aspx)
For More Information

Phoebe Center for Excellence in Dementia Care
610-794-5141
www.phoebe.org/cedc
Development of Effective Interdisciplinary Teams

Programmatic Development Neurocognitive Engagement Therapy (NET)
What is NET?

• **Innovative approach to effectively provide therapy services to individuals with cognitive loss and dementia.**

• **Goals of NET:**
  – Improve the function of individuals with cognitive impairment by fully engaging them in therapeutic activities that address underlying physical impairments
  – Techniques utilized in NET will draw upon the interests, abilities and strengths of the individual while also addressing the physical impairments contributing function loss
  – Interventions draw upon the life history and abilities of the individual and serve as familiar and enjoyable activities, making the individual more likely to engage fully in the therapy process.
Neurocognitive Engagement Therapy

- Developed to address problems in traditional Therapy practices
  - Therapists have a difficult time providing effective treatment sessions to patients with cognitive impairment
    - Lack of comfort
    - Lack of training, clinical practice, and mentoring through the education process
    - Patients with cognitive impairment do not respond as well to traditional therapy techniques
  - Care provided to patients with cognitive impairment may be withdrawn due to poor engagement in therapy sessions
A Picture is Worth a 1,000 Words

Phoebe NET video on YouTube
Development of an Interdisciplinary Program

Problem
Identify and define the problem

Team of Experts
Convene experts together to develop strategies

Testing
• Work the strategies in the actual environment
• Team communication and assessment of finding

Program
• Implementation
• Regular Team assessment
Programmatic Examples

• NET Team Rounds

Convene a Team

- Physical Therapist
- Occupational Therapist
- Speech Therapist
- Social Services
  - Nursing
  - Dietary
  - Housekeeping
- RNAC

Team Communication
Programmatic Example

• NET Team Rounds
  – Test the solution in the live environment
  • Utilize interdisciplinary team strategies
    – Respect for contributions of each discipline and level of expertise
    – Active collaboration
    – Consistent communication and coordination of activities
    – Patient and family considered team members and integrated into decision making
Barriers to Program Implementation

**Barriers**
- Time of Rounds
- How much time daily can everyone spare
- Location

**Solutions**
- Selected a time that limited the impact to patient care
- Communication with team and leadership to determine an acceptable time limit and the offset to other activities
- Select a location that limited impact to patient care but protected patient privacy
Programmatic Example

- NET Dining – Breakfast

Problem

- Patients arriving to the Dining Room for Breakfast

Convene the Team

- Weekly NET Interdisciplinary Team Meeting
### Barriers to Program Implementation

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Solutions</th>
</tr>
</thead>
</table>
| • Volume of patients to get ready for 1 hour point of service breakfast meal | • Identify the amount of patient ADLs nursing and therapy can complete by 8am  
• Order robes for all rooms to allow patients to go to breakfast comfortably |
Ongoing Programmatic Assessment NET
Dining - Breakfast

**Barriers**
- Volume of patients to get ready for 1 hour point of service breakfast meal
- Space Limitations of Dining Room

**Solutions**
- Expand the service times of Breakfast with a continental breakfast service
- Utilize staggered seating times and adjacent unit’s dining room space