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# MS Progress Notes...

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## INTERDISCIPLINARY CARE IN MULTIPLE SCLEROSIS

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The term interdisciplinary is used to refer to a wide variety of practices involving more than one health profession. "Interdisciplinary" has been used interchangeably and incorrectly with multidisciplinary, collaborative, and team.

Interdisciplinary Care (IDC), implies the following: learning, planning and practice are informed by understanding of the overlap of disciplinary competence and interrelationship of health issues. Disciplines meet to evaluate problems, set goals and interventions. Task assignment is flexible and based on competence, expertise, interest, talent of participants and circumstances. Disciplines work individually or jointly, learn together, and practice competence and identity not confined within discipline of origin. Work is integrated. IDC recognizes unique contributions of each participant and capitalizes on interrelationships.

A spectrum of models of disciplinary working relationships in addition to IDC includes: Unidisciplinary (each discipline learns, works alone); Multidisciplinary (disciplines meet, share information, assign tools, learn & work alone) Paradisciplinary (information exchanged; work alone); Pandisciplinary-single unitary discipline encompasses all (evaluation, educations, work, etc.)

A benefit of IDC is that the interrelationship of expertise and disciplines in education and practice match the interdependence of health needs and resources that the health professionals face. Another is that it illuminates problems from multiple perspectives and is thus better able to tailor solutions to patient's needs.

RATIONALE FOR INTERDISCIPLINARY CARE IN MULTIPLE SCLEROSIS. Multiple sclerosis is a complex disease which engenders a multitude of challenges in neurology, psychosocial intervention and neurorehabilitation. The IDC approach to MS has proven to be cost effective with decreased complications, nursing home admissions and acute hospitalizations. There has been documented decreased disability and handicap with increased independence and decreased caregiver burden.[1] The complexity and unpredictability of MS calls for numerous professionals with increasingly sophisticated roles. Caring for such patients is best served by a wellness approach that espouses maintenance of optimal health within the physical and emotional confines of MS. This approach must address the disease process - inflammatory demyelination of brain and spinal cord with immune modulation, immunosuppression, etc. its primary symptoms such as weakness, numbness, etc. with symptomatic therapy, its secondary symptoms e.g. urinary tract and respiratory infections, decubiti, etc and its tertiary symptoms such as vocational, avocational and marital problems. Providers caring for MS patients share common concerns and needs including the safety of patients and caregivers, lack of cohesive care planning, conflicting priorities and goals, differing and unrealistic expectations, feelings of frustration and of being overwhelmed, a lack of patient adherence to therapeutic and medication regimens; and need for education, communication and cost efficacy.

GOAL: The overriding goal in serving those with MS must be safe and optimal function and independence, a reduction of disability and handicap, and the maintenance of optimal health within the physical and emotional confines of MS. There must be consideration for quality of life and fulfillment of human potential, life goals, and the roles of the individual at home, work and in society. This vision includes the reestablishment of psychosocial equilibrium of the individual with his/her MS, the maintenance of relationships and finally the encouragement of a creative and productive life.

A MODEL OF AN INTERDISCIPLINARY TEAM – THE MT. AUBURN HOSPITAL MULTIPLE SCLEROSIS COMPREHENSIVE CARE CENTER (MAH MS CCC)

Embarking on interdisciplinary care for individuals with MS at MAH, a proposal for IDC was presented to the parent organization's administration. The extent of the problem was assessed. The Central New England Chapter of the NMSS provided figures from needs assessment data and has remained an integral support of the MAH MS CCC since its planning and inception in 1994. HIPAA-compliant space was needed for peer counseling, educational programs, and consultation/examination, storage and conference areas. The Care Center was allotted evening hours which helped to enfranchise caregivers and

facilitated transportation. The parent organization has provided for a nurse, a social worker and secretarial support.

TEAM RECRUITMENT: More important than experience, interest and commitment have proven critical for success. At MAH a seven-member team meets weekly, generating 21 working interrelationships. In addition to weekly meetings, a nurse coordinator and neurologist see patients throughout the week. The neurologist, serving as Medical Director, a nurse as Clinic Coordinator, a physiatrist (rehabilitation medicine), a psychiatrist, a social worker, a physical therapist and an occupational therapist comprise the team. There is regular participation of a durable medical equipment vendor and an orthotist. A speech therapist and Chaplin are readily available.

Process. The process begins with a screening evaluation that entails a detailed neurological assessment with focus on prior medical and rehabilitation management detailing participation and adherence of the individual and their responses to past interventions. Very few patients are screened out, predominantly those who have sabotaged prior attempts at comprehensive care and those with severe personality disorder unfit for team management. The prescribing physicians are responsible for ordering medication, therapies, durable medical equipment and referrals, with input from the entire team.

A nurse coordinator performs an in-person or telephone assessment and schedules appointments with necessary team members in the center. As much as feasible, "one-stop shopping" is achieved. In between appointments those with MS and family members/caregivers participate in educational and peer counseling programs. Periodic assessments are carried out as is follow up with various providers as indicated. The Neurologist and nurse see patients throughout the week in addition to weekly center sessions.

LEADERSHIP: At the MAH MS CCC a neurologist, the medical director, is the prescribing physician of record and is held accountable for care and education. The Medical Director facilitates relationships among team members, sets the agenda, addresses team conflict with consensus building and keeps the team on task, making sure that all members have been heard. Leadership is also provided by the nurse coordinator who arranges schedules; case manages care, and attends to nursing needs such as teaching immune modulation and self care skills. The nurse plays an integral part in patient/family MS literacy and reinforces program adherence. The nurse is the liaison with others dealing with the patient such as home care providers, and hospital case managers.

Each MS Center session concludes with a team care meeting. Assessments are presented, problems identified and solutions are offered and integrated into the care plan, with assignment of tasks to team members on the basis of interests, competence and circumstances. The team encourages the interests and expertise of its professionals and together its members enjoy cross stimulation with enriched creative problem solving.

The IDC team encourages independence and self-reliance, allowing those with MS to cope successfully and to learn from and be supported by the team. The team encourages health maintenance with responsibility on the part of those with MS in areas such as: stress reduction, regular exercise, healthy diet, reduction of unhealthy habits (i.e. smoking, overeating), and finally adherence to medical and therapeutic regimens.

ICD TEAM PRINCIPLES:

- Comprehensive teamwork
- Follow through and periodic evaluations. There is a need to monitor the effects of MS upon the nervous system (impairments), on disability (on activities of daily living) and on function within family, community and society (handicap).
- Communication must be ongoing to PCP and home health providers. Communication for team members includes "teaming up" once a week and via email and telephone. Family-team conferences are important so that everyone gets the same information at the same time. Patient and family input during goal setting is essential for adherence and success.
- The medical record includes team conference notes with details of decision making and task assignments and reports from each discipline, with copies going to primary care providers, referring neurologists and pertinent consultants.

OUTCOMES: The healthcare professionals working as a team provide hope, counsel, guidance and treatment to individuals with MS, assisting them in their quest for independence, safety and optimal function and health. This helps patients gain a sense of control over negative aspects of MS, to develop skills and strengths to compensate for lost function and to establish healthy, positive attitudes. An attempt is made to give the individual the feeling that the team is there to go the distance with them, offering a supportive environment and comprehensive consistent care.

In regards to the team itself, members experience enrichment of their professional practice and growth, as multiple needs, systems and disciplines interact. The team as an entity has ongoing development of competence, style and identity. Growth and morale are abetted with new challenges and programs (e.g. a caregiver support course, and a symposium presented to those with MS and their families), and by attendance at professional educational programs, and most of all by positive outcomes.

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