Chapter 2
The Team Approach for Those with MNCD: Interdisciplinary and Collaborative

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A high-functioning team is critical when caring for older adults with dementia. Theoretically a simple concept, teams become complicated when working with those having multiple and complex functional needs. Healthcare and the provision of daily services for older adults with competing opportunities and challenges are difficult at times. Definitions, benefits, and drawbacks of multidisciplinary and interdisciplinary teams focusing on collaboration will be explored in this chapter. Potential members of a team, their scope of practice and roles on a team specifically designed to work with those with major neurocognitive disorders, and examples of potential roles will then be reviewed. There are multiple visions for what constitutes an ideal team. The actual team that one is a member of is often driven by external constraints unrelated to the ideal model of care, for example, the existence and experience of specific professionals in the area one lives, the financial resources of the person, and the specific healthcare or social system one belongs to in addition to other indi-

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vidual factors. Similarly, the type of team one is likely to need depends on where one is living: one's own home, an assisted living facility, a memory care community, or a nursing facility. Communication is the cornerstone of successful teamwork as well as high-quality care. Several techniques to enhance communication in teams will be discussed.

There are many examples of the need for good team-based care of those living with dementia. Studies of older adults newly receiving community-based long-term supports and services (LTSS), many of whom have dementia, found common barriers to person-centered care: disorganized and poor staff communication; substantial delays in receiving care when older adults were transferred to the emergency department; perceived inaccessibility and poor responsiveness of healthcare staff in hospital settings; little to no transfer of information about individualized needs, goals, and plan of care at the time of transfer; limited preparation and time for staff in both LTSS and hospital settings to respond to residents' acute and long-term needs; and lack of mutual respect between acute and long-term care staff [12]. These are the types of challenges that a successful team implementing comprehensive person-directed and person-centered care can minimize.

Individual Providers Versus a Multidisciplinary Team Versus an Interdisciplinary Team

Usual Care

When there are a group of individual providers, different specialists and professionals may not even know that others are seeing the person. Even if they are aware that others are involved, they do not share records or assessments; they do not have team meetings to discuss a person and their situation. The healthcare providers do not think of themselves as part of the same team with each other, the person living with dementia, and the person's family or other natural supports.

Example of several independent providers when someone is living in their own home:

- Jane is seeing a cardiologist for heart problems, her primary care provider (PCP) for other chronic conditions, a home health speech therapist (ST) for swallowing problems, and a private care aide for activities of daily living (ADL) assistance. Each provider assesses from their discipline's perspective the developments and implements a plan for Jane. The benefit here is that Jane is accessing multiple kinds of needed care: medical including cardiac, ST, and ADL help.

How this can become a challenge:

- It is entirely possible that none of these individuals are aware of the other's involvement in the care of the person living with dementia. Unless the professionals specifically ask Jane or her family, it may not occur to Jane to mention the other professionals. Even if asked, Jane may not recall who she sees for what due to her dementia. Potential problems include Jane cannot swallow all of her pills but the cardiologist assumes that she is taking all of her medications as prescribed. This leads her to increase doses based on this misunderstanding; the care aide is putting some of Jane's pills in orange juice without realizing that some pills are inactivated due to the acid in orange juice. Then there is an acute crisis caused by not receiving enough cardiac medication. Jane is hospitalized, and most of her medications are restarted as prescribed though the doses of some are increased further resulting in a significant inadvertent overdose. Those healthcare providers in the hospital cannot easily figure out what is happening in a way that is quickly helpful to Jane. She ends up with a much longer hospital stay leading to muscle loss and functional decline. Her ability to ambulate deteriorates, and she is not safe to return home.

How this challenge could have been different:

- Jane's daughter accompanies her mother to most of her medical appointments. When she is unable to do so, she calls the healthcare professional's office prior to the visit and gives an update to the medical assistant in the office with details about the medications her mother is taking or not taking and a list of all other healthcare providers and their contact information currently involved in her mother's care. She makes sure to get a report from the ST as well as the cardiologist, PCP, and other people involved in her mother's care, and she personally makes sure that information is provided where needed. Jane's daughter is acting as Jane's care manager in this role. It takes time, effort, and financial resources for Jane's daughter to make sure her mother's needs are met. This may not help with Jane's swallowing problems but the excessive medications in the hospital could be prevented.

Multidisciplinary Care

Multidisciplinary teams consist of several individual clinicians from different disciplines who independently evaluate and develop a plan of care for a person's problems that fall into their own area. These care plans are implemented parallel to one another, and there is no specific consideration of their mutual interactions. The assessments and plans are provided to all team members, and there are team meetings, though not every team member will attend them. One advantage of this model is access to multiple different clinical points of view. Team members theoretically can use informal relationships to improve the general knowledge of other team members. One challenge of this structure is that there is often no unifying philosophical framework. Some of the team members will likely feel pressure to adapt their own clinical

lens to the culture of the dominant discipline. An example of disciplines with varied philosophies includes the differing cultures of nursing, social work, medicine, and rehabilitation. Each discipline has its own tradition, language, and terminology that may clash with another's. Often the PCP is thought

Example of a multidisciplinary team when someone is living in an assisted living facility (ALF):

- John has been told he has a mild form of dementia. He has a PCP for acute and chronic health conditions who wrote the admission orders for him to move to the ALF. There are aides at the ALF who provide him with ADL help, there are medication aides who administer all of his prescribed medications to him, there is an activity director at the ALF who did an assessment and provides activities for all of the resident's to attend, meals are provided by the ALF, and there is an RN at the ALF who can assist with medication questions and communication with his PCP. John has a service plan at the ALF, and he and his daughter have attended meetings together with the ALF staff to discuss his care needs and how he is doing.
- As is common with most of those with dementia, John is having sleep problems. He tells his daughter about this, and she buys him an over-the-counter sleep aide without realizing that it is anticholinergic and worsens confusion in most older adults, especially those with dementia. Because it is an over-the-counter medication (OTC), it does not occur to her to tell the ALF or his PCP.

How this can become a challenge:

- John becomes more acutely confused and accuses his neighbor of stealing from him leading them to have a physical altercation. The RN who is present at the assisted living 2 days per week comes in for her regu-

lar shift and is told that John is having aggressive behaviors. She is unaware of the new OTC medication. She goes to talk to John and finds that he is extremely anxious. She calls his PCP and asks for medication for anxiety. The PCP writes a prescription for an antianxiety medication that leaves John more confused and at higher risk of falling. He does fall and is hospitalized for evaluation. The assisted living tells his family that John is no longer a good fit for their facility and requests that they find a different setting for him to live in.

How this challenge could have been different:

- As soon as the RN at the ALF realizes that John is acting very differently, she asks him what has changed. John states only that the neighbor is now stealing from him. The RN also calls his daughter to ask her if she knows of anything being different for John. She is told about the new sleep medication. She lets John and his daughter know some of the problems with these medicines. She asks John's daughter to come and remove this medication from John's room. The RN makes an appointment for John to see his PCP about his sleep problems as well as what happened with the OTC pill including the delusion about theft. The PCP does a full assessment of John and his medications. He orders functional cognition testing and a home safety evaluation from occupational therapy (OT) to make sure John has what he needs to succeed at the ALF.

of as the team's medical leader though the PCP is unlikely to attend a routine team meeting.

When a multidisciplinary team is used in the care of someone with dementia, it is especially important that family members or other natural supports are included as members of the team and educated about sharing concerns they have

or learn about. It is important that they know that the ALF and PCP need to know about all medications even those from the corner drug store. Even if not all members of the team are in the same meeting (such as the PCP), there is coordination of information among everyone on the team.

Decision-making can become "siloed" where one discipline does not seek nor value input from other team members. For example, if the PCP in the example above did not listen to the concerns of the ALF nurse and did not consider all the factors that were involved in John's recent reaction, he may not have ordered the OT assessment to maximize John's ability to stabilize at the ALF. A common example is when there are multiple medical specialists involved in caring for the same person, but they prescribe medications that counteract each other. The older adult with dementia may suffer and families may be confused. End-of-life issues are a particularly vulnerable area where siloed care can be a source of long-lasting distress and self-doubt for the person with dementia and their families. The chapter on palliative care has information about advanced care planning and other factors to consider that may decrease distress when one's dementia advances. In addition to communication challenges and the risk of competing priorities and medical interventions, interpersonal conflict occurs more commonly in multidisciplinary team. This is especially so when there is uncertainty about the expected role of each team member and the existence of different value systems [6].

Interdisciplinary Teams

A more collaborative and interactive model than multidisciplinary teams are interdisciplinary (also known as interprofessional) teams. The hallmark of the interdisciplinary team approach is a group from varied professional backgrounds collaborating with unified goals and a common purpose. Resources and decision-making are shared as well as the responsibility for outcomes. This approach is a preferred

decision-making and care planning model when working with older adults with complex medical and social needs. There is greater potential for creative problem-solving when those with varied training and experiences can work on meeting the care challenges that naturally occur in those with dementia. A high-functioning interdisciplinary team will have a process for professionals to develop an integrated and cohesive plan to assess and address the needs of those with dementia [13]. The strength of the interdisciplinary team is based on the depth and creativity of discussion and the ability to be flexible and adjust to the changes that the person with dementia will experience. This model involves an interdisciplinary team providing multicomponent interventions with a shared understanding. The goal is delivery of person-centered care to those living with dementia and their caregivers using comprehensive assessment tools to measure signs and symptoms, meet needs, and monitor interventions and the individual's response. Care protocols need to be driven by person-directed goals and a shared decision-making process with measurable outcomes and quality indicators. The interdisciplinary team can provide the most comprehensive care. Note that collaborative care is defined differently among differing healthcare disciplines. Current evidence supports improved outcomes with the collaborative care model in primary care. Collaborative primary care usually involves teams of physicians, nurse practitioners, nurses, and social workers. Case management and care coordination are key factors. When collaborative care focusses on working with those with dementia, disciplines that have been involved include occupational therapy, geriatricians, pharmacists, physical therapists, psychologists, geriatric psychiatrists, applied behavioral analysts, personal care aides, nurses, and dieticians, among others. Each member of the care team provides their own vision of the situation, providing explanation and problem-solving to enable the person and their caregiver's broad support, comprehensive assessment, and care planning. It is important to remember the importance of including and consulting other members of the team that are often forgot-

ten, including the person with dementia, their family/natural supports, housekeeping, direct care workers, and dietary staff, when present. These sometimes-overlooked team members often have unique and intimate information that is extremely helpful in planning and implementing care approaches. The idea is to combine the strengths, knowledge, and insights of all team members while minimizing the chance of missed opportunities to improve care and communication [5].

Shared decision-making (SDM) is essential for truly person-directed and person-centered care: Essentially the person's priorities, abilities, character, and interests should inform all decision-making. SDM implies that the healthcare provider is acting as a consultant to the decision-maker – the patient. Many times, professionals and caregivers assume that a person with dementia is incapable of participating in and making decisions. SDM is different from substituted decision-making if the person's current wishes are not consulted [3].

Three ways those living with dementia conceptualized SDM were:

- Subtle support versus taking over
- Hanging on versus letting go
- Being central versus being marginalized or excluded

For many people with dementia, the participation or "sharing" in the decision-making process is as (if not more) important than making the decision itself [3].

Interdisciplinary team care involves a partnership between all involved health providers and the person and their family or natural supports participating collaboratively. Shared decision-making regarding both health and social issues is essential to full team partnership. Interdisciplinary collaborative practice depends on synergistic communication and decision-making. Each profession shares their own knowledge and skills. Ideal elements of collaborative practice

include shared responsibility, accountability to each other, coordination of efforts, regular communication, cooperation with each other, assertiveness in expressing thoughts and ideas, shared autonomy, and, finally, mutual trust and respect. It is this partnership of an interdisciplinary team working toward common goals that leads to improvement in clinical and functional outcomes for the person living with dementia. Collaborative interactions exhibit a blending of professional cultures and are achieved through sharing skills and knowledge. Success depends upon all team members recognizing each of their roles as important to the team. Further, open expressive and receptive communication, the existence of autonomy for each team member, and equitable access to resources are key. Poor interdisciplinary collaboration can have a negative impact on the quality of care. Thus, skills in working as an interdisciplinary team are quite important for high-quality care [2]. Interdisciplinary team care implies that everyone has some ownership for each part of the care and the whole team is responsible for all tasks and assessments. This distribution of responsibility is a major risk point in interdisciplinary care. When something is everyone's responsibility, it can become equivalent to being no one's responsibility. This is one reason coordination, comprehensive communication, and having a specific person assigned to verify every task's completion are vital to team success [14].

Collaborative Interdisciplinary Teams

Interdisciplinary teams are studied in several diverse types of settings. One effort is the Marian S. Ware Alzheimer Program at the University of Pennsylvania. This philanthropic and university partnership was designed to advance knowledge in four areas. They sought to improve the integration and continuity of Alzheimer's disease care, identify biomarkers for early diagnosis of Alzheimer's disease and related neurodegenerative cognitive disorders, use clinical trials to more effectively test new Alzheimer's disease interventions and

translate them into real-world clinical practice, as well as discover disease-modifying treatments for Alzheimer's. The Ware Program focused first on using an interdisciplinary team to address acute illness episodes in those with dementia. These types of hospitalizations are frequent, disruptive, costly, and often associated with poor outcomes. Specific areas of concern are accelerated cognitive, physical, and functional decline that occurs in those with dementia and the high rates of adverse events and rehospitalization. The Ware Program used an interdisciplinary team of scholars from nursing, medicine, healthcare economics, and biostatistics to design interventions to better address the complex care needs of this high-risk group of individuals and their family caregivers. They also focus on increasing the efficiency of the healthcare system. The program uses their findings to influence healthcare policy and improve clinical practice. This led to the development of the transitional care model (TCM) for those with dementia and their caregivers. The TCM uses a person-centered approach by focusing on identifying older adults' health goals, coordinating care before, during, and after every episode of acute illness. The TCM model evolved from a multidisciplinary model to an interdisciplinary model involving physicians, nurses, other healthcare staff, as well as the person and their caregivers working together. A major component of this model is the development of a specific, clear care plan and involvement of the person and their caregivers on the planning, details, and implementation of care. They were able to show fewer hospitalizations as well as fewer rehospitalizations. These results are cost-effective, but more importantly these types of outcomes decrease stress for those living with dementia and their caregivers, decrease risk of more rapid decompensation, as well as minimize those with dementia having to endure painful medical procedures that do not offer them a benefit in quality or quantity of life [12].

One particularly robust example of the interdisciplinary team model is the Program of All-inclusive Care for the Elderly (PACE). There are now 124 PACE programs operating 255 PACE adult day health centers in 31 states [10].

PACE programs serve frail older adults, known as program participants, who meet state Medicaid criteria for nursing home level of care through a specific Medicare PACE program. To enroll in a PACE program, one must live in the service area of the PACE program and be able to be cared for safely in the community (not a nursing facility) with the supports of the PACE program at the time of enrollment. Most PACE enrollees are dually eligible for Medicare and Medicaid and many have a dementia diagnosis. PACE uses an interdisciplinary approach to care with a specifically large interdisciplinary team (known as the IDT). The IDT consists of a medical provider (including nurse practitioners in some states as well as physicians), adult day health center and home care nurses, personal care aides, master's level social workers, occupational therapists, physical therapists, activity coordinator or recreational therapist, dietician, drivers, home care coordinator, and day health center manager. The IDT operates collectively in a care management role. IDT members jointly and regularly assess and reassess participant needs. Based on these assessments, care plans are developed and regularly updated. The model honors an individual's wishes to live in the community as much as possible. Being much more risk tolerant than most traditional healthcare is essential for a PACE IDT. Another way to view risk tolerance is seeing choices as participant centered, allowing frail older adults to make choices that might have greater risk but are aligned with a person's values and wishes. The interdisciplinary team develops a unified care plan. This care plan is the central organizing document describing all care provided to the participant. When indicated, other services such as PACE employees, or other contracted providers provide speech therapy and behavioral health services. This ensures that all medically indicated services are delivered in a person-directed way. Additionally, the IDTs monitor participant status and care, adjust services, track quality and costs. Considerable staff time is devoted by team members to formal and informal idea and information exchange. The structure and process of team care in this model are firmly grounded in what has been referred to as a "geriatric interdis-

ciplinary team." This type of team care has been found to be particularly effective when working with older adults who have significant multiple disease states. Group decision-making and consensus building, inherent in such teams, facilitate better care management and service performance. An emphasis on providing significant care to maintain function is one key component of this chronic care model rather than focusing on acute medical events. Ongoing rehabilitation and other services are not limited to those who continue to improve. Another key to successfully meeting frail older adults' needs is identifying when it is appropriate to shift the goals as the end-of-life nears. Evaluations have shown that PACE program participants experience a higher quality of life and greater confidence in their ability to maintain control of their lives and deal with day-to-day problems, in part through spending fewer days in hospitals and nursing homes [8].

The Indianapolis Discovery Network for Dementia has developed a team-based pathway through the Healthy Aging Brain Center in Indiana. This team developed a care pathway starting with an initial cognitive assessment which includes neuropsychological testing, brain imaging, medication review, and structured neurological and physical evaluations. An important part of the team is the person with the neurocognitive disorder. The person living with dementia and their family provide context, life philosophy, and personal details which inform all aspects of the treatment plan. The personal treatment plan that is developed includes recognizing potentially harmful medications, prescribing new medications where indicated, initiating brain and physical exercise regimens, training in problem-solving, and working on reducing stress to improve daily life. Physicians, nurses, social workers, occupational therapists, and other staff members work closely with both the older adult and family caregivers. Both the evaluation and the plan include information obtained from the exam room and the home. Communication occurs face to face, as well as over the phone and via email. The goal for both brain and physical health is to deliver care to improve and restore function where possible, maintain function when

able, and support as functioning declines. Even as functional abilities of the person decline, resilience and support can be built into the environment around the person and their family through the collaborative efforts of the person, their family, and the interdisciplinary team members. The Healthy Aging Brain Center care model also provides additional resources to the primary care physician for more effective and efficient management of the patient's dementia and/or depression, reduces emergency department visits and hospitalizations, and encourages the use of medications that are not harmful to older brains [1, 4].

Responsibilities and Relationships Among Different Team Members of an Interdisciplinary Team

The art of a successful team when caring for someone with dementia is collaboratively combining expertise, talent, and perspective of all team members to assist and support the central member of the team, the person living with dementia. The various healthcare members assess the person functionally, medically, and socially. Treatment and intervention options are described to the person and their caregivers so that choices can be made which are consistent with the person's cultural values and personal beliefs using an SDM model. Discussion of potential roles for various team members working with someone living with dementia will be reviewed. Figures 2.1 and 2.2 are examples of common interdisciplinary care teams for those living with dementia.

Members of an IDT

The Central Member of the Team Is the Person Living with Dementia Themselves For an empowering care plan, one needs comprehensive information on the social history of the

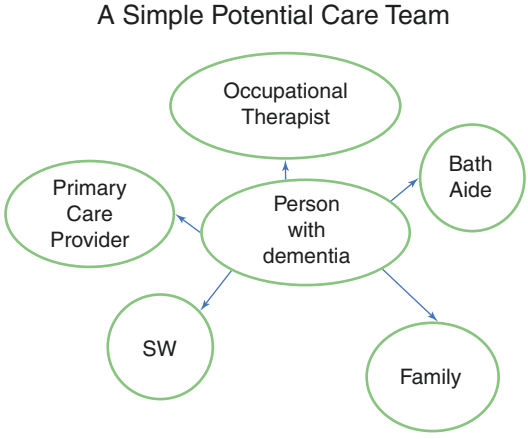

FIGURE 2.1 Example of a common interdisciplinary care team when someone is living in their own home or with family (Copyright Maureen C. Nash, MD. 2018)

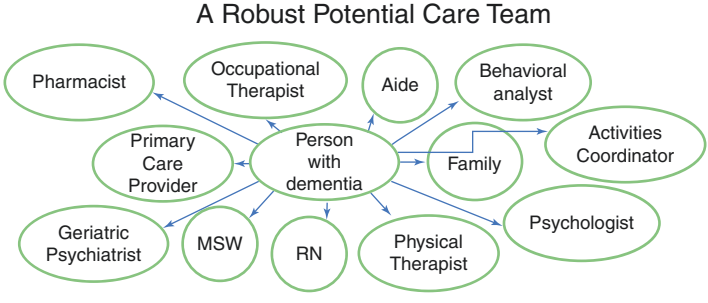

FIGURE 2.2 Example of a common interdisciplinary care team when someone is living in a facility experiencing more significant NPS (Copyright Maureen C. Nash, MD. 2018)

person, career details, support networks and involved family members, information sharing agreements, details of all medical conditions, and medications. One needs to know what the person understands about their dementia and what they expect to occur in the near and midterm future. Any specific goals and actions for how the person plans to manage

his/her health and well-being and the support available to them should be identified. Periodic updates to the support team need to be made as family, friends, and professional staff enter and leave a person's life. If the person was diagnosed early in the course of the disease, then they will be able to more fully participate in providing information. Some people may wish for a referral to a research center specializing in dementia care, hoping to improve the knowledge available for future generations. When a diagnosis is first made, it is timely to help a person identify personal, unfinished business and think through what actions make sense. If the diagnosis occurs later in the disease process, family, friends, and other natural supports may need to fill in details. Regardless of the stage of the disease, it is always recommended for people with a life-limiting condition that there should be conversations about the person's goals of care and advanced care planning. When someone lives to the late stages of dementia, the person may lose the verbal and cognitive skills required to express their wishes. In that case, identifying past wishes and philosophy are important. It is also vital to continue to listen to the communication of a person's wishes by observing and analyzing behaviors. As stated in the first chapter, all behavior has meaning. For example, the person may refuse therapy, even when approached in a skillful manner, or may begin to refuse to eat. This is where a good, collaborative team can shine, sorting out what the person is telling them with their behaviors. Appointing a healthcare power of attorney and recommending consideration of a financial power of attorney should be reviewed. It is important for the person with dementia to document who they want to make decisions for them if they cannot make them for themselves. It is also essential to encourage healthcare powers of attorney and next of kin to have open and honest discussions around future end-of-life choices.

Each professional member of the team first considers what their discipline contributes to the assessment and care recommendations. Which of the person's goals are being addressed

and what is the evidence that the suggested interventions will help move toward the goals the person has outlined? Clearly delineate the treatment objectives specific to this person, currently, for all recommendations as well as what evidence supports the recommendations. Consider whether there are missing team members and consider need for other consultants depending on the specific situation. Review what other information is needed from the person or their family to guide ongoing care. Whenever there is a transition from one care setting to another, for example, moving from an independent home to an assisted living facility, or a transition from one healthcare professional to another, such as changing primary care providers, there are many risks of loss of information and disrupted continuity of care. Also, whenever a person has a change in condition, either their health takes a significant turn for the better or for the worse, assessments need to be repeated and goals readdressed. Risks around transitions are multiplied when the person has neurocognitive deficits because their ability to communicate their history may be compromised. The person may not be able to convey their goals or desires clearly compared to other times in their life.

Primary Care Provider (PCP) May Describe a Physician, Nurse Practitioner, and/or Physician Assistant Their role centers on being the first point of contact for the assessment of acute symptoms and following those with chronic conditions providing ongoing continuity of care. There is also a component of care coordination whenever specialist care is needed. This becomes especially important when working with older adults having multiple medical comorbidities where the US has many healthcare guidelines. This information is one vital part of the care plan. Changes in condition, unusual or atypical presentations, are often assessed first by the medical members of the team. Tests including imaging, lab work, and other medical procedures are considered and ordered when indicated and consistent with the person's goals of care after shared decision-making discussions. Referrals to other consultants are coordinated as needed. Information after evalua-

tion and testing is communicated to members of the team and incorporated into the care plan.

Occupational Therapist (OT) Uses Objective Evaluations to Determine Individual Strengths, Impairments, and Performance Areas Requiring Intervention OTs are experts at evaluating creative ways to compensate for deficits and then can adapt the environment or use strategies so that a person's strengths can best serve their goals. Specifically, OTs focus on four areas: health promotion and maintaining strengths, remediation interventions to improve the performance of activities of daily living and functional mobility, assist with maintaining habits and routines to prolong independence, and modifying the environment to be as supportive and safe as possible. OTs use critical and creative thinking to ensure the environment is best suited to enhance functioning. Information after assessment is communicated to members of the team and incorporated into the care plan.

Registered Nurses (RN) Most Often Serve as Care Managers When Working on a Transdisciplinary Team Working with Someone with Dementia They help to plan, coordinate, and implement the overall approach to care. Other specific tasks may include nursing assessments, memory testing, skin and wound checks, explaining instructions and follow-ups, medication reconciliation, coordinating care aides, and assisting with information exchange between healthcare professionals, as well as with the person with dementia and their family. Education about medical problems and tasks such as wound care and foot care often fall under the purview of RNs. Information after assessment is communicated to members of the team and incorporated into the care plan.

Social Workers (SW) Are Experts at Gathering and Integrating Biopsychosocial Information into the Care Plan The initial social work assessment is a comprehensive biopsychosocial history including significant life events (family of origin, relationships and family, employment, lifestyle preferences and

values, spirituality) that the person has experienced throughout his/her life. This initial assessment will note behavioral health issues including any history of trauma. The social worker explores what is important to the participant as they approach this phase of their life with dementia. Cultural, racial, gender, social, and other value beliefs and preferences are essential components of a person-centered care plan. The social worker contributes perspective and knowledge about the individuals and current emotional stability, quality of life factors, living environment and how it supports the person with MNCD, family system, and coping. The social work perspective is generally a strength-based assessment that parallels the person-centered care planning. The social work contribution to the care plan is a collaborative process including contact with the participant's family and caregiver for collateral information and assessment of the family and caregiver needs.

Housekeepers Work to Organize and Clean in a Person-Centered Way This is an example of a nearly invisible member of an interdisciplinary team in a facility setting. A housekeeper may be the first person to notice when someone is no longer engaging with their environment. This person will see that nothing has been moved or that the person used to engage in brief social interactions but is no longer doing so. A housekeeper can help implement a care plan by engaging someone in meaningful conversation about books or other belongings. This staff member can ask the person living with dementia for their opinion, letting them be the expert for example. A housekeeper is likely to see someone multiple times per week, giving them keen insights into a person's habits and routines and able to let other team members know when something has changed.

A geriatrician or physician specializing in care of older adults or gerontologist, an MS or PhD in gerontology or related field, can be a valuable consultant if one is not on the primary team caring for the person. This type of consultant can be especially valuable at the beginning of developing a care plan or at major

times of transition. These specialists have the background to describe familiar challenges and point out areas commonly challenging for older adults. Care of elders is a specialty that requires a deeper yet broader knowledge of who the person is and was and realistic goals for the future. Lacking the focus in deciding on a plan of care can lead to siloed, inappropriate, costly, and painful interventions.

Pharmacists Are Experts in Medications and Drug Interactions They have the background to review and help coordinate prescription and over-the-counter medications as well as assess a person's ability to safely self-administer medications. Review of the medication list can reveal medications that may be worsening cognition, behaviors, and other medical symptoms. The pharmacist can give tips on when to take or avoid certain medications, review for drug-drug interactions or drug-disease interactions, and bring questions and issues to the attention to the person and other care team members.

Psychiatrists and Psychiatric Mental Health Nurse Practitioners Who Have Experience in Geriatric Care Are Experts in Assessment of Neuropsychiatric Symptoms in Those with Mental Illness as well as Dementia These professionals often have a long history of working collaboratively in team environments. They are experts in knowing when to use or avoid medications especially for neuropsychiatric symptoms. Psychiatrist's training overlaps the training of neurologists. They have significant education and experience in working with both neurologic and psychiatric illness. They have experience and expertise at discerning delirium from dementia and are often knowledgeable on drug-drug and drug-disease interactions in this population. Most geriatric psychiatrists and neuropsychiatrists have extensive experience in working with those with dementia.

There are many other potential members of an interdisciplinary team. The exact composition of a team will depend on the past, current, and expected future challenges that a person has as well as where they are living and with whom. It is

quite important to periodically reassess the team members, matching the current needs of the person living with dementia to the available resources.

Measuring Outcomes of Interdisciplinary Collaboration Around Older Adults

The overall effects of interdisciplinary interventions for older adults are generally positive, but assessment of interdisciplinary care is based on heterogeneous outcomes. Most of the evidence has come from nursing homes, hospitals, and primary care homes as well as specialized programs such as PACE programs. There is evidence that interdisciplinary care can lower overall healthcare costs. Other outcome indicators of interdisciplinary care for older adults showing the most positive effects include measures of collaboration and at the level of the person's experience. Outcome indicators which are key elements of collaboration include improvements in professional and personal satisfaction as well as the quality of care. On the individual person's level, outcome indicators with the most evidence include decreased pain, decreased fall incidence, improved quality of life, maintenance of independence for daily life activities, decreased depression and agitated behavior, decreased transitions of care, decreased length of stay in hospital, decreased mortality, and decreased period of rehabilitation [13]. PACE programs with their extensive interdisciplinary teams have demonstrated decreased cost of care while improving quality of life as evidenced by increasing the amount of time living in a community setting. Surveys indicate that comparison of other home- and community-based services enrollees with PACE enrollees showed that PACE participants had better health management outcomes including having advanced care planning documents such as advanced directives and healthcare powers of attorney in place, reported less pain that interfered with normal daily functioning, and reported fewer unmet needs in getting around and dressing [9].

Communication: Central to all Teamwork

All well-functioning teams communicate regularly and clearly. Structured communication enables consistent, succinct, and respectful sharing of information. This allows for a shared understanding of the current situation and plan as well as enabling the incorporation of added information and regular updating of the care plan. The foundation of collaborative interdisciplinary teams includes trust, respect, shared accountability, and shared decision-making. All of these require effective communication among team members.

Huddles are a common check-in communication tactic. They are short, daily sessions for the care team to rapidly prepare for managing the day. As an excellent form of communication, it is most often used in a facility setting or a provider's office but could be adapted for use in a person's home when there are different team members handing off duties to each other. Huddles are often quite brief such as 5 minutes at the start of a day. Topics may include anything from adjustments to workflow or schedule, crisis management, and special challenges that are expected to arise. In a clinic setting, these will often be documented, perhaps in the electronic health record. Others use a white board to note agenda items throughout the day for the next day's discussion. Patient-centered medical homes are required to document huddles. In an ALF, Memory Care Unit (MCU), or NH, huddles can be used to quickly relay community-wide events or planned disruptions, as well as passing on brief updates about community members.

Team meetings are more formal meetings to review current information, regular reassessments of the person's situation, and care plan and/or to make decisions. Training might be included in this category of communication. When the person living with dementia is attending, special efforts are needed to make sure that the pace and content of the conversation is appropriate to the person's needs. Remember that SDM research has shown how much people living with dementia value being a participant in the discussion rather than being talked about or talked over.

Family conferences are a common and foundational forum for communication. Healthcare professionals, including the

Outline for an Initial Care Conference After Assessments

- Introduction of everyone and their role.
- Review purpose of meeting and the time frame available.
- Presenting problem, if any, that started assessment process.
- Outline of tests and assessments performed with explanations of results in lay language.
- Diagnoses.
- Stop and address any questions up to this point.
- Discuss trajectory of disease and where person is at this time.
- Review expected timelines for future when known.
- Discuss potential behavioral and pharmacological interventions.
- Answer questions.
- Explore fears, hopes, and aspirations for the future.
- Review and agree on next steps.

care coordinator, community representatives, the person and/or their family, and other natural supports meet to discuss options for treatment, to help the patient and family prepare for a significant change in lifestyle or to face a life-changing event. Careful preparation is needed to ensure a successful conference. Important tools that are complementary to such conferences are shared decision-making and patient self-management tools [11]. It is also important to remember that the definition of family or other natural supports will vary from one individual to another.

There are many different tools available to improve and structure communication. It is important that the interdisciplinary team has several different standard types of communication habits. Regular team meetings where a set agenda and process for discussion helps keep communication clear. Tools around contingency planning and ways for team members to discuss acute or unexpected changes are important. Also, com-

munication tools for those who are off-site as well as those within a single facility need to be explored and agreed upon ahead of time. Additionally, ways to communicate during an emergency are important for everyone to know. This enables communication to be appropriate to the situation, happening at the right time, in the right way to meet the needs of the person living with dementia and all those involved in their care [7].

This chapter reviewed some of the advantages of a highly functioning interdisciplinary team approach for those living with dementia. There is good evidence that an interdisciplinary team allows access to high-quality care, an improved quality of life, and improved satisfaction with healthcare. Those living with dementia benefit from a specialized shared decision-making approach. The center of every team is the person living with dementia. The composition of a team will always depend on the specific person and their situation. Finally, the importance of communication is emphasized.

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