Dear Dr. Jeff: I keep reading about the “interdisciplinary team,” but at my facility the feeling is more that of a free-for-all. Getting different departments and different disciplines to work together seems almost impossible. Do you have any suggestions about how to make this work?

Dr. Jeff responds: Simply calling people a team doesn’t make it so. Actually, it is amazing to me that professional and non-professional staff coming from extremely varied educational backgrounds and training, representing different departments, different care philosophies, and certainly very different status positions, can work together at all.

Moreover, using the “team” metaphor, there is often no clarity as to who is the “captain.” In the office, physicians typically practice completely independently. In hospitals, except perhaps in a few acute care of elderly units, physicians are accustomed to making all the major decisions. A few of us, when we were interns, were smart enough to listen to the whispered advice of experienced nurses, but all too often, as physicians, we feel more secure in our role, so we “take charge.” The world of postacute and long-term care (PA/LTC) is, and should be, very different. After all, they are called nursing homes for a reason.

In PA/LTC, certain processes, such as completing the Minimum Data Set assessment and generating a care plan, encourage departments to function together. Section 483 of the Code of Federal Regulations mandates an interdisciplinary approach to care planning, but other than the requirement that a physician and a registered nurse must somehow be involved and communicate, the specifics are rather vague.

Physicians rarely attend meetings on care plans, so much of their communication with nurses about patients occurs without the presence, much less the input, of the other members of the interdisciplinary team. At many facilities, the various disciplines make their assessments in a vacuum, often entering their findings on different computers, and waiting for the nursing department to meld them into a care plan.

An expectation exists that dietary, social work, recreation, and other department personnel will ultimately sign the form so everyone can happily consider it ready for the patient’s chart. The attending physician is expected to sign the document without necessarily reading it. Finally, the care plan is enshrined in a book with those of other patients while a different reality is enshrined in a book with those of another patient, saying instead, “Aren’t there any other professionals in the facility to do resident therapy outside their traditional roles?” The world of PA/LTC embraces an incredible number and variety of thoughtful, knowledgeable, and creative individuals. All too often, the talents that they bring to the table are not fully utilized. And, in the end, it is the residents who suffer the consequences of this oversight.

Dr. Jeffrey Nichols, MD

By Jeffrey Nichols, MD

We Work Together, But Are We a Team?

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An expectation exists that dietary, social work, recreation, and other department personnel will ultimately sign the form so everyone can happily consider it ready for the patient’s chart. The attending physician is expected to sign the document without necessarily reading it. Finally, the care plan is enshrined in a book with those of other patients while a different reality proceeds on the units. All this creates the appearance of a team process but negates every potential benefit of true interdisciplinary cooperation.

Unfortunately, many forces within an institution work in direct opposition to effective interdisciplinary teamwork. There may be few rewards and sometimes significant punishments for being a team player. Although the facility’s mission statement may talk about quality care and service to the resident, the message given to senior staff may be quite different.

**Playing Positions**

The administrator will be evaluated by, and have his or her job security based on, the financial bottom line. Evaluations of the director of nurses may be based on state survey outcomes rather than quality measures. All too often, this encourages an approach of risk avoidance. The director of rehabilitation may be evaluated by the number of residents provided services and, literally, the number of minutes of rehab provided.

Medical directors are required to have two major roles. One is to consult on policies, and the other is to coordinate resident care. Although these might suggest support of the interdisciplinary process, the charge has been largely interpreted to be coordination among physicians.

Moreover, many facilities select medical directors primarily for their ability to bring in new admissions, whether these are from their own practices or from those of their colleagues, rather than for their medical knowledge or collaborative skills. Although it would be a violation of the Stark law to directly reimburse physicians for referrals, they often, indirectly, figure in the evaluation of performance.

No one would argue that financial losses can be ignored, deficient practices should be tolerated, or frail seniors should not receive every rehabilitation treatment that might benefit them. Nevertheless, the success of the team as a whole doesn’t necessarily figure into anyone’s bonus.

Although physicians are usually identified as the obstacles to collaboration, many administrators (especially those trained as nurses), and even more so the directors of nursing, are frankly unenthusiastic about disciplines other than nursing being involved in care planning and problem solving. I have been to facilities that were happier when the doctors were neither seen nor heard. They regarded a physician as an unpleasant formality in getting orders signed. Many facilities do not readily welcome social workers who consider themselves advocates for residents’ needs, or physical therapists who might interfere with floor ambulation schedules, or recreation therapists who push nurses to do resident therapy outside their traditional roles.

To further complicate this process, the knowledge and skills that different team members bring varies widely from facility to facility and sometimes from nursing unit to nursing unit. An experienced certified nursing assistant (CNA) may have a great deal more insight into what is going on with their resident than a newly graduated charge nurse, despite the registered nurse’s license.

On the other hand, seasoned nursing home charge nurses have often had years of knowledge absorbed from other disciplines, whereas the CNA staff leaves every 3 months to get a better salary flipping burgers.

The dietitian may have a sophisticated understanding of the nutritional needs of the frail elderly or be a moonlighting registered dietician who has been hired to come in on weekends to provide required documentation on charts. Similarly, the physician might be a perfectly competent community doctor who has never cared for a nursing home resident before, has never heard of OBRA ’87 regulations, and has no idea why other professionals in the facility might want to discuss the care of his or her patient, saying instead, “Aren’t there orders on the chart?”

**A Little Help**

Certainly, the movement toward having physicians specialize in PA/LTC, whether formally recognized with certifications or not, has the potential to elevate the entire interdisciplinary process. Also, many facilities are moving to models in which much of the primary care is provided by nurse practitioners, with physicians coming only for federally mandated patient visits or extraordinary problems. In this model, the care plan is still theoretically (and by regulation) formulated with the physician, yet the nurse practitioner would know the resident and their family best, and may be best suited for the interdisciplinary discussions.

JAMDA recently published a systematic review of nursing home interdisciplinary interventions (JAMDA 2013;14:471-8). Dr. Arif Nazir and a team of physicians from Indiana University (not an interdisciplinary team) performed an extensive review of the medical literature since 1990, looking for randomized controlled trials in nursing homes or nonpsychiatric residential care facilities that used an interdisciplinary approach. Outcomes of interest included decreased use of psychotropic medications, less undesirable patient behavior, reduction of falls, fewer hospitalizations, decreases in polypharmacy, and some others. The researchers identified 27 publications, of which only 10 came from U.S. facilities. Interestingly, although interdisciplinary care correlated with a statistically significant positive effect in 18 studies, it had no correlation in 7. In two studies, a significant negative effect was actually found. The authors suggest that in these two studies the interdisciplinary process might actually have drawn time and resources away from direct patient care. Although there was no consistent composition of the interdisciplinary teams in the successful trials, it appeared that medication-related interventions may have been more successful when a pharmacist was involved. Medications play an enormous role in American nursing homes, yet the clinical pharmacy consultant is not a routine member of most interdisciplinary teams.

Unless you are the owner or administrator of your facility, you cannot fix the problems you raise by yourself. Even if you have been part of the problem, simply changing your own behavior probably won’t change the team dynamic. The creation of an effective interdisciplinary process requires champions, but it particularly requires leaders who truly want this to happen. It has to be part of the care philosophy of the facility, a value, and a goal. Those who don’t play nicely in the sandbox need to be given a time-out, and those who work together effectively must be rewarded, certainly with praise, but probably with money as well.

The job of the “care plan nurse” who generates pretty pieces of paper with nice-sounding goals must be transformed. Because interdisciplinary care done well is time-consuming, this time must be factored into schedules and work assignments. And the structure of the team must be individualized to the facility.

The world of PA/LTC embraces an incredible number and variety of thoughtful, knowledgeable, and creative individuals. All too often, the talents that they bring to the table are not fully utilized. And, in the end, it is the residents who suffer the consequences of this oversight. In the short run, you should be comforted that you are trying to address a difficult but important problem.

Dr. Nichols is the medical director of Our Lady of Consolation and Good Samaritan Nursing Homes in Suffolk County, N.Y., and senior vice president for clinical effectiveness of the Catholic Health Care System of Long Island. He invites your questions for possible discussion in this column, to caring@elsevier.com.