Integrating Care Across Disciplines

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KEYWORDS

• Interdisciplinary care • Geriatrics • Heart failure • Team

KEY POINTS

- The goal of the interdisciplinary team is to work in a patient-centered manner to manage patient symptoms and prevent complications and readmissions.
- Members of the interdisciplinary care team include physicians, nurses, social workers, pharmacists, dietitians, and physical and occupational therapists.
- Interdisciplinary care can take place in the hospital, outpatient clinic, at home, or remotely via telemonitoring.
- In patients with heart failure, interdisciplinary teams are effective at preventing exacerbations and readmissions, and can improve the quality of care.

INTRODUCTION

Interdisciplinary teams (IDTs) are found throughout modern complex health care systems.[1] They function in acute care hospitals, ambulatory care clinics, home care settings, nursing homes, and hospices. They are often found in disease-specific areas, such as diabetes or cardiovascular clinics, or in cancer centers, and in site-based care programs, such as home care or postacute transitional care programs. IDTs are key components of patient-centered medical homes in primary care[2] and in some specialty care settings, and multiple types of IDTs are part of the infrastructure of organized systems of care such as managed and accountable care organizations.[3] This article focuses on those IDTs in care settings that deal with older adults with cardiovascular disease (CVD) and multiple chronic conditions (MCCs). It reviews the history and structure of such IDTs, and the components of effective IDT care and its barriers. This article provide an overview of team care in CVD, and discusses heart failure (HF) IDTs in some detail because IDT care in HF has been extensively studied and widely implemented, and evidence for efficacy and effectiveness is available.[4]

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The health care professionals comprising IDTs work together to implement a coordinated plan for each patient.[5] Historically, a distinction was made between IDTs and multidisciplinary teams, which were considered to involve members working separately and without collaborating on a treatment plan. However, given the rapidly increasing complexity of the health care system, the aging of the population, and the increase in the number of older adults with MCCs, it is now clear that IDT–based health care in which team members work together to meet the complex needs of patients is essential to safe and effective patient care. IDTs bring together practitioners with a diverse set of skills and specialties (such as physicians, nurse practitioners, social workers, and physical therapists), and can provide measurable value to patients.[6] Multiple providers are needed on the care team because no single profession provides practitioners with the resources or educational background to handle all aspects of care for a patient.[7] In a 2006 position paper, the American Geriatrics Society noted that interdisciplinary care is important for older adults with complex comorbidities.[8] More recently, principles and models of effective team-based care were described by an Institute of Medicine discussion paper (2012),[1] and IDT care is fostered and promoted by national organizations such as the Patient-Centered Primary Care Collaborative and the Interprofessional Education Collaborative.[9–11]

HISTORY OF INTERDISCIPLINARY CARE FOR OLDER ADULTS

Geriatrics has been on the leading edge of the development of IDT care. Since the 1940s, IDTs have been instrumental in managing geriatric patients at home.[11] Team training in health care was adopted early by geriatric medicine and gerontology, and the Health Resources and Services Administration was issuing grants related to teaching collaboration and teamwork in geriatrics as far back as the 1980s.[12] On the inpatient side, IDTs in geriatrics began in the 1970s, even before Medicare reforms, because hospitals experienced bed shortages when patients had extended lengths of stay waiting for nursing home placement. The geriatric IDTs of that era helped to facilitate discharge planning and ease this problem.[13]

Geriatrics also developed comprehensive geriatric assessment (CGA) in the inpatient, ambulatory and home care settings[14–16] in the 1990s. Many types of comprehensive assessments with variable methods of assessing and managing problems were tested. This early geriatrics model advanced the approach to care of complex patients by pioneering patient evaluation in multiple domains, including medical, pharmacologic, and psychosocial. Importantly, CGA pointed out the importance of functional and cognitive evaluation of older adults, and is foundational to many care models that are now in widespread use. IDTs were and are a fundamental component of CGA because the complementary skills of different team members improve the quality of assessments.

Cardiologists dealing with older patients with HF and complex health care status also realized the importance of IDTs for these patients. HF clinics began to appear in 1983, but became more respected and widespread after a seminal study by Rich and colleagues[17] in 1993 found that patients who were part of a HF IDT clinic intervention had both fewer readmissions and decreased length of stay. In 2004, Naylor and colleagues[19] showed that nurse care coordination can improve the transition from hospital to home and reduce complications.[18,19] This nurse care coordination can also address lapses in communication among providers and between providers and patients and caregivers. For example, physicians may not properly educate patients and caregivers on medication regimens, and/or may not recognize enhanced vulnerabilities of older patients with HF because of their comorbidities, cognitive impairment,