Transforming Care via Teamwork and People Skills

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Our Learning Objectives…

• Define at least 3 signs of Person Centered Care (PCC)
• Describe the ways in which medical model approaches can interfere with PCC
• Analyze the benefits of psychosocial theories and approaches in PCC
• Discuss the ways in which mental health providers can offer leadership and to interdisciplinary processes directed at PCC
A Bit of Context….

• 61.5% of nursing home residents present with moderate to severe cognitive impairment*

• 49% of nursing home residents in the US present with a diagnosis of depression**

• The average 75 year old has 3 medical comorbidities and is on 5 medications***

• 43% to 68% of NH residents have 4 to 5 functional losses*

*2015 Nursing Home Compendium, Center for Medicare and Medicaid Services

**2011-2012 data from the Center for Disease Control, retrieved at: https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6304a7.htm

***Medical Care for the Elderly, National Care Planning Council, 2017
Person Centered Care

- Term first coined by Thomas Kitwood
- Dementia Reconsidered (1997)
- Response to the loss of “personhood” in care for residents with dementia in long term care settings
- Concept adopted by advocates of culture change
- Now widely accepted as the standard of care
Tenets of PCC

• Care is directed by the needs, preferences and values of the individual
• The individual has the freedom to exercise choice and assert control over care
• Care is delivered within the context of genuine and respectful relationship with the care provider
• Care is holistic – taking into account the emotional, social, physical and spiritual
Implications of PCC

• It’s not about us or our convenience
• We must view ourselves as partners with the patient and be willing to cede control
• Having a genuine relationship means we must know the person and understand their values and preferences
• Current systems – based on hierarchical medical models – don’t do PCC well
• Holistic care requires an interdisciplinary approach
Barriers Created by Medical Model

• Focus is on deficit and disease remediation – rather than strengths and relationship
• Collaboration among providers is hierarchical – valuing physical over all other aspects of the person
• Convenience and efficiency of staff take priority over individual needs
Artifacts of Culture Change

- Assessment tool commissioned by CMS and funded by the Commonwealth Fund
- Developed for use in long term care settings to assess culture change
- Culture change is defined as movement toward PCC and homelike environment
- Defines 6 domains and 79 observation points to determine presence of culture change and PCC
- Available on Pioneer Network website
Domains of PCC

- Care practices
- Environment
- Treatment of Family and Community
- Leadership
- Workplace practices
- Outcomes and occupancy rates
Healthcare is Late to the Party

- The same tenets we call PCC can be observed in the “culture change” in other industries and care for special populations
  - Mental health: Recovery and resiliency
  - IDD: “Everyday Life”
  - Substance Abuse: Recovery
  - Children’s Services: Wrap around care
Psychosocial Contributions to PCC

• Thought leaders in the field are professionals from psychosocial disciplines
  – Nursing and medicine are recent adoptees

• PCC is based upon foundation of Rogerian and humanistic theories in psychology
  – Operates within genuine relationship
  – Ensures unconditional positive regard
  – Emphasizes the role of understanding the client perspective and experience
  – Focusses on strengths and potential over deficits
Mental Health Toolbox

• Communication
• Relationship building
• Empathy as a tool in healing
• Understanding the viewpoint of the other
• Group facilitation
• Conflict resolution
• Behavioral analysis and intervention
IN SUM, MENTAL HEALTH PROFESSIONALS ARE TRAINED IN AND EXPERT AT THE VERY TOOLS THAT SERVE AS THE FOUNDATION OF PCC

• Fostering relationships
• Understanding the perspective of others
• Team facilitation, communication skills, and conflict resolution
• Interventions that are behaviorally based and driven by person-centered assessment
How can MH Professionals Help?

• Psychological and behavioral expertise – as contribution to holistic care
• Guidance in development of person-centered and behavioral interventions
• Training, mentoring and modeling of PCC philosophy and approaches
• Facilitation of dynamic interdisciplinary team processes
Complex and Interrelated Needs

Identified Needs

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

Medical Issues

Function
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

Benefits of IDT Collaboration

Healthcare Outcomes
- Improved clinical outcomes
- Improved coordination of care and care transitions
- Decreased healthcare costs

Healthcare Processes
- Improved work environment
- Maximize efficiency and impact in context of workforce shortages
- Improved job satisfaction – particularly among less empowered staff.

Phoebe
“Unfortunately, teams, let alone effective ones, don't just happen. It takes training”.

Hartford Institute for Geriatric Nursing (2016).
http://hartfordign.org/education/gitt/
Community Care Team Model

- Developed in 1990 as part of the **Eldercare Method**
- Offered in a range of regional long term care settings
- In response to unmet behavioral health needs in long term care
- Predicated on principles of “wrap around” care
- Evidence informed model aligned with Geropsychology guidelines and best practices

Community Care Team Participants

• **Neighborhood based:**
  • Mental Health Professional - Facilitator
  • Licensed nurse(s)
  • Social services
  • Community Life
  • CNA’s and other direct care workers
  • Housekeeper, dietary staff, chaplain and/or RNAC – as appropriate
Community Care Team Process

• Weekly 1-hour team meetings
• Resident reviews informed by interdisciplinary assessments and observations
• “Collaborative discussion”* - shared problem solving and decision making
• Development of a Person Centered Behavioral Support Plan

And also, CCTs lead…

• “Quality Improvement” projects developed to support person centered care
• Enhancing environmental and procedural contributions to PCC
• Measurement and monitoring of clinical outcomes, team effectiveness and process
• Staff support and education
Community Care Team Outcomes

- Enhanced person centered care
- Reduction in falls, antipsychotic medications, staff injuries and responsive behaviors
- Increased staff satisfaction
- Empowerment of direct care staff
- Increased problem solving at level of neighborhood

In Sum...

- PCC is the right thing to do and is expected by all stakeholders, but
- Is not easy to achieve in medically oriented care settings
- Infusion of “the second half” of biopsychosocial expertise will enhance PCC
- MH professionals are equipped to support staff, residents, families and organizations in the culture change journey.
A Final Thought…

…those of us who have chosen to specialize in work with older adults have particular compassion for those who have lived long enough to face the challenges of diminishing health and vigor. We appreciate the wisdom of years and recognize the resiliency and courage that it takes to live a long life with all of its joys and sorrows. We want to help elders to live their lives well until their time is done.
And so....

Regardless of the reason for our presence within long term care settings, once we are there, we cannot help but see the multiplicity of factors that affect the happiness and wellbeing of those who reside and work in these settings. And once we have seen the factors at play, how can we not attempt to intervene? How can we possibly bring less than the full extent of our professional skills and resources to bear on behalf of those who suffer and struggle in long-term care?

For More Information,

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Bibliography


Bibliography


